NHS Ipswich and East Suffolk Clinical Commissioning Group

NHS West Suffolk Clinical Commissioning Group

NHS North East Essex Clinical Commissioning Group

Suffolk and North East Essex ICS
Clinical Priorities Policy

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Clinical Priorities Policy

SNEE/2020/042

Target Audience	Optometrists, Secondary Care consultants, Referral Service Triagers, Service Providers, Community Services, Public and Patients
Brief Description (max 50 words)	This policy sets out the funding arrangements for treatments/ interventions/ procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded. This policy should also be read in conjunction with the CCG Fertility Services commissioning Policy.
Next Review Date	December 2023

Review and Approval

Reviewed/Approved	Date	Amendment
ICS CPP Review Working Group	January 2019 – January 2020	Review of all Threshold, Prior Approval, Exceptional Clinical Circumstances Funding Policies to streamline ICS Policies.
IES & WS Clinical Scrutiny Panels	23 & 24 June 2020	Approved prior to consultation stage of review process
NEE Alliance Committee	7 July 2020	Approved prior to consultation stage of review process.
NEE Alliance Committee	4 May 2021	Approved prior to consultation stage of review process – Hip Injection and Cataract policies.
IES Clinical Executive Committee	11th May 2021	Approved prior to consultation stage of review process – Hip Injection and Cataract policies.
WS Clinical Executive Committee	2nd June 2021	Approved prior to consultation stage of review process – Hip Injection and Cataract policies.
NEE Alliance Board	7th Dec 2021	Final Approval given.
IES Clinical Executive Committee	15th Dec 2021	Final Approval given.
WS Clinical Executive Committee	10th Jan 2022	Final approval given.

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Statement of Overarching Principles
All Policies, Procedures, Guidelines and Protocols of the CCGs are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

Executive Summary, Purpose and Definitions

This policy sets out the funding arrangements for treatments/ interventions/ procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded.

This policy covers the following types of treatments/ interventions/ procedures:

Threshold & Prior Approvals – Those procedures which may be offered on a routine basis but only for patients who meet defined criteria agreed in a clinical protocol.

The responsibility for adherence to these policies lies with the referring and accepting clinicians and prior approval should be sought from the CCGs (see below) where this is part of the contracting arrangements.

Individual Funding Requests (IFR) - Those procedures which are not routinely provided by the CCGs and where provision is only possible on an individual patient basis.

For these procedures, the criteria listed form provide guidance to referring clinicians and the CCG commissioner. In instances in which eligibility is unclear the final decision is made through the application of the Exceptional Cases process.

Exceptional Clinical Circumstances (ECC) – These are procedures which are only funded in exceptional circumstances, (e.g. breast augmentation).

Applications for these procedures should be made to the Clinical Priorities Exceptional Case Team and should only be made where the patient demonstrates exceptionality.
The Exceptional Clinical Process cannot be offered where legal restrictions apply (e.g. Surrogacy).

Principles
Please read before making any referral.

In line with national health promotion messages and the Heath Education England messages in making every contact count the ICS policy is to promote the message that individuals can make changes to their own lifestyle which will significantly reduce the risk of ill health in the long and short term not just in relation to a referral for any elective treatments. We therefore actively encourage the promotion of stop smoking services, weight management opportunities and alcohol support services as part of all contacts for primary and secondary health services. Please refer to the Weight Management and Smoking Cessation Prior to Elective Surgery Policy.

General
The use of scoring tools prior to referral should be undertaken as a guide only however we request that the tool accompany referrals as part of a holistic understanding of the patient's

symptoms and impacts on the activities of daily living.

All patients being considered for joint replacement must be offered at least the core treatments for osteoarthritis (as per NICE guidance see recommendation 1.2.5), and give them information about:

- the benefits and risks of surgery and the potential consequences of not having surgery
- recovery and rehabilitation after surgery
- how having a prosthesis might affect them
- an understanding of how care pathways are organised locally to support their recovery

Please be advised that revision/cosmetic surgery will not be funded for purely aesthetic reasons or for predictable changes following pregnancy, including revisions following surgery as the result of pregnancy. Please refer to the "**Cosmetic Interventions: General Principles**" Commissioning Statement within this Policy Document. on the relevant CCGs website. Applications for these procedures should be made to the Exceptional Clinical Case Team and should only be made where the patient demonstrates exceptionality.

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Policy name	**Acne Vulgaris - Scar Revision**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Resurfacing and other surgical interventions
Included condition/ indication(s)	Facial scars resulting from acne vulgaris
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Acne vulgaris - scar revision

1. **Interventions covered by this policy**
   Resurfacing and other surgical interventions

2. **Conditions to be considered for treatment under this policy**
   Facial scars resulting from acne vulgaris.

3. **Eligibility criteria for provision of the intervention**
   Resurfacing and other surgical interventions which aim to improve facial scars resulting from acne vulgaris are considered low priority procedures and will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement - **Cosmetic Interventions: General Principles**.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for acne vulgaris scar revision. This may include the following conditions which are offered as examples to potential referrers and ECC panels (note: these are **not** referral criteria):
   - the patient has severe facial post-acne scarring
   - the acne is no longer active
   - primary care interventions have been ineffective

   Medical photographs will be required to support any application for funding.

6. **Compliance with NICE guidance**
   No relevant NICE guidance

7. **References**

7a. References included in original Suffolk / North East Essex policy / policies.
None

7b. Additional guidance referred to in production of ICS policy.
Hay RA et. al, 2016. Interventions for Acne Scars. Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD011946.pub2

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Policy name	**Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain**
Policy type	Threshold with prior approval
Included intervention(s)	Arthroscopic subacromial decompression
Included condition/ indication(s)	Subacromial shoulder impingement
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T49: Shoulder arthroscopy
NEE CCG policy	Shoulder arthroscopy

1. **Interventions covered by this policy**
   Arthroscopic subacromial decompression is a surgical procedure that involves decompressing the subacromial space by removing bone spurs and soft tissue arthroscopically.

2. **Conditions to be considered for treatment under this policy**
   Pure subacromial shoulder impingement: this means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy.

   It usually resolves with conservative treatment such as analgesia, shoulder exercises or a steroid injection into the joint.

3. **Eligibility criteria for provision of the intervention**
   Arthroscopic subacromial decompression should only be considered for patients who have subacromial pain when:
   - they have persistent or progressive symptoms
     AND
   - the patient's symptoms have not responded to non-operative treatment such as physiotherapy and exercise programmes
     AND
   - the potential benefits and risks of subacromial shoulder decompression surgery have been discussed with the patient and a shared decision reached as to whether to proceed with surgical intervention

4. **Exclusions**
   This policy does not cover:
   patients with 'red flag' conditions requiring urgent referral, such as a history of acute trauma, signs suggestive of an unreduced dislocation, or symptoms or signs suggestive of tumour or infection.

5. **Additional notes**
   This policy is based on 'Evidence-based interventions: guidance for CCGs' published by NHS England in November 2018.

   Please refer to the policy within this document that covers 'Shoulder arthroscopy for conditions other than pure subacromial impingement'.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for arthroscopic shoulder decompression.

Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of
this type of surgery.

A more recent prospective randomised trial comparing the long-term outcome (10 year follow up) of surgical or non-surgical treatment of subacromial impingement showed surgery to be superior to non-surgical treatment. Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails. There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines. A review of the literature identified one further systematic review that looked at the effectiveness of surgery. The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.

Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain (British Orthopaedic Association, 2014).

Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Coghlan JA, Buchbinder R, Green S, Johnston RV, Bell SN, Surgery for rotator cuff disease, Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005619. DOI: 10.1002/14651858.CD005619.pub2
- NICE CKS revised April 2015 accessed online via http://cks.nice.org.uk/shoulder-pain#!scenariorecommendation on 01/06/2016
- Woo Hyung Lee et al, Clinical Outcomes of Conservative Treatment and Arthroscopic Repair of Rotator Cuff Tears: A Retrospective Observational Study, Ann Rehabil Med 2016;40(2):252-262 pISSN: 2234-0645 eISSN: 2234-0653 http://dx.doi.org/10.5535/arm.2016.40.2.252
- Baums et. al. Functional outcome and general health status in patients after arthroscopic release in adhesive capsulitis. Knee Surg Sports Traumatol Arthrosc. 2007 May; 15(5):638-44.
- Snow M, Boutros I, Funk L. Posterior arthroscopic capsular release in frozen shoulder. Arthroscopy. 2009 Jan; 25(1):19-23.
- Fernandes MR. Arthroscopic treatment of adhesive capsulitis of the shoulder with minimum follow up of six years. Acta Ortop Bras. 2015 Mar-Apr; 23(2): 85–89. doi: 10.1590/1413-78522015230200613 PMCID: PMC4813413
- Wei Dong et. al. Treatments for Shoulder Impingement Syndrome. A PRISMA Systematic Review and Network Meta-Analysis, Medicine, Volume 94, Number 10, March 2015
- Longo et. al. Humeral Avulsion of the Glenohumeral Ligaments: A Systematic Review.

Arthroscopy. 2016 May 12. pii: S0749-8063(16)00248-6. doi: 10.1016/j.arthro.2016.03.009

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- British Orthopaedic Association, 2014. Subacromial shoulder pain commissioning guide. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- NHS Choices. Shoulder impingement https://www.nhs.uk/conditions/shoulder-impingement-syndrome/

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Policy name	**Bariatric Surgery**
Policy type	Threshold with prior approval
Included intervention(s)	Bariatric surgery
Included indication/ condition(s)	Morbid obesity
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Bariatric surgery

1. **Interventions covered by this policy**
   Bariatric surgery.

2. **Conditions to be considered for treatment under this policy**
   Patients who are morbidly obese and have not achieved or maintained adequate, clinically beneficial weight loss through attending a Tier 3/4 service.

3. **Eligibility criteria for provision of the intervention**
   Bariatric surgery will only be considered as a treatment option for people with morbid obesity if they meet **all** the following criteria:

   They have **one** of the following:
   - BMI ≥40kg/m^2
     OR
   - BMI ≥35kg/m^2
     AND
   - Other significant diseases
     AND
   - They have undergone a formalised MDT-led process for the screening of co-morbidities and the detection of other significant diseases, with appropriate specialist referral for medical management if required
     AND
   - Morbid/severe obesity has been present for at least five years.
     AND
   - They have recently received and complied with a local specialist obesity service weight loss programme (nonsurgical Tier 3/4), run by a multidisciplinary team (see further details below).
     AND
   - They have attended the service for a duration of 12-24 months, with the exception of the following two groups, when assessment for bariatric surgery may be expedited:
     - BMI >50kg/m^2 and other interventions have not been effective;
     - BMI ≥35kg/m^2 and have recent-onset type 2 diabetes

4. **Exclusions**
   This policy does not cover:
   Children and young people (aged 18 and under)

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement ‘Cosmetic interventions: general principles’.

Please refer to the Policy within this document that covers Tier 3 weight management services.

Please refer to the Policy within this document that covers body contouring procedures.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for bariatric surgery.

The NHS Commissioning Board commissioning policy provides the following further description of the Tier 3/4 service which patients should have attended:

This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity.

There are different models of local MDT structure. Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care the service will select and refer appropriate patients for consideration for bariatric surgery.

Types of bariatric surgery include gastric banding, gastric bypass, sleeve gastrectomy and duodenal switch. For appropriate, selected patients with severe and complex obesity that has not responded to all other non-invasive therapies it has been shown to be highly cost effective.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NHS Commissioning Board, 2013. Clinical Commissioning Policy: Complex and Specialised Obesity Surgery https://www.england.nhs.uk/wp-content/uploads/2016/05/appndx-6-policy-sev-comp-obesity-pdf.pdf

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2014. Obesity: identification, assessment and management. CG189 https://www.nice.org.uk/guidance/cg189

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Policy name	Benign Skin Lesions - Management
Policy type	Threshold with prior approval
Included intervention(s)	Removal of benign skin lesions
Included indication/ condition(s)	Benign skin lesions identified in this policy
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T28: Management of benign skin lesions in secondary care T37: Treatment of benign perianal skin lesions in secondary care
NEE CCG policy	Benign skin lesions

1. Interventions covered by this policy

Removal of benign skin lesions.

This policy applies to all providers, including GPs, GPs with an enhanced role, independent providers, and community or intermediate services.

2. Conditions to be considered for treatment under this policy

This policy refers to the following benign lesions when there is diagnostic certainty:

- Benign moles (excluding large congenital naevi)
- Solar comedones
- Corn/callous
- Dermatofibroma
- Lipomas
- Milia
- Molluscum contagiosum (non-genital)
- Epidermoid & pillar cysts (sometimes incorrectly called sebaceous cysts)
- Seborrhoeic keratoses (basal cell papillomata)
- Skin tags (fibro epithelial polyps) including anal tags
- Spider naevi (telangiectasia)
- Non-genital viral warts in immunocompetent patients
- Perianal viral warts which have failed to respond to non-surgical treatment
- Xanthelasmata
- Neurofibromata

3. Eligibility criteria for provision of the intervention

Removal of one of the benign skin lesions listed above should only be considered if they meet at least **one** of the following criteria:

- 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 2 or more courses of antibiotics (oral or intravenous) per year

OR

- There is repeated infection requiring 2 or more courses of antibiotics per year

OR

- The lesion bleeds in the course of normal everyday activity

OR

- The lesion causes regular pain

OR

- The lesion is obstructing an orifice or impairing the field of vision

OR

- The lesion significantly impacts on function e.g. restricts joint movement, or perianal skin tags which give rise to fecal seepage

OR

- The lesion causes pressure symptoms e.g. on nerve or tissue

OR

- If left untreated, more invasive intervention would be required for removal

OR

- Facial viral warts

OR

- Facial spider naevi in children causing significant psychological impact

OR

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

OR

- Perianal viral warts (condylomata) which have failed to respond to non-surgical treatment and are so extensive that surgical excision is required.

4. Exclusions

This policy does not cover:

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

5. Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for removal of benign skin lesions.

There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- National Institute for Health and Clinical Excellence. Guidance on cancer services – improving outcomes for people with skin tumours including melanoma (update): the management of low risk basal cell carcinomas in the community.

https://www.nice.org.uk/guidance/csg8/resources/improving-outcomes-for-people-with-skintumours-including-melanoma-2010-partial-update-pdf-773380189 [Accessed 22.5.17]
(Being updated 2019 https://www.nice.org.uk/guidance/csg8)

- National Institute for Health and Clinical Excellence. NICE guideline (NG) 12 – Suspected cancer: recognition and referral. https://www.nice.org.uk/guidance/ng12 [Accessed 22.5.15]
- Kerr OA, Tidman MJ, Walker JJ *et al.* The profile of dermatological problems in primary care. *Clin Exp Dermatol*. 2010; (4):380-3
- http://www.patient.co.uk/doctor/minor-surgery-in-primary-care
- George S, Pockney P, Primrose J *et al.* A prospective randomised comparison of minor surgery in primary and secondary care. The MiSTIC trial. *Health Technology Assessment* 2008;12(23): iii-iv, ix-38.
- Centers for disease control and prevention (CDC). 2010 STD Treatment Guidelines. *Genital warts.* http://www.cdc.gov/std/treatment/2010/genital-warts.htm (Accessed 23/09/16)
- Bouguen G, Siproudhis L, Bretagne JF, Bigard MA, Peyrin-Biroulet L. Nonfistulizing Perianal Crohn's Disease: Clinical Features, Epidemiology, and Treatment. Inflammatory Bowel Diseases, Vol16. Is8. p1267–1446 (2010).

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2015. Suspected cancer: recognition and referral https://www.nice.org.uk/guidance/ng12

Appendix

NICE recommendations on referral for suspected skin cancer

(National Institute for Health and Care Excellence, 2015. Suspected cancer: recognition and referral https://www.nice.org.uk/guidance/ng12)

NICE recommend the following groups should be referred using a suspected cancer pathway referral (for an appointment within 2 weeks):

People with suspected **malignant melanoma**:

- if they have a suspicious pigmented skin lesion and a score of 3 or more on the following checklist:

  Major features of the lesions (scoring 2 points each):
  - Change in size
  - Irregular shape
  - Irregular colour.

  Minor features of the lesions (scoring 1 point each):
  - Largest diameter 7 mm or more
  - Inflammation
  - Oozing
  - Change in sensation

OR

- if dermoscopy suggests melanoma of the skin

OR

- if they have a pigmented or non-pigmented skin lesion that suggests nodular melanoma

People with a skin lesion that raises the suspicion of **squamous cell carcinoma**.

People with a skin lesion that raises the suspicion of a **basal cell carcinoma** ONLY if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size; otherwise routine referral.

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Policy name	**Blepharoplasty**
Policy type	Threshold with prior approval
Included intervention(s)	Blepharoplasty
Included condition/ indication(s)	Functional problems due to impairment of the visual fields, defects predisposing to corneal or conjunctival irritation, or other impairments affecting periorbital tissue.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T20: Functional upper eyelid blepharoplasty
NEE CCG policy	Blepharoplasty

1. Interventions covered by this policy

Blepharoplasty is a surgical procedure to remove excess tissue, mostly skin, from around the eyes.

2. Conditions to be considered for treatment under this policy

Upper eyelid blepharoplasty will be considered to correct functional impairment in the following circumstances:

- There is impairment of the visual fields resulting in significant interference with vision
- There are defects predisposing to corneal or conjunctival irritation
- There are other impairments affecting the periorbital tissue which result in functional problems

Lower eyelid blepharoplasty will be considered to correct functional impairment in the following circumstances:

- There are defects predisposing to corneal or conjunctival irritation

3. Eligibility criteria for provision of the intervention

Upper eyelid blepharoplasty will be considered in the following conditions when the specified criteria are met.

***Impairment of visual fields**:*

- Documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelids or seeing the upper eyelid skin
  AND
- There is redundant skin overhanging the upper eyelid margin and resting on the eyelashes when gazing straight ahead
  AND
- There is supporting evidence from visual field testing that drooping eyelid skin impinges on visual fields reducing field to 120° or less horizontally and/or 40° or less vertically

Defects predisposing to corneal or conjunctival irritation

- There are defects predisposing to corneal or conjunctival irritation such as entropion or lesions of the eyelid skin or lid margin.

Other impairments of periorbital tissue

- To treat periorbital sequelae of nerve palsy, blepharochalasis, floppy eyelid syndrome or chronic inflammatory skin conditions,

OR

- To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue,
  OR
- Following skin grafting for eyelid reconstruction,
  OR
- At the same time as ptosis correction for the upper eyelid if the surplus skin is felt to be excess on lifting the ptotic eyelid.

Lower eyelid blepharoplasty will be considered in the following conditions when the specified criteria are met.

Defects predisposing to corneal or conjunctival irritation

- There are defects predisposing to corneal or conjunctival irritation such as ectropion or entropion or lesions of the eyelid skin or lid margin.

4. Exclusions

This policy does not cover:

- Children and young people (aged 18 and under).
- Blepharoplasty which is only for cosmetic reasons such as puffy, hooded, wrinkled or tired-looking eyes.

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy/policies.

- Hacker H.D. and Hollsten D.A, 1992. "Investigation of automated perimetry in the evaluation of patients for upper lid blepharoplasty". Ophthalmic, Plastic & Reconstructive Surgery 8 (4) pp. 250-255.
- Purewal B.K. and Bosniak S., 2005. "Theories of upper eyelid blepharoplasty". Ophthalmology Clinics of North America 18 (2) pp 271-278.
- American Academy of Ophthalmology, 1995. "Functional Indications for Upper and Lower Eyelid Blepharoplasty". Ophthalmic Procedures Assessment American Journal of Ophthalmology 102 (4) pp. 693-695.
- Kosmin A.S., Wishart P.K., Birch M.K., 1997. "Apparent glaucomatous visual field defects caused by dermatochalasis". Eye 11 pp. 682-686
- NHS Modernisation Agency. Action on plastic surgery: Information for Commissioners of Plastic Surgery Services. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
- Somerset CCG www.somersetccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=5061
- Greater Manchester CCGs http://northwestcsu.nhs.uk/BrickwallResource/GetResource/c116623a-5ccd-4e8d-b4cd-d6ca4a0b1060
- Devon CCG Blepharoplasty (upper and lower lid) including brow lift https://southwest.devonformularyguidance.nhs.uk/referral-guidance/policies/blepharoplasty-upper-and-lower-lid-including-brow-lift

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Bobath Therapy**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Bobath therapy
Included condition/ indication(s)	Patients requiring rehabilitation
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Bobath therapy

1. **Interventions covered by this policy**
   Referral for assessment and/or treatment at specific Bobath centres.
   The Bobath approach is a neurophysiological approach to rehabilitation which may be used for patients with stroke.

2. **Conditions to be considered for treatment under this policy**
   Patients requiring rehabilitation, for example after stroke.

3. **Eligibility criteria for provision of the intervention**
   Referral for assessment and/or treatment at specific Bobath centres is considered a low priority intervention and will not usually be funded.

4. **Exclusions**
   This policy does not apply to Bobath therapy provided as part of routine therapy services.

5. **Additional notes**
   Suffolk and North East Essex CCGs commission a number of Bobath trained therapists as part of routine therapy services.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for referral to a Bobath centre.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None

   7b. Additional guidance referred to in production of ICS policy.

   - Kollen BJ, Lennon S, Lyons B, Wheatley-Smith L, Scheper M, Buurke JH, Halfens J, Geurts AC, Kwakkel G, 2009. The effectiveness of the Bobath Concept in stroke rehabilitation: what is the evidence? *Stroke* 40(4): e89-e97 https://www.ahajournals.org/doi/epub/10.1161/STROKEAHA.108.533828
   - Scottish Intercollegiate Guidelines Network, 2010. SIGN 118: Management of patients with stroke: rehabilitation, prevention and management of complications, and discharge planning. https://www.sign.ac.uk/assets/sign118.pdf

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Policy name	**Body Contouring**
Policy type	Threshold with prior approval (abdominoplasty / apronectomy) Exceptional clinical circumstances (all other body contouring procedures)
Included intervention(s)	Abdominoplasty, apronectomy, buttock lift, thigh lift, brachioplasty and liposuction
Included indication/ condition(s)	Patients requesting procedures to remove excess fat and skin following weight loss
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE103: Body contouring
NEE CCG policy	Abdominoplasty or apronectomy Liposuction Skin contouring

1. **Interventions covered by this policy**
   Body contouring surgery including abdominoplasty, apronectomy, buttock lift, thigh lift and brachioplasty (upper arm reduction).
   Liposuction / Liposculpture / Suction Assisted Lipectomy

2. **Conditions to be considered for treatment under this policy**
   Patients requesting procedures to remove excess fat and skin following weight loss.

3. **Eligibility criteria for provision of the intervention**

   Abdominoplasty/Apronectomy
   Patients may be considered for abdominoplasty/apronectomy if they meet **one** of the following criteria:
   - The procedure is required as part of abdominal hernia correction or other abdominal wall surgery
     OR
   - The patient has a significant abdominal apron as a result of weight loss with a flap (panniculus) which hangs at or below the level of the symphysis pubis
     AND
   - They have severe functional problems*****
     AND
   - They meet either of the following weight loss criteria:
     - an initial BMI >40kg/m^2 and a current BMI< 25kg/m^2 which they have maintained for at least 2 years
       OR
     - an initial BMI >50kg/m^2 and achieved a minimum drop of 20 BMI points and have maintained this BMI (reduction of a minimum of 20 points) for at least 2 years

   ***Severe functional problems include**:
   - Chronic and persistent skin condition (for example, intertriginous dermatitis, and cellulitis or skin ulceration) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should have included

topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics as appropriate
- Abdominal wall prolapse with proven urinary symptoms
- Problems associated with poorly fitting stoma bag

Other body contouring procedures including buttock lift, thigh lift, brachioplasty and liposuction
Other body contouring procedures are considered a low priority and will not usually be funded.

4. Exclusions

This policy does not cover:
- Children and young people (aged 18 and under)
- Patients with predictable abdominal changes following pregnancy
- Patients with primary or secondary lymphedema
- Patients with body dysmorphic disorder

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Please also refer to the Policy that covers Tier 3 weight management services
Please also refer to the Policy that covers Bariatric surgery

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery (for those requesting abdominoplasty/apronectomy who do not meet the above criteria, or those requesting other procedures).

The following are offered as advice to potential referrers and ECC panels as circumstances in which surgery may be considered (note: these are **not** referral criteria):
- The patient has achieved significant weight loss which has been maintained for at least two years
- There are documented symptoms, including pain and discomfort or personal hygiene problems that interfere with work or activities of daily living
- The patient suffers from chronic and persistent skin problems in the affected areas which have not responded to non-surgical management, and there is documented evidence of this
- Physiological assessment and support has been undertaken
- If the patient is suffering psychological distress, appropriate referrals should have been made and other potential causes of psychological distress should have been appropriately evaluated and treated. Documentation of mental health status should be provided

Abdominoplasty involves the removal of excess fat and skin from the abdominal wall between the pubic area and the umbilicus and tightening of the abdominal muscles.

An apronectomy is a modified mini-abdominoplasty, mainly for patients who have a large excess of skin and fat hanging down over the pubic area and only the surplus skin and fat is removed.

Thighplasty is aesthetic reshaping surgery with the removal of excess skin and fat. Buttock or thigh lift surgery is performed to lift the excess skin to firm and tighten the skin around the buttocks and/or thighs.

Brachioplasty is a surgical procedure which removes and tightens loose skin and excess fat in the upper arm.

Liposuction is a technique to remove unwanted fat deposits and can be performed on several areas of the body including the thighs, neck, arms, tummy, inner side of the knees and the ankles. Liposuction for the purposes of cosmetic body contouring will not be routinely funded.

There is evidence that body contouring is more likely to be successful in patients with lower BMI who have maintained weight loss. Risks of the procedures include poor aesthetic scaring and infection. There is little evidence that body contouring procedures will improve all round quality of life and there is no evidence that reducing fat deposits through surgery will reduce the onset of other disease.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- British Association of Plastic Reconstructive and Aesthetic Surgeons. New national body contouring surgery guide launched to promote equality in provision and improved care for weight loss patients. http://www.bapras.org.uk/media-government/media-resources/press-releases/new-national-body-contouring-surgery-guide-launched-to-promote-equality-in-provision-and-improved-care-for-weight-loss-patients. Published 2014. Accessed October 12, 2016.
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in Patients Seeking Abdominoplasty, Rhinoplasty, and Rhytidectomy. *Plast Reconstr Surg*. 2016;137(2):462–471. https://www.ncbi.nlm.nih.gov/pubmed/26818280.
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7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence. Liposuction for chronic lymphedema. IPG588 (replaces IPG251) https://www.nice.org.uk/guidance/ipg588
- RCS/BAPRAS, 2017. Massive weight loss body contouring: Commissioning guide. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/2017--draft-for-consultation--body-contouring-surgery-commissioning.pdf?sfvrsn=0

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Policy name	**Bone healing ultrasound system - EXOGEN**
Policy type	Threshold with prior approval
Included intervention(s)	Bone healing ultrasound system
Included indication/ condition(s)	Long bone fractures which have failed to heal
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Bone healing ultrasound system - EXOGEN

1. **Interventions covered by this policy**
   The EXOGEN ultrasound bone healing system delivers low-intensity pulsed ultrasound waves with the aim of stimulating bone healing. It is thought that healing is promoted by stimulating the production of growth factors and proteins that increase the removal of old bone, increase the production of new bone and increase the rate at which fibrous matrix at a fracture site is converted to mineralised bone.
   The EXOGEN system is a single hand-held device.

2. **Conditions to be considered for treatment under this policy**
   Long bone fractures which have failed to heal after 9 months.

3. **Eligibility criteria for provision of the intervention**
   Use of the EXOGEN ultrasound bone healing system may be considered in patients with a long bone fracture which has failed to heal after 9 months, but less than 12 months.

4. **Exclusions**
   This policy does not cover:

   - Patients aged ≤18 years
   - Use of the EXOGEN system for long bone fractures with delayed healing (no radiological evidence of healing after 3 months, but less than 9 months).
   - Use of the EXOGEN system for treatment of non-union of fractures in long bones in cases of unstable surgical fixation, where the fracture is not well aligned or where the interfragment gap is >10mm.

5. **Additional notes**
   Use of the EXOGEN ultrasound bone healing system to treat long bone fractures with non-union is associated with a cost saving, through avoiding surgery. The use of the EXOGEN system to treat long bone fractures with delayed union is associated with a cost increase compared with current management and is not recommended by NICE.

   This policy is in line with the guidance from the East of England Prescribing Advisory Committee.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for EXOGEN.

6. **Compliance with NICE guidance**
   This policy complies with relevant NICE guidance.

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7. References

7a. References included in original Suffolk / North East Essex policy / policies.

National Institute for Health and Care Excellence, 2013. EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing. MTG12. https://www.nice.org.uk/guidance/mtg12

7b. Additional guidance referred to in production of ICS policy.

National Institute for Health and Care Excellence, 2019. EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing (update). MTG12. https://www.nice.org.uk/guidance/mtg12

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Policy name	**Breast Implants - Surgery to remove or replace**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Surgical removal or removal and replacement of breast implants
Included indication/ condition(s)	Breast implant(s) for which removal or removal and replacement is being sought
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE 114. Surgery to remove or replace breast implants
NEE CCG policy	Breast reconstruction

1. **Interventions covered by this policy**
   Surgery to remove or remove and replace breast implants.

2. **Conditions to be considered for treatment under this policy**
   Breast implant(s), for which removal or removal and replacement is being sought.

3. **Eligibility criteria for provision of the intervention**
   Breast implant removal or removal and replacement for the sole purpose of changing the cosmetic appearance of the breast are considered low priority procedures and will not normally be funded.

4. **Exclusions**
   This policy does not apply to breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management).

5. **Additional notes**
   Surgery for breast enlargement, breast ptosis or breast asymmetry (which may include the insertion of a breast implant) are covered in Policy 'Breast surgery (excluding cancer-related surgery)'.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC Panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery.

   The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria):

   - Funding for breast implant removal may be considered where there is a clear clinical need and where specialist clinical opinion is that the benefit of the procedure outweighs the risk of harm. Clinical need may include:

  - Pain due to capsular contracture grade III/IV on Baker classification[1]
  - Silicone implant leakage or rupture
  - Implants complicated by recurrent infection
  - Breast disease, where implant removal is required for diagnosis and/or management
  - In order to comply with any national guidance relating to removal of specific types of implant
- Where funding for removal is approved, the CCG may wish to consider funding the replacement of implants if the original procedure was funded by the NHS AND the patient remains eligible for breast augmentation in accordance with current policies
- Patients who have had implants inserted privately should be directed back to the private provider in the first instance

The ECC Panel may also wish to consider the following general guidance regarding surgical breast procedures, as appropriate:

- Requests should only be considered in women aged 21 and over as this will allow time for them to receive the necessary support and counselling to arrive at an informed decision once breast development is completed
- BMI should be stable and sustained below 30kg/m^2 for at least 1 year prior to referral (unless there are urgent clinical indications for implant removal)
- The panel should consider the impact on the breasts of any likely changes associated with pregnancy and breast feeding
- If patients are suffering psychological distress, appropriate referrals should have been made and other potential causes of psychological distress should be appropriately evaluated and treated. Documentation of mental health status should be provided
- Patients who smoke should be offered support to stop smoking as an opt-out, in line with the 'Weight management and smoking cessation prior to elective surgery' policy

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy/ Policies.

- Rocco N, Rispoli C, Moja L, Amato B, Iannone L, Testa S, Spano A, Catanuto G, Accurso A, Nava MB. Different types of implants for reconstructive breast surgery. Cochrane Database of Systematic Reviews 2016, *Issue* 5. *Art. No.: CD010895. DOI: 10.1002/14651858.CD010895.pub2.*
- NHS Choices http://www.nhs.uk/conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx
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- NHS Digital Breast and Cosmetic Implant Registry (BCIR) http://content.digital.nhs.uk/bcir
- NHS Modernisation Agency. Action on plastic surgery: Information for Commissioners of Plastic Surgery Services. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

[1] Baker classification system (see Association of breast clinicians, 2010)
I - the breast is normally soft, and looks natural
II – the breast is a little firm, but appears natural (minimal contracture)
III – the breast is firm, and is beginning to appear distorted in shape (moderate contracture)
IV – the breast is hard, and has become quite distorted in shape (severe contracture)

- Lancashire North CCG http://www.lancashirenorthccg.nhs.uk/download/governing-body-papers/Agenda%20Item%2010.5.%20Commissioning%20Policy%20for%20Breast%20Implant%20Removal%20and%20Replacement.pdf.
- Devon CCG https://northeast.devonformularyguidance.nhs.uk/referral-guidance/commissioning-policies/breast-implants---removal-and-replacement
- NHS Kernow CCG http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG/IndividualFundingRequests/Policies/RemovalAndReplacementBreastImplantsPolicy.pdf
- Gloucestershire CCG www.gloucestershireccg.nhs.uk/.../Removal-and-replacement-of-breast-implants.doc
- East Midlands commissioning policy for cosmetic procedures www.southernderbyshireccg.nhs.uk/EasySiteWeb/GatewayLink.aspx%3FalId%3D3284+&cd=8&hl=en&ct=clnk&gl=uk

7b. Additional guidance referred to in production of ICS policy.

- Association of breast clinicians, 2010. Best practice diagnostic guidelines for patients presenting with breast symptoms. https://www.evidence.nhs.uk/document?id=2013590&returnUrl=search%3Fq%3Dhc11%26sp%3Don&q=hc11
- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101

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Policy name	**Breast Reduction**
Policy type	Threshold with prior approval
Included intervention(s)	Breast reduction surgery
Included indication/ condition(s)	Breast hyperplasia (enlargement)
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE 110: Breast reduction
NEE CCG policy	Breast reduction

1. **Interventions covered by this policy**
   Breast reduction surgery.

2. **Conditions to be considered for treatment under this policy**
   Breast hyperplasia (enlargement) where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects on quality of life.

3. **Eligibility criteria for provision of the intervention**
   Breast reduction surgery should only be considered if **all** the following criteria are met:
   - The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain
     AND
   - In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
     AND
   - The patient's 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
   - The breast reduction is planned to be 500gms or more per breast or at least 4 cup sizes (as assessed by a specialist)
     AND
   - The patient's body mass index (BMI) is <27kg/m^2 and has been stable for at least twelve months
     AND
   - The woman has been provided with written information to allow her to balance the risks and benefits of breast surgery, and if relevant has been informed that breast reduction surgery can cause permanent loss of lactation

   Unilateral breast reduction may be considered for breast asymmetry if:
   - there is a difference of 150-200gms size as measured by a specialist
     AND
   - The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain
     AND
   - In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
     AND

- The patient's 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
- The woman has been provided with written information to allow her to balance the risks and benefits of breast surgery, and if relevant has been informed that breast reduction surgery can cause permanent loss of lactation

4. Exclusions

This policy does not cover:

- Breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management)
- Breast reduction in gynaecomastia.
- Suspected malignancy, when referral should be made through the appropriate route

5. Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Please refer to Policy that covers breast surgery (other than cancer-related surgery) including mastopexy, breast augmentation and augmentation surgery for breast asymmetry.
Please refer to Policy that covers breast implant removal or removal and replacement.
Please refer to Policy that covers breast reduction in gynaecomastia.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for breast reduction.

One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery. Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring.

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

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- GP notebook. http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20120513155707778590

- NHS Choices http://www.nhs.uk/conditions/breast-reduction/Pages/Introduction.aspx
- Royal College of Surgeons / BAPRAS commissioning guide breast reduction surgery http://www.rcseng.ac.uk/healthcare-bodies/docs/breast-reduction-commissioning-guide/view
- Adult Exceptional Aesthetic Referral Protocol (AEARP) September 2011 NHS Scotland. http://www.sehd.scot.nhs.uk/mels/CEL2011_27.pdf
- Breast reduction surgery for hypermastia: clinical effectiveness and guidelines. Ottawa: Canadian Agency for Drugs and Technologies in Health (CADTH). Rapid Response. 2014 https://www.cadth.ca/breast-reduction-surgery-hypermastia-clinical-effectiveness-and-guidelines
- North and East London Commissioning Support Unit Procedures of Limited Clinical Value 2013-2014 WELC (Waltham Forest, East London and City) Clinical Commissioning Groups http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Plans%20Strategies%20and%20Forms/POLCV-2013-14-WELC.pdf
- North Durham CCG Value Based Commissioning http://www.northdurhamccg.nhs.uk/wp-content/uploads/2013/07/Value-Based-Clinical-Commissioning-APRIL-2015.pdf
- South East London Treatment Access Policy http://www.lewishamccg.nhs.uk/about-us/Who-weare/Governing%20Body%20papers/Enc%2020.1%20SE%20London%20Treatment%20Access%20Policy.pdf
- O'Hare PM, Frieden IJ. Virginal Breast Hypertrophy. Pediatr Dermatol. 2000 Jul-Aug; 17(4):277-81.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101
  (this replaces CG80)

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Policy name	**Breast surgery (excluding cancer-related surgery)**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Mastopexy, breast augmentation, augmentation surgery for breast asymmetry
Included indication/ condition(s)	Patients seeking breast lift, breast augmentation or augmentation surgery for breast asymmetry
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE 109. Breast augmentation PE111. Mastopexy (breast lift) PE116. Surgery for breast asymmetry
NEE CCG policy	Breast surgery (excluding cancer related surgery)

1. Interventions covered by this policy

Breast augmentation refers to an operation whereby breasts are made larger by inserting an implant underneath the breast tissue or the muscle below the breast. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients.

Mastopexy or breast lift surgery refers to an operation whereby the breasts are reshaped and remodelled by removing surplus skin and if required repositioning the nipple. This is usually done as a treatment for breast ptosis, or drooping.

Surgery for breast asymmetry usually involves augmentation of one breast by inserting an implant, and/or reduction in the size of one breast.

2. Conditions to be considered for treatment under this policy

Surgery to enlarge the breasts may be sought by patients who consider their breasts are smaller than they would wish. In some cases this may be a consequence of congenital failure of breast development, endocrine abnormalities, or trauma during or after breast development.

Breast ptosis (droopiness) is a normal female process with pregnancy, breast feeding, gravity, weight change and the menopause all possibly contributing to the skin stretching, alongside changes to the supportive tissue which helps maintain the youthful breast shape.

Breast asymmetry may happen as part of development when breasts first form, with underdevelopment or overdevelopment of one breast, a difference in shape or difference in position of the nipple. Some degree of breast asymmetry is very common; very few people have breasts that are exactly identical.

There is no medical advantage associated with any of the above procedures for these conditions, but they may have positive psychological effects in some circumstances.

3. Eligibility criteria for provision of the intervention

Breast augmentation surgery, mastopexy or breast lift surgery, and augmentation surgery for breast asymmetry, are all considered low priority procedures and will not normally be funded.

4. Exclusions

This policy does not apply to breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management).

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5. Additional notes

All referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Please refer to Policy that covers breast implant removal or removal and replacement.
Please refer to Policy that covers breast reduction (including reduction for asymmetry)
Please refer to Policy that covers breast reduction in gynaecomastia.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery.

The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria):

- Requests should only be considered in women aged 21 and over as this will allow time for them to receive the necessary support and counselling to arrive at an informed decision once breast development is completed
- BMI should be stable and sustained below 35kg/m^2 for at least 1 year prior to referral
- The panel should consider the impact on the breasts of any likely changes associated with pregnancy and breast feeding
- If patients are suffering psychological distress, appropriate referrals should have been made and other potential causes of psychological distress should be appropriately evaluated and treated. Documentation of mental health status should be provided
- Patients who smoke should be offered support to stop smoking as an opt-out, in line with the 'Weight management and smoking cessation prior to elective surgery' policy

Taking into account the above guidance, funding for bilateral breast augmentation may be considered in cases of:

a) Congenital amastia / amazia – developmental failure resulting in bilateral absence of breast tissue
b) Bilateral loss of breast tissue or failure of breast tissue to develop as the result of burns or trauma

Funding for breast asymmetry surgery may be considered in cases of:
a) Developmental failure resulting in unilateral absence of breast tissue
b) Patients with gross asymmetry (defined as a difference greater than 3 standard cup sizes, as assessed by a specialist or professional bra fitting service) which has a significant impact on the patient's physical or mental health, and all reasonable steps have been taken to address this

Patients for whom funding is approved should be appropriately counselled regarding the risks of the procedure and (where applicable) the risks associated with the use of implants.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

***Breast augmentation**:*

- NICE CG 80 Early and locally advanced breast cancer: diagnosis and treatment https://www.nice.org.uk/guidance/CG80/chapter/1-Guidance#breast-reconstruction

- NHS choices http://www.nhs.uk/conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx
- Guidance for Doctors Who Offer Cosmetic Interventions, GMC, 2016 http://www.gmc-uk.org/guidance/ethical_guidance/28687.asp
- The Royal College of Surgeons Professional Standards for Cosmetic Surgery guidance published in April 2016 https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/
- NHS Modernisation Agency Action on Cosmetic Surgery http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

Mastopexy:

- British Association of Aesthetic and Plastic Surgeons Mastopexy https://baaps.org.uk/patients/procedures/5/breast_uplift_mastopexy
- Medscape Breast Mastopexy http://emedicine.medscape.com/article/1273551-overview#showall
- *Surgery for breast asymmetry*:
- Crerand, Canice E, Magee, Leanne Cosmetic and reconstructive breast surgery in adolescents: psychological, ethical, and legal considerations. Seminars in plastic surgery, vol. 27, no. 1, p. 72-78, 1535-2188 (February 2013)
- Queen Victoria Hospital Breast Asymmetry http://www.qvh.nhs.uk/wp-content/uploads/2015/09/Breast-Asymmetry-Rvw-Oct-17.pdf
- NICE Clinical Guidance CG80 https://www.nice.org.uk/guidance/CG80
- NHS Dorset Clinical Commissioning Group Breast Surgery Criteria Access Based Protocol http://www.dorsetccg.nhs.uk/Downloads/aboutus/Policies/Clinical/Policies%20from%20Sept%202014/Criteria%20Based%20Access%20Protocol%20-%20Breast%20Surgery.pdf
- Bristol CCG Breast surgery https://www.bristolccg.nhs.uk/media/medialibrary/2016/09/breast_surgery_female.pdf
- Hull CCG Breast surgery http://www.hullccg.nhs.uk/uploads/policy/file/4/Hull_CCG_breast_surgery_January_2015.pdf
- Bury CCG aesthetic breast surgery http://www.buryccg.nhs.uk/Library/Your_local_nhs/CCGPlanspoliciesandreports/EURpolicies/Aesthetic%20Breast%20Surgery%20Policy%20-%20April%202014.pdf
- Camden CCG http://www.camdenccg.nhs.uk/Downloads/ccg-public/Publications/policies/NCL-Procedures-of-Limited-Clinical-Effectiveness-PoLCE-Policy-June-2015-2016.pdf

7b. Additional guidance referred to in production of ICS policy.

- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101
  (This replaces CG80)

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Policy name	Caesarean Section (elective)
Policy type	Threshold with prior approval
Included intervention(s)	Elective Caesarean Section
Included indication/ condition(s)	Specified clinical or psychological indications
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Caesarean Section

1. **Interventions covered by this policy**
   Elective Caesarean section.

2. **Conditions to be considered under this policy**
   Elective Caesarean section may be carried out where there are clear clinical or psychological indications that this is the best option for the mother and baby.

3. **Eligibility criteria for provision of the intervention**
   Women may be offered a planned Caesarean section (after discussing the risks and benefits of Caesarean section and vaginal birth in line with NICE CG 132) in the following circumstances:
   - At least 2 previous Caesarean sections and no previous vaginal births
   - A previous Caesarean section with classical or T shaped incision
   - Previous uterine rupture
   - Previous 3rd or 4th degree tear with associated morbidity and proven anal sphincter damage on ultrasound
   - Previous difficult second stage Caesarean section following failed instrumental delivery, with extension of the uterine incision, supported by documentation by surgeon at time of operation that future vaginal delivery is not indicated
   - Proven cephalo-pelvic disproportion
   - Proven macrosomia
   - Known malposition/malpresentation
   - A singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful
   - A placenta that partly or completely covers the internal cervical os (minor or major placenta praevia)
   - Women suspected to have morbidly adherent placenta
   - A chronic medical or obstetric condition which means that the risks associated with vaginal delivery are greater than those associated with Caesarean section
   - Women with HIV who are not receiving any anti-retroviral therapy, OR who are receiving any anti-retroviral therapy and have a viral load of 400 copies per ml or more
   - Women who are co-infected with hepatitis C virus and HIV
   - Women with primary genital herpes simplex virus infection occurring in the third trimester of pregnancy
   - Twin pregnancy (dichorionic diamniotic or monochorionic diamniotic) if the first twin is not cephalic at the time of planned birth
   - Twin pregnancy (monochorionic monoamniotic) at the time of planned birth (between 32^{+0} and 33^{+6} weeks) OR after any complication is diagnosed in the pregnancy requiring earlier delivery
   - Triplet pregnancy, at the time of planned birth (35 weeks) OR after any complication is diagnosed in the pregnancy requiring earlier delivery

- Psychological indications, which should be discussed on a case-by-case basis, such as anxiety about childbirth which may have followed previous traumatic delivery, and which is unresolved following support from an experienced midwife or other healthcare professional

4. Exclusions

All women who have had a previous Caesarean section (CS) for non-recurrent reasons will automatically default at booking to the normal care pathway for vaginal birth. Non-recurrent reasons for CS include previous CS due to breech, fetal distress, failure to progress with malposition, multiple birth, maternal request, intra-uterine growth retardation, macrosomia or placental site insertion.

5. Additional notes

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for elective Caesarean section.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy/ies.

None.

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2011 (updated 2019). Caesarean section. CG132. https://www.nice.org.uk/guidance/cg132

- National Institute for Health and Care Excellence, 2019. Twin and triplet pregnancy. NG137 https://www.nice.org.uk/guidance/ng137/chapter/Recommendations#mode-of-birth

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Policy name	Carpal Tunnel Syndrome Surgery
Policy type	Threshold with prior approval
Included intervention(s)	Surgery to release the median nerve from the carpal tunnel
Included indication/ condition(s)	Carpal tunnel syndrome
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T9a: Carpal tunnel syndrome surgery
NEE CCG policy	30: Carpal tunnel surgery

1. **Interventions covered by this policy**
   Surgery to release the median nerve from the carpal tunnel.

2. **Conditions to be considered for treatment under this policy**
   Carpal Tunnel Syndrome (CTS) is a set of symptoms caused by compression of the median nerve within the space between the flexor muscles and tendon sheath of the wrist. The severity of symptoms is correlated to the amount of nerve compression occurring over a period of time. Patients with CTS typically present with nocturnal dysaesthesia in the hands that wears off with activity; pins and needles, and sometimes numbness and weakness affecting the thumb, index middle and ring fingers; clumsiness and frequently dropping things.

3. **Eligibility criteria for provision of the intervention**
   Surgical release of the median nerve as treatment for carpal tunnel syndrome should only be considered if **one** of the following criteria is met:

   Patients who have symptoms but no evidence of risk of permanent nerve damage
   Patients in these groups should have a trial of conservative treatment before surgery is considered.

   - The symptoms significantly interfere with daily activities and/or sleep and have not settled to a manageable level with:
     - one local corticosteroid injection

     AND/OR
     - nocturnal splinting for a minimum of 8 weeks

     OR

   - The symptoms are intermittent or mild to moderate with some interference with daily activities and/or sleep and have not settled to a manageable level with:
     - two local corticosteroid injections

     AND/OR
     - nocturnal splinting for a minimum of 3 months

   Patients in whom there is considered to be risk of permanent nerve damage
   Urgent referral for surgery should be considered for patients in these groups. They are not required to have had a trial of conservative treatment, or to meet the guidance regarding weight management and smoking cessation in Policy 'Weight management and smoking cessation prior to elective surgery'.

   - There is a permanent (ever-present) reduction or alteration in sensation in the median nerve distribution

   OR

- There is muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

4. Exclusions
None.

5. Additional notes
This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery' (with the exception of those in whom there is considered to be a risk of permanent nerve damage, as above).

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for carpal tunnel surgery.

Carpal tunnel syndrome is very common, and mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection; there is good evidence of short-term benefit (8-12 weeks), but many progress to surgery within 1 year. Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.

In refractory or severe cases surgery should be considered; there is good evidence of excellent clinical effectiveness and long term benefit. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.

The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.

6. Compliance with NICE guidance
No relevant NICE guidance.

7. References
7a. ***References included in original Suffolk / North East Essex policy / policies****.*
Treatment of painful tingling fingers, Commissioning Guide, British Orthopaedic Association 2013

Hospital Episode Statistics 2011/12.

http://www.bssh.ac.uk/education/guidelines/carpal_tunnel_syndrome.pdf
British Society for Surgery of the Hand (2011) BSSH Evidence for Surgical Treatment (BEST): Carpal Tunnel Syndrome (CTS) [Online] Available from:

http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003219/abstract - Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome (2003)

Carpal tunnel syndrome Part I: Effectiveness of nonsurgical treatments – A systematic review Huisstede, Bionka M. et al., Archives of Physical Medicine and Rehabilitation , Volume 91 , Issue

7 , 981 – 1004, July 2010

Marshall SC, Tardif G, Ashworth NL. Local corticosteroid injection for carpal tunnel syndrome. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.:CD001554. DOI:10.1002/14651858.CD001554.pub2.

http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12012011347 - Shi Q, MacDermid JC. Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? A systematic review. Journal of Orthopaedic Surgery 2011;

http://www.westnorfolkccg.nhs.uk/sites/default/files/pdf/Carpal%20Tunnel%20Policy.pdf West Norfolk CCG

http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2014/04%20February/Agenda%20Item%2004.5c%20-%20App%20C%20Carpal%20Tunnel.pdf

http://www.enhertsccg.nhs.uk/sites/default/files/documents/Mar2015/Guidance_36-carpal-tunnel-dupuytrens-trigger-finger-March2014.pdf

*7b. **Additional guidance referred to in production of ICS policy**.*

NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

Policy name	**Cataract Surgery**
Policy type	Threshold with prior approval
Included intervention(s)	Surgery for cataract
Included condition/ indication(s)	Cataract in one or both eyes.
Date produced	July 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T11: Cataract surgery
NEE CCG policy	Cataracts

1. **Interventions covered by this policy**
   Surgery for cataracts, in which the natural lens is replaced by a clear intraocular lens implant.

2. **Conditions to be considered for treatment under this policy**
   This policy applies to cataracts in one or both eyes, which are adversely affecting the patient's vision and lifestyle.

   A cataract is defined as any opacity in the crystalline lens of the eye. The changes to the transparency and refractive index of the lens result in various levels of visual impairment, which may restrict the person's ability to carry out daily activities and function independently, and increase the risk of accidents and falls. Cataracts most commonly affect adults as a result of biological ageing but can also occur secondary to hereditary factors, trauma, inflammation, metabolic or nutritional disorders, and exposure to radiation.

3. **Eligibility criteria for provision of the intervention**
   The potential to benefit from cataract surgery depends on a number of factors including the patient's visual acuity, whether they have any visually disabling symptoms such as glare and the severity of the symptoms, the impact of any visual disability on the patient's ability to function, maintain independence and remain safe, and the impact on their ability to conduct any activities which are important to them and/ or which require particularly good vision. The benefits of second eye surgery have been demonstrated and patients with bilateral cataract should be offered second eye surgery provided they meet the criteria.

   Patients may benefit from cataract surgery in the first or second eye when:
   - They have evidence of significant cataract on assessment

   AND any of the following:
   - Visual disability: can no longer undertake their usual activities such as reading or watching television, or particular activities relating to their employment (if applicable)

   OR
   - Visual symptoms attributable to cataract: eg significant glare and dazzle in daylight or difficulties with night vision, due to the lens opacity. This may particularly affect patients who need to drive at night

   OR
   - Asymptomatic risk/ disability : They have difficulty with activities of daily living or self-care, and/or are at increased risk of falls due to impaired vision

   OR
   - They are a carer for their partner or other dependent adult and the cataract limits their ability to provide care.

   OR

- Acuity: corrected binocular VA is 6/9 or worse (0.20 logMAR) OR they have a monocular VA of 6/18 (0.40 logMAR) or worse in the affected eye

AND

- The patient has confirmed that they wish/agree to be referred to consider surgery.

4. Exclusions

This policy does not apply in patients who require cataract surgery for any of the following reasons:

- The patient has significant optical imbalance between the two eyes (anisometropia) which will be reduced or resolved by removal of the cataract (this may be the result of cataract surgery on the first eye);
- The patient has a co-existing eye condition and the removal of the cataract is required to enable better surveillance or management of the condition, for example diabetic and other retinopathies, age-related macular degeneration, glaucoma, inflammatory eye disease or neuro-ophthalmological conditions;
- The patient has corneal or conjunctival disease where cataract removal would reduce the risk of losing corneal clarity or reduce the risk of complications;
- The patient has a refractive error which is primarily due to the presence of the cataract;
- The patient has post-vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.

5. Additional notes

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for cataract surgery.

6. Compliance with NICE guidance

NICE NG77 recommends that access to cataract surgery should not be restricted on the basis of visual acuity.

7. References

7a. ***References included in original Suffolk / North East Essex policy / policies.***

The Royal College of Ophthalmologists. Commissioning Guidance 2015. Available from: http://www.college-optometrists.org/filemanager/root/site_assets/guidance/Commissioning-Guide-Cataract-Surgery-Final-February-2015.pdf

Desai P. Cataract surgery: one or both eyes? Br J Ophthalmol. 2012 Jun 13; bjophthalmol–2012–301733.

West Suffolk Clinical Commissioning Group. Clinical Thresholds. Available from: http://www.westsuffolkccg.nhs.uk/clinical-area/clinical-thresholds-lpps/

NICE. Cataracts in adults: management. Available from: ttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0741http://cks.nice.org.uk/cataracts#!scenarioCambridge

NICE Clinical Knowledge Summaries. Cataracts 2015.Adults Scenario. Available from: http://cks.nice.org.uk/cataracts#!scenario

Cambridgeshire and Peterborough Clinical Commissioning Groups. Clinical Policies. Available from: http://www.cambsphn.nhs.uk/CCPF/PHPolicies.aspx

Somerset Clinical Commissioning Group. Policies. Available from:

http://www.somersetccg.nhs.uk/publications/policies/

The Royal College of Ophthalmologists. Cataract Surgery Guidelines 2010. Available from: https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/

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Gov.uk. Driving eyesight rules. Available from: https://www.gov.uk/driving-eyesight-rules

Sheffield Local Optemetric Committee. Sheffield Cataract Assessment Form. (Appendix 2)

The NHS Atlas of Variation in Healthcare. Reducing Unwarranted Variation to Increase Value and Improve Quality. 2010. Available from: http://www.rightcare.nhs.uk/atlas/qipp_nhsAtlas-LOW_261110c.pdf

Tan A, Tay WT, Zheng YF, et al. The impact of bilateral or unilateral cataract surgery on visual functioning: when does second eye surgery benefit patients? Br J Ophthalmol 2012;96:846e51.

Frampton G, Harris P, Cooper K, Lotery A, Shepherd J. The clinical effectiveness and cost-effectiveness of second-eye cataract surgery: a systematic review and economic evaluation. Health Technol Assess [Internet]. 2014 Nov 18;18(68). Available from: http://journalslibrary.nihr.ac.uk/hta/hta18680

Lundström M, Brege KG, Florén I, Stenevi U, Thorburn W. Impaired visual function after cataract surgery assessed using the Catquest questionnaire. J Cataract Refract Surg. 2000 Jan;26(1):101–8.

7b. ***Additional guidance referred to in production of ICS policy.***

NICE, 2017. Cataracts in adults: management. NG77. https://www.nice.org.uk/guidance/ng77

Royal College of Ophthalmologists, 2018. Adult Cataract Surgery: Commissioning guide. https://www.rcophth.ac.uk/2018/02/rcophth-commissioning-guide-for-adult-cataract-revised-january-2018/

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Policy name	**Chalazia Removal**
Policy type	Threshold with prior approval
Included intervention(s)	Incision and curettage of chalazia
Included indication/ condition(s)	Chalazia
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	34: Chalazia

1. Interventions covered by this policy

Incision and curettage of the contents of chalazia.

2. Conditions to be considered for treatment under this policy

Chalazia (meibomian cysts), which are benign lesions on the eyelids due to blockage and swelling of an oil gland.

3. Eligibility criteria for provision of the intervention

Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least **one** of the following criteria has been met. The chalazion:

- has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
  OR
- interferes significantly with vision
  OR
- interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
  OR
- is a source of infection that has required medical attention twice or more within a six month time frame
  OR
- is a source of infection causing an abscess which requires drainage

4. Exclusions

This policy does not apply to:

- suspected malignancy e.g. Madarosis/recurrence/other suspicious features, in which case the patient should referred via the appropriate pathway and the lesion should be removed and sent for histology

5. Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'

Referral may be made to the ECC panel for patients who do not meet the policy criteria in

whom there are considered to be exceptional circumstances supporting the need for intervention for chalazia.

NICE (Clinical Knowledge Summary, 2019) recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. Co-amoxiclav) be used. Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.

Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm. However, there are a small number which are persistent, very large, or can cause other problems such as distortion of vision. In these cases, surgery can remove the contents from a chalazion. However, all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back.

The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding. Some trials comparing the two treatments suggest that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction but less pain and patient inconvenience. However, this is controversial and other studies show that steroid injection is less effective than surgery. Therefore, both options can be considered for suitable patients.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

None

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2019. Meibomian cyst (chalazion): Clinical Knowledge Summary. https://cks.nice.org.uk/meibomian-cyst-chalazion#!topicSummary

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Policy name	Communications Support Services
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Communications support services
Included indication/ condition(s)	Patients requiring communications support
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Communications support services

1. **Interventions covered by this policy**
   Communications support services, including but not limited to translator services, interpreter services and communication guide services (including sign language).

2. **Conditions to be considered under this policy**
   Patients requiring communications support.

3. **Eligibility criteria for provision of the intervention**
   Communications support services including but not limited to translator services, interpreter services, and communication guide services (including sign language) will not usually be funded by the CCG.

4. **Exclusions**
   None.

5. **Additional notes**
   Communications support is arranged directly by the service providing patient care and commissioned through provider core contracts.

   Access to communications support in primary care, including GP and dental services, is funded and arranged by NHS England.

6. **Compliance with NICE guidance**
   No relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None
   7b. Additional guidance referred to in production of ICS policy.
   None

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Policy name	Complementary and Alternative Therapies
Policy type	Exceptional clinical circumstances
Included intervention(s)	Complementary and alternative therapies
Included indication/ condition(s)	Various
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Complementary and alternative therapies

1. **Interventions covered by this policy**
   Complementary and alternative therapies, including but not restricted to:
   Acupuncture*****, Alexander Technique, Applied Kinesiology, Aromatherapy, Autogenic Training, Ayurveda, Chinese Medicines, Chiropractic Therapy*****, Osteopathy*****, Clinical Ecology, Healing, Herbal Remedies, Homeopathy, Hypnotherapy, Massage, Meditation, Naturopathy, Nutritional Therapy, Reiki, Shiatsu, Reflexology and other therapies considered alternative or complementary. ***see exceptions below**.

2. **Conditions to be considered for treatment under this policy**
   Various.

3. **Eligibility criteria for provision of the intervention**
   Treatment with complementary and alternative therapies is considered a low priority and will not usually be funded.

4. **Exclusions**
   This policy does not cover:
   - Osteopathy and chiropractic when used within services provided by back and neck pain multidisciplinary teams.
   - Acupuncture when used within services provided by MSK multidisciplinary teams.
   - Procedures which are available as part of palliative care provision which is funded from charitable sources

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.
   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for complementary and alternative therapy. This will require proven evidence of effectiveness of the therapy for the specific condition, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners.

6. **Compliance with NICE guidance**
   This policy complies with relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk / North East Essex policy / policies.
   None
   7b. Additional guidance referred to in production of ICS policy.
   https://www.england.nhs.uk/wp-content/uploads/2019/08/items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf

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Commissioning statement	Cosmetic Interventions: General Principles
Included intervention(s)	Surgery and other procedures which are carried out to improve appearance.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Cosmetic surgery general principles Cosmetic surgery on mental health grounds

1. **Interventions covered by this commissioning statement**
   Surgery and other procedures which are being proposed for reasons which are considered to be primarily cosmetic (that is, to improve appearance).

2. **Conditions to be considered under this commissioning statement**
   A wide range of conditions may lead patients to request interventions to change their appearance. These include (but are not restricted to):
   - Scars which are considered unsightly (which may be a consequence of surgery, trauma or conditions such as acne)
   - Dissatisfaction with body shape, size or appearance, which may follow weight gain, weight loss, pregnancy or changes associated with age
   - Dissatisfaction with facial appearance
   - Dissatisfaction with appearance of the skin or hair

3. **Principles**
   A number of the conditions and interventions to which this commissioning statement applies are also covered by separate policies, which should be referred to in individual decision-making.

   Cosmetic interventions undertaken exclusively to improve appearance are considered low priority procedures and should not usually be funded in adults.

   Cosmetic interventions undertaken primarily with the aim of improving psychological distress or mental ill health should not usually be funded in adults. There is generally insufficient evidence to support the effectiveness of cosmetic interventions in the treatment of mental health conditions.

   Where there is a possible underlying medical condition, such as an endocrine, congenital or other condition, this should be fully investigated by an appropriate specialist prior to consideration of any cosmetic intervention.

   Surgery should be supported for patients who were accepted onto an NHS waiting list prior to taking up residence in Suffolk or North East Essex, providing the existing clinical evidence has remained the same.

   Referrals for the revision of treatments originally performed outside the NHS should first be made to the practitioner who carried out the original treatment for resolution, where this does not endanger the health of the individual. Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be funded unless the patient meets local criteria for the original treatment, or a failure to refer within the NHS would endanger the health of the individual.

Interventions to treat conditions secondary to body piercing, including ear piercing or any other body adornments will not usually be funded.

Interventions to treat conditions secondary to predictable changes associated with age or pregnancy will not usually be funded.

Exceptional circumstances

Referral may be made to the ECC panel for patients who do not meet the relevant conditions above or the criteria specified in any relevant policy, in whom there are considered to be exceptional circumstances supporting the need for the cosmetic intervention. The referral will need be supported by evidence of the exceptional clinical circumstances and the patient's capacity to benefit from the intervention.

Examples of exceptional clinical circumstances which may be considered to support the case for funding may include:

- Conditions which result from previous trauma, disease or congenital deformity
- Conditions due to an adverse outcome of previous NHS funded treatment, for example resulting from complications or technical difficulties with the original procedure

Note: these examples are intended as supporting guidance only and are **not** referral criteria.

Children and young people

Children and young people are generally defined in Suffolk and North East Essex policies as those aged 18 and under, in line with the definition used in The National Service Framework for Children. Funding for cosmetic interventions for this age group should only be considered if there is a problem which is judged to be likely to impair normal emotional development.

The child's ability to be involved in decisions about their health and healthcare will be influenced by a range of factors including their age, understanding and development. Requests for referrals, particularly of younger children, may reflect concerns expressed by the parents rather than the child, and this should be taken into consideration prior to referral. Older children may be able to take responsibility for decisions about their health and healthcare, including whether they wish to have a cosmetic intervention, and can consent to treatment without a parent's involvement if they are judged to be 'Gillick competent'. This recognises that children aged under 16 years can consent to medical treatment or intervention if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. There is no lower age limit for Gillick competence to be applied, but it is considered that it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent's involvement.

4. References

4a. References included in original Suffolk/NEE policy/policies.

- DH, October 2014. National Service Framework for Children, Young People and Maternity Services

4b. Additional guidance referred to in production of ICS policy.

- CQC, 2018. Nigel's surgery 8: Gillick competency and Fraser guidelines. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines

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Policy name	**Cryopreservation of Sperm, Oocytes and Embryos**
Policy type	Threshold with prior approval
Included intervention(s)	Cryopreservation of oocytes, sperm or embryos
Included indication/ condition(s)	Patients undergoing treatment which poses a risk to their fertility
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T40: Cryopreservation of sperm, oocytes and embryos in patients whose treatment poses a risk to their fertility
NEE CCG policy	Sperm, Oocyte (Egg) or Embryo storage/cryopreservation

1. Interventions covered by this policy

Cryopreservation of sperm, oocytes and embryos.

Cryopreservation involves storage of male or female reproductive tissue for future use in conception via assisted reproductive techniques. Cryopreservation of sperm is a well-established technique used to maintain an individual's fertility. Cryopreservation of eggs requires ovarian stimulation and oocyte collection; this would be followed by in vitro fertilisation if cryopreservation of embryos is required.

2. Conditions to be considered for treatment under this policy

Patients receiving NHS-funded treatments which pose a risk to their fertility. This includes cytotoxic chemotherapy or radiotherapy and other medical or surgical treatments which have a significant likelihood of making them infertile, and individuals undergoing gender reassignment, where fertility preservation forms part of the clinical pathway.

This policy covers all individuals who meet the eligibility criteria regardless of gender, sexual orientation, and marital or relationship status.

3. Eligibility criteria for provision of the intervention

To be eligible for NHS-funded cryopreservation of sperm, oocytes or embryos patients must meet **all** the following criteria:

- They are about to undergo NHS-funded treatment which poses a risk to their fertility
  AND
- Females must be aged less than 43 years and males aged less than 55 years; there is no specified lower age limit
  AND
- If female, they are well enough to undergo ovarian stimulation and egg collection, it will not worsen their condition, and enough time is available before the planned start of their treatment
  AND
- They are registered with a GP practice within Ipswich and East Suffolk, West Suffolk or North East Essex CCGs
  AND
- They have not undergone sterilisation (male or female) in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)
  AND
- The patient has been fully counselled with respect to the duration of storage and conditions for subsequent use of the stored material.

Duration of storage

Where patients meet the criteria for fertility preservation sperm, oocytes or embryos will be stored for an initial period of 10 years, as permitted in current legislation.

It may be possible to extend the funded period of storage if the material has not been used. This would require CCG approval through the ECC process. Patients may explore privately funded options once the funded period of storage ends.

For men, a clinical review of their testicular function should take place 3 years after material has been stored. If semen analysis confirms a full return to spermatogenesis, funding of the storage of the patient's material will cease 1 month following the outcome of the test results being communicated by recorded delivery to and acknowledged by the patient.

For all patients, if fertility returns as demonstrated by conception, funding for ongoing storage of remaining stored material will cease.

In the event the patient dies or lacks the capacity to make decisions during the funded storage period and has nominated next of kin for material to be passed to, the CCG will continue to fund storage of material for a further six months whilst the next of kin consider what to do with the stored material. Should the gamete provider's nominated next of kin wish to continue storing the material beyond this six-month period, they can make arrangements directly with the provider.

Before storage begins, patients should sign consent forms which confirm their understanding of arrangements for storage and specify what should happen to the material if the gamete provider were to die or lack capacity to make decisions.

Use of stored material

Eligibility for fertility preservation does not entitle patients to funding for use of stored materials for assisted conception treatments such as in-vitro fertilisation (IVF). Patients requiring assisted conception treatments following funded cryopreservation and storage will only be funded if they meet the criteria specified in the policy applicable at the time of use.

4. Exclusions

This policy does not cover:

- Fertility preservation for social or non-clinical reasons, such as patient choice to delay conception
- Patients who are infertile due to an existing congenital disorder
- Cryopreservation as part of infertility treatment, such as the freezing of additional embryos during a cycle of IVF

5. Additional notes

Please refer to policy that covers subfertility investigation and treatment in secondary care. Please refer to policy covers specialist fertility services.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for cryopreservation.

All patients whose treatment poses a threat to their fertility must have the opportunity to discuss fertility, regardless of their eligibility for gamete or embryo cryopreservation. Where appropriate clinicians should refer to the guidance set out in 'The effects of cancer treatment on reproductive functions' and NICE Clinical Guideline 156 'Fertility: assessment and treatment for people with fertility problems' (see full references below).

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6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Campos JR, de Sá Rosa-e-Silva ACJ. Cryopreservation and Fertility: Current and Prospective Possibilities for Female Cancer Patients. ISRN Obstet Gynecol. 2011; 2011: 350813.
- The Royal College of Physicians, Royal College of Radiologists, Royal College of Obstetricians and Gynaecologists. 'The Effects of Cancer Treatment on Reproductive Functions: guidance on management' [Online]. The Royal College of Physicians, Royal College of Radiologists, Royal College of Obstetricians and Gynaecologists. 2007 [accessed January 2017]. Available from: https://www.rcr.ac.uk/system/files/publication/field_publication_files/Cancer_fertility_effects_Jan08.pdf
- Timmerman KW. Fertility preservation for non-malignant medical conditions – Clinical Update [online].
- Reproductive Medicine Associates of New Jersey. 2013; issue 40 [accessed January 2017] Available via URL: http://www.rmanj.com/wp-content/uploads/2013/10/Fertility-preservation-for-nonmalignant-medicalconditions.pdf
- Walsh SJ, Rau LM: Autoimmune diseases: a leading cause of death among young and middle-aged women in the United States. Am J Public Health 2000, 90(9): 1463-1466
- Mahmoud HK, Elhaddad AM, Fahmy OA, Samra MA, Abdelfattah RM, El-Nahass YH. Allogeneic
- hematopoietic stem cell transplantation for non-malignant hematological disorders. J Adv Res. 2015 May; 6(3): 449–458. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4522586/
- National Institute of Health and Care Excellence (NICE). 'Fertility: assessment and treatment for people with fertility problems' [Online]. NICE. 2013 [accessed January 2017]. Available from URL:
- http://www.nice.org.uk/nicemedia/live/14078/62769/62769.pdf

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2019. Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions) https://www.england.nhs.uk/wp-content/uploads/2019/07/service-specification-gender-dysphoria-services-non-surgical-june-2019.pdf
- National Institute for Health and Care Excellence, 2019. Cryopreservation to preserve fertility in people diagnosed with cancer. NICE fertility pathway https://pathways.nice.org.uk/pathways/fertility

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Policy name	Dilatation and curettage (D&C) for heavy menstrual bleeding
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Dilatation and curettage
Included indication/ condition(s)	Heavy menstrual bleeding.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Dilatation and curettage / hysteroscopy

1. **Interventions covered by this policy**
   Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).

2. **Conditions to be considered for treatment under this policy**
   Heavy menstrual bleeding.

3. **Eligibility criteria for provision of the intervention**
   Dilation and curettage (D&C) is considered a low priority procedure and will not usually be funded for the investigation or treatment of heavy menstrual bleeding.

4. **Exclusions**
   None.

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Please refer to policy that covers uterine artery embolisation
   Please refer to policy that covers Hysterectomy for heavy menstrual bleeding.

   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. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) can treat heavy periods. 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.

6. **Compliance with NICE guidance**
   This policy complies with relevant NICE guidance.

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7. References

7a. ***References included in original Suffolk / North East Essex policy / policies****.*

- National Institute for Health and Care Excellence, 2018. Heavy menstrual bleeding: diagnosis and management. NG88. www.nice.org.uk/guidance/ng88

7b. ***Additional guidance referred to in production of ICS policy****.*

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

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Policy name	**Diagnostic Medial Branch Block +/- Radiofrequency Denervation**
Policy type	Threshold with prior approval
Included intervention(s)	Diagnostic medial branch block, which may be followed by radiofrequency denervation
Included condition/ indication(s)	Chronic low back pain without radiculopathy
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T43: Facet Joint Injection (medial branch block) for the diagnosis of persistent (chronic) back pain T44: Radiofrequency Denervation in the management of persistent (chronic) back pain
NEE CCG policy	Spinal injections (therapeutic) for pain related to the lumbar spine

1. Interventions covered by this policy

Diagnostic medial branch block is an injection of local anaesthetic and steroid into the area of the facet joints which is supplied by the medial branch nerve.

People who experience short-term relief in response to the diagnostic medial branch block may be offered radiofrequency denervation.

Radiofrequency denervation is carried out by inserting an insulated needle through the skin to make contact with the target medial branch nerve. Radiofrequency energy is delivered along the needle and heats and denatures the nerve. Over time the nerve may regenerate, requiring a repeat of the procedure.

2. Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

This policy applies to the use of diagnostic medial branch block, which may be followed by radiofrequency denervation if indicated, in patients with chronic low back pain without radiculopathy which is thought to be arising from the lumbar facet joints.

3. Eligibility criteria for provision of the intervention

Referral for *diagnostic medial branch block* will be considered for patients with chronic low back pain when:

- The pain has lasted for 3 months with no evidence of other pathology on MRI AND
- Non-surgical treatment has been ineffective. Non-surgical treatments may include:
  - Advice and information, encouragement to continue usual activities and take appropriate exercise
  - Pain management including adequate analgesia with anti-neuropathic medication
  - Manual therapies (including physiotherapy)
  - Psychological interventions as part of a treatment package

- A combined physical and psychological treatment programme, where appropriate

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve (in the opinion of a MDT, pain specialist or MSK physician/GPwSI),
AND
- They have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale of 0-10, or equivalent) at the time of referral, which is having a significant impact on their daily functioning.

Radiofrequency denervation will be considered for patients with chronic low back pain as defined above when:

- they have had a positive response to a diagnostic medial branch block (an analgesic effect outlasting the expected duration of local anaesthesia)
- Repeat radiofrequency denervation may be considered where there has been a sustained response to the first radiofrequency denervation lasting 16 months or more.

4. Exclusions

This policy does not cover:

- Conditions of a non-mechanical nature, including;
  - Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
  - Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
  - Neurological disorders (including cauda equina syndrome or mononeuritis)
  - Adolescent scoliosis
- Conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
- Other conditions including pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.
- Patients who have sciatica without back pain.
- Children and young people (aged 16 and under)

5. Additional notes

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joints.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

No.	Policy	Interventions	Indication	Policy type
	Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
	Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
	Diagnostic sacroiliac joint	Diagnostic sacroiliac joint	Back pain thought to be	ECC

	injection, +/- radiofrequency denervation of the sacroiliac joint	injection Radiofrequency denervation of SI joint	arising from the sacroiliac joints	
	Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
	Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- National Institute of Health and Clinical Excellence. NICE guideline (NG)59 – low back pain and sciatica in over 16s: assessment and management. Available online at: https://www.nice.org.uk/guidance/ng59 [Accessed 6.6.17]
- Cohen SP, Moon JY, Brummett CM, White RL, Larkin TM. Medial Branch Blocks or Intra-Articular Injections as a Prognostic Tool before Lumbar Facet Radiofrequency Denervation: A Multicenter, Case-Control Study. Reg Anesth Pain Med. 2015 Jul-Aug;40(4):376-83.
- Derby R, Melnik I, Choi J, Lee JE. Indications for repeat diagnostic medial branch nerve blocks following a failed first medial branch nerve block. Pain Physician. 2013 Sep-Oct;16(5):479-88..

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management: Invasive treatments; methods, evidence and recommendations. https://www.nice.org.uk/guidance/ng59/evidence/full-guideline-invasive-treatments-pdf-2726157998
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

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Policy name	**Diagnostic Sacroiliac Joint Injection, +/- Radiofrequency Denervation of the Sacroiliac Joint**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Diagnostic sacroiliac joint injection, which may be followed by radiofrequency denervation of the sacroiliac joint.
Included condition/ indication(s)	Low back pain thought to be arising from the sacroiliac joints
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T45: Sacroiliac joint injection for the diagnosis of persistent (chronic) back pain
NEE CCG policy	-

1. **Interventions covered by this policy**
   Diagnostic sacroiliac joint injection, which may be followed by radiofrequency denervation of the sacroiliac joints.

2. **Conditions to be considered for treatment under this policy**
   Low back pain thought to be arising from the sacroiliac joints.

3. **Eligibility criteria for provision of the intervention**
   Diagnostic sacroiliac joint injection, with or without radiofrequency denervation of the sacroiliac joints, are low priority procedures and will not normally be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   There is very little evidence to support the effectiveness of diagnostic sacroiliac joint injection and radiofrequency denervation of the sacroiliac joints. NICE does not make any recommendation about the use of these procedures. Two recent systematic reviews (Maas et al, 2015 (a Cochrane review), and Piso et al, 2016) found limited evidence, of low quality. Piso et al commented 'the strength of evidence for the effectiveness of radiofrequency denervation for sacroiliac joint pain in comparison to placebo (sham intervention) is low to very low'. They found that there might be an improvement for between 1 and 3 months, but there was no evidence beyond 3 months. Maas et al reported no difference between radiofrequency denervation and placebo used for sacroiliac joint pain in the effects on pain and function over the short term, and limited evidence from one study of a small effect over the intermediate term.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joints.

   Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain	Therapeutic injections including facet joint injection,	Non-specific low back pain without	ECC

without radiculopathy	therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	radiculopathy	
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Rashbaum RF, Ohnmeiss DD, Lindley EM, Kitchel SH, Patel VV. Sacroiliac Joint Pain and Its Treatment. Clin Spine Surg. 2016 Mar;29(2):42-8.
- Simopoulos TT, Manchikanti L, Gupta S, Aydin SM, Kim CH, Solanki D, Nampiaparampil DE, Singh V, Staats PS, Hirsch JA. Systematic Review of the Diagnostic Accuracy and Therapeutic Effectiveness of Sacroiliac Joint Interventions. Pain Physician. 2015 Sep-Oct;18(5):E713-56.
- Manchikanti L, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician. 2013;16(2):S49-283

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management: Invasive treatments; methods, evidence and recommendations. https://www.nice.org.uk/guidance/ng59/evidence/full-guideline-invasive-treatments-pdf-2726157998
- National Institute for Health and Care Excellence, 2017. Spondyloarthritis in over 16s: diagnosis and management (NG65) https://www.nice.org.uk/guidance/ng65
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf
- Maas ET, Ostelo RWJG, Niemisto L, Jousimaa J, Hurri H, Malmivaara A, van Tulder MW, 2015. Radiofrequency denervation for chronic low back pain. The Cochrane database of systematic reviews. 2015;10:CD008572. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008572.pub2/epdf/full
- Piso B, Reinsperger I, Rosian K, 2016. Radiofrequency denervation for sacroiliac and facet joint pain. Decision Support Document No. 99. Vienna: Ludwig Boltzmann Institute for Health Technology Assessment. http://eprints.hta.lbg.ac.at/1096/1/DSD_99.pdf

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Policy name	**Dupuytren's Contracture**
Policy type	Threshold with prior approval
Included intervention(s)	Fasciotomy, fasciectomy or dermofasciectomy.
Included indication/ condition(s)	Dupuytren's contracture
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T9: Dupuytren's contracture
NEE CCG policy	Dupuytren's contracture

1. **Interventions covered by this policy**
   Needle fasciotomy: the division of one of more fibrous bands in the palm or digits using a blade or the bevel of a needle.

   Fasciectomy: removal of segments of the fibrous band, or the entire fibrous band, through one or more small incisions.

   Dermofasciectomy: removal of the fibrous band together with the overlying skin and replacement of the skin with a graft taken usually from the upper arm.

2. **Conditions to be considered for treatment under this policy**
   Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully.

3. **Eligibility criteria for provision of the intervention**
   An intervention (needle fasciotomy, fasciectomy or dermofasciectomy) should only be considered for patients with Dupuytren's contracture meeting **one** of the following criteria:
   - They have finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.
     OR
   - They have severe thumb contractures which interfere with function

4. **Exclusions**
   This policy does not cover:
   - Children and young people (aged 18 and under)

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for an intervention for Dupuytren's contracture.

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

There is currently insufficient evidence to say which interventions are the most effective in restoring and maintaining hand function throughout the rest of the patient's life, and which are the most cost-effective in the long term. Collagenase injection is no longer available in the UK and is not recommended as an option for patients with Dupuytren's contracture, following the withdrawal of NICE technology appraisal guidance (TA459) in February 2020.

All treatments aim to straighten the finger(s) to retain or restore hand function, but there is a risk of recurrence after any intervention. Contractures left untreated usually progress and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.

Tendon injury is possible but very rare. Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy/ies.

- Hurst LC, Badalamente et al. Histopathology and cell biology. In: Tubiana, Leclerq, Hurst et al. Dupuytrens Disease. London: Martin Dunitz, 2000.
- Rodrigues, Becker, Ball et al. Surgery for Dupuytren's contracture of the fingers. Cochrane Database Syst Rev. 2015 Dec 9;12:CD010143. [Epub ahead of print]
- West Suffolk Clinical Commissioning Group. Clinical Thresholds. Common Hand Conditions-Dupuytrens. Available from: http://www.westsuffolkccg.nhs.uk/clinical-area/clinical-thresholds-lpps/
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- South, Central and West Commissioning Support Unit. Dupuytren's Surgery. Policy Statement. 2014. Available from: https://www.bristolccg.nhs.uk/media/medialibrary/2015/12/dupuytrens_policy.pdf
- NHS England. Interim Clinical Commissioning Policy: Dupuytren's Contracture Surgery. November 2013. Available from: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC012.pdf
- Clinical Knowledge Summaries- Dupuytren's Disease (November 2015). Available from: http://cks.nice.org.uk/dupuytrens-disease#!topicsummary
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7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2016. Radiation therapy for early Dupuytren's disease. IPG573 https://www.nice.org.uk/guidance/ipg573 (replaces IPG368)
- British Society for Surgery of the Hand: Dupuytren's disease. https://www.bssh.ac.uk/patients/conditions/25/dupuytrens_disease

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Policy name	**Dysthyroid Eye Disease**
Policy type	Threshold with prior approval
Included intervention(s)	Surgery for Proptosis
Included condition/ indication(s)	Proptosis due to thyroid eye disease
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T20: Functional upper eyelid blepharoplasty
NEE CCG policy	Dysthyroid eye disease

1. **Interventions covered by this policy**
   Surgery for proptosis, which may involve one or more of orbital decompression, eyelid surgery or eyelid muscle surgery.

2. **Conditions to be considered for treatment under this policy**
   Proptosis (otherwise known as exophthalmos) is the protrusion of the eyeball, the most common cause of which is thyroid eye disease, when it is a consequence of an increase in the muscle and fatty tissue around the eye. The resulting exposure of the eye can lead to eye dryness and irritation and increase the risk of corneal ulceration or infection. Some patients experience double vision and less commonly impairment of vision can occur due to compression of the optic nerve.

3. **Eligibility criteria for provision of the intervention**
   Surgical intervention for proptosis should only be considered when:
   - Artificial tears have been tried for at least 6 months and have been unsuccessful
   - Other non-surgical interventions such as corticosteroids and other pharmacological treatments and radiotherapy have been considered, and are either not clinically appropriate or have been tried and were unsuccessful

4. **Exclusions**
   This policy does not cover children and young people (aged 18 and under).

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

6. **Compliance with NICE guidance**
   This policy complies with relevant NICE guidance.

7. **References**
   7a. ***References included in original Suffolk/NEE policy / policies****.*
   None
   7b. ***Additional guidance referred to in production of ICS policy****.*

   - NHS Choices. Exophthalmos (bulging eyes) https://www.nhs.uk/conditions/bulging-eyes/
   - NICE, 2005. Retrobulbar irradiation for thyroid eye disease. IPG 148. https://www.nice.org.uk/guidance/ipg148

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- Rajendram R, Bunce C, Lee R, Morley A, 2012. Orbital radiotherapy for adult thyroid eye disease.
- Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD007114.pub2

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Policy name	**Ear Lobe Repair**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Surgical repair of ear lobes
Included indication/ condition(s)	Ear lobes which have been torn, stretched or otherwise damaged secondary to ear piercing or other adornments
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE106: Ear lobe surgery
NEE CCG policy	Repair of ear lobes

1. **Interventions covered by this policy**
   Surgical repair of ear lobes.

2. **Conditions to be considered under this policy**
   Tears to the ear lobe, stretched ear lobes (flesh tunnels) or other damage to the ear lobes which have occurred secondary to ear piercing or other ear adornments.

3. **Eligibility criteria for provision of the intervention**
   Surgery to repair torn, stretched or otherwise damaged ear lobes is considered a low priority procedure and will not usually be funded.

4. **Exclusions**
   This policy does not apply to the primary repair of ear lobes as part of the immediate management of injury due to trauma (i.e. resulting from an unexpected external force that results in injuries which include the damage to the earlobe), which should be carried out as soon as possible after the trauma occurs.
   This policy does not apply to children and young people (aged 18 years and under).

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

6. **Compliance with NICE guidance**
   No relevant NICE guidance.

7. **References**
   7a. ***References included in original Suffolk/NEE policy / policies****.*

   - NHS Choices*, Ear Correction Surgery*, 2015, Available at: http://www.nhs.uk/conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx
   - *Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery* (NHS Modernisation Agency) London British Association for Plastic Reconstructive and Aesthetic Sugeons (BAPRAS). 2014 Available ONLINE at http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 Accessed 11/10/2016
   - Brunton G, Paraskeva N, Caird J, Bird KS, Kavanagh J, Kwan I, Stansfield C, Rumsey N, Thomas J. *Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment*. Aesthetic plastic surgery. 2014 Oct 1;38(5):1030-40.
   - Kang S, Moon SJ, Suh H. Traumatic cleft earlobe repair: using a double triangular flap for differently sized components on either side of the cleft. Aesthetic plastic surgery. 2013 Dec 1;37(6):1163-6.

   7b. ***Additional guidance referred to in production of ICS policy****.* None

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Policy name	Ear Wax Removal in Secondary Care
Policy type	Threshold with prior approval
Included intervention(s)	Ear wax removal in secondary care
Included indication/ condition(s)	Impacted ear wax
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T52: Ear wax removal in secondary care
NEE CCG policy	Microsuction/ ear wax removal

1. **Interventions covered by this policy**
   Referral to secondary care for removal of ear wax.

2. **Conditions to be considered for treatment under this policy**
   Earwax is a normally-occurring substance made up of dead cells, hair, external material such as dust, and cerumen wax. In some people earwax can become impacted and cause problems including pain, loss of hearing, itching, tinnitus and vertigo.

3. **Eligibility criteria for provision of the intervention**
   Patients with impacted earwax giving rise to symptoms may be referred for removal in secondary care if they meet either of the following criteria:
   - Irrigation has been attempted twice (after the use of ear drops) but has not been successful
     OR
   - Irrigation is not clinically appropriate for this patient for one of the following reasons:
     - The person has (or is suspected to have) a chronic perforation of the tympanic membrane.
     - There is a past history of ear surgery.
     - There is a foreign body, including vegetable matter, in the ear canal.
     - There is a visible tympanic membrane perforation
     - Ear drops have been unsuccessful and irrigation is contraindicated because the patient has one of the conditions listed below:
       - A history of any previous problem with irrigation (pain, perforation, severe vertigo).
       - Current perforation of the tympanic membrane.
       - A history of perforation of the tympanic membrane in the last 12 months.
       - Grommets in place.
       - A history of any ear surgery (except extruded grommets within the last 18 months, with subsequent discharge from an Ear Nose and Throat department).
       - A mucus discharge from the ear (which may indicate an undiagnosed perforation) within the past 12 months.
       - A history of a middle ear infection in the previous 6 weeks.
       - Cleft palate, whether repaired or not.
       - Current symptoms of acute otitis externa with an oedematous ear canal and painful pinna.
       - Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness.
       - Confusion or agitation, as they may be unable to sit still.
       - Inability to cooperate, for example young children and some people with learning difficulties.

NOTE: urgent advice from an ENT specialist should be sought if:

- Infection is present and the external canal needs to be cleared of wax, debris, and discharge
- The patient experiences severe pain, deafness, or vertigo occur during or after irrigation.

4. Exclusions

None

5. Additional notes

Removal of ear wax by irrigation after the use of ear drops can usually be carried out in primary care or a community setting (including non-NHS provision), but in some cases this is unsuccessful or contraindicated. Self-care should be the first line of treatment and the need for irrigation may be avoided by the use of drops. Occasional complications of irrigation include otitis externa, perforation of the tympanic membrane, damage to the external auditory meatus, pain, vertigo and nausea, and otitis media due to water entering the middle ear when there is a previous perforation. Procedures for removal in secondary care include microsuction and removal under direct vision.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for ear wax removal in secondary care.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NICE Clinical Knowledge Summary. Scenario: Management of earwax. May 2012. Available at http://cks.nice.org.uk/earwax#!scenario
- NICE Clinical Knowledge Summary. Scenario: Ear irrigation http://cks.nice.org.uk/earwax#!scenariorecommendation:5

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Clinical Knowledge Summary: Earwax. https://cks.nice.org.uk/earwax

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Policy name	**Face Lift**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Face lift surgery and related interventions
Included indication/ condition(s)	Dissatisfaction with facial appearance.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE107: Face lifts
NEE CCG policy	Face lifts and brow lifts

1. **Interventions covered by this policy**
   Face lift surgery; this may include traditional, minimal access cranial suspension (MACS) or keyhole surgery, which may also be combined with other procedures such as endoscopic brow lift or eyelid reduction.

2. **Conditions to be considered under this policy**
   Dissatisfaction with facial appearance, which may be a consequence of the normal ageing process, trauma or specific conditions.

3. **Eligibility criteria for provision of the intervention**
   Face lift and related surgery is considered a low priority procedure and will not usually be funded.

4. **Exclusions**
   This policy does not apply to children and young people (aged 18 years and under).

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery, when facelift is proposed as part of the treatment to restore appearance and function for an individual patient. This may include the following conditions which are offered as examples to potential referrers and ECC panels (note: these are **not** referral criteria):
   - Congenital facial abnormalities or facial palsy **and** treatment could alleviate the physical disability or psychological difficulty
   - As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
   - To correct the consequences of trauma **and** treatment could alleviate the physical disability or psychological difficulty
   - To correct deformity following surgery **and** treatment could alleviate the physical disability or psychological difficulty

6. **Compliance with NICE guidance**
   No relevant NICE guidance.

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7. References

7a. References included in original Suffolk/NEE policy / policies.

- *Facelifts,* British Association for Aesthetic Plastic Surgeons (BAAPS), 2015, Available ONLINE at http://baaps.org.uk/procedures/facelifts Accessed: 11/10/2016
- *Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery* (NHS Modernisation Agency) London British Association for Plastic Reconstructive and Aesthetic Surgeons (BAPRAS). 2014 Available ONLINE at http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 Accessed 11/10/2016
- Kosins, A. M., Hurvitz, K. A., Evans, G. R., & Wirth, G. A. (2007). Facial paralysis for the plastic surgeon. *The Canadian Journal of Plastic Surgery*, *15*(2), 77–82.
- Brunton G, Paraskeva N, Caird J, Bird KS, Kavanagh J, Kwan I, Stansfield C, Rumsey N, Thomas J. *Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment*. Aesthetic plastic surgery. 2014 Oct 1; 38(5):1030-40.
- De Sousa, Avinash. “Psychological Issues in Acquired Facial Trauma.” *Indian Journal of Plastic Surgery: Official Publication of the Association of Plastic Surgeons of India* 43.2 (2010): 200–205. *PMC*. Web. 19 Oct. 2016.

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Female Sterilisation**
Policy type	Threshold with prior approval
Included intervention(s)	Female sterilisation
Included indication/ condition(s)	Women requesting a permanent sterilisation procedure
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T26: Female surgical interval tubal sterilisation
NEE CCG policy	Sterilisation (female)

1. **Interventions covered by this policy**
   Elective female sterilisation may be achieved by the occlusion or interruption of the fallopian tubes. Most commonly this is done via laparoscopy, when the fallopian tube is occluded with a tubal ring or clip, a modified Pomeroy technique can be performed using endoscopic sutures, or diathermy can be used to destroy a segment of the tube.

2. **Conditions to be considered for treatment under this policy**
   Women requesting a permanent sterilisation procedure.

3. **Eligibility criteria for provision of the intervention**
   Women may be referred for consideration of permanent sterilisation if they meet **all** the following criteria:
   - The woman is certain her family is complete or that she never wants children
     AND
   - The woman has received counselling*****. This should include:
     - a discussion about her options including consideration of all other forms of long-acting contraceptives, and, if she has a partner, vasectomy
     - the woman is aware that sterilisation is considered permanent and that reversal is not routinely funded on the NHS

     AND
   - The woman is considered able to make an informed decision and to give valid, informed consent
     AND
   - The woman has had a flexible 12-month trial of long-acting reversible contraception (LARC) methods******, either the LNG-IUS, Implant or Injectable (DMPA) OR the woman has been fully counselled about LARC methods and declined a trial

   Counselling: Additional care must be taken when counselling individuals requesting sterilisation who are under the age of 30 years, who have no children, who have recently been pregnant, who have recently lost a relationship, are at risk of coercion, or who are experiencing any cultural, religious, psychosexual or psychological issues.

   ****** ***Flexible*** *12 month trial*: if the woman has concerns about trying a LARC, they should receive counselling from a healthcare professional experienced in providing them. If the patient wishes to accept a trial of a LARC method, she will be offered a flexible 12 month trial period unless extending the trial to 12 months would not be of benefit to her (e.g. she experiences side effects which affect her quality of life). Under these circumstances, a decision will be made to reduce the duration of the trial, based on clinical judgment.

4. **Exclusions**
   This policy does not cover:

- Children and young people (aged 18 and under)
- Where sterilisation is to take place at the time of another procedure such as Caesarean section (counselling and consent should have been given at least two weeks prior to the procedure).
- Where there is a medical contraindication to the use of LARC
- Where there is an absolute contraindication to pregnancy
- Hysteroscopic sterilisation by insertion of intrafallopian implants; NICE guidance on this intervention is currently suspended due to withdrawal of the CE mark from the insert used

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Please refer to policy that covers vasectomy under General Anaesthetic.
Please refer to policy that covers reversal of sterilisation.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for sterilisation.

The lifetime failure rate for laparoscopic tubal occlusion with clips is up to 2–5 in 1000 procedures at 10 years. These failure rates are higher than for the most effective long-acting reversible contraception methods, for example implant and intrauterine system (IUS). Pregnancies following female sterilisation are rare, but when they do occur there is an increased risk of ectopic gestation; the incidence of ectopic pregnancy varies depending on the method of tubal occlusion used.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Royal College of Obstetricians and Gynaecologists (RCOG). *Male and female sterilisation. London* (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p. (Evidence-based Clinical Guideline; no. 4)
- Marvranezouli I. *The cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence* (NICE) clinical practice guideline. Human Reproduction. 2008. 23 (6)
- 1338-1345
- Wilcox, L. S., Chu, S. Y., Eaker, E. D., Zeger, S. L., & Peterson, H. B, *Risk factors for regret after tubal sterilization: 5 years of follow-up in a prospective study*. Fertility and sterility, 1991 55(5), 927-933
- NICE Clinical Knowledge Summaries *Hysteroscopic sterilisation by tubal cannulation and placement of intrafallopian implants,* National Institute of Care and Excellence (NICE), September 2009: https://www.nice.org.uk/guidance/ipg315, (Accessed: 4/09/2016)
- Faculty of Sexual and Reproductive Healthcare (FSRH), *Clinical Guidelines, Male and Female Sterilisation,* FSRH, Royal College of Obstetricians & Gynaecologists, 2014
- Available from: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-summary-sep-2014.*pdf (*Accessed: 19.09.2016)

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Clinical Knowledge Summaries: Contraception – sterilization. https://cks.nice.org.uk/contraception-sterilization
- National Institute for Health and Care Excellence, 2017. Hysteroscopic sterilisation by insertion of intrafallopian implants (IPG 587) Guidance suspended October 2017

https://www.nice.org.uk/guidance/IPG587

- Royal College of Obstetricians and Gynaecologists, 2016. Female Sterilisation: Consent Advice. https://www.rcog.org.uk/globalassets/documents/guidelines/consent-advice/consent-advice-3-2016.pdf
- Faculty of Sexual and Reproductive Healthcare, 2017. Contraception after pregnancy. https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/

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Policy name	**Fenton's Procedure**
Policy type	Threshold with prior approval
Included intervention(s)	Fenton's procedure
Included condition/ indication(s)	Vaginal scarring associated with specified conditions
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Fenton's procedure (gynaecology)

1. **Interventions covered by this policy**
   Fenton's procedure or Fenton's repair is an operation to remove scar tissue and widen the vaginal opening when a woman experiences persistently painful sexual intercourse.

2. **Conditions to be considered for treatment under this policy**
   Vaginal scarring causing persistently painful sexual intercourse, associated with:
   - Complications of childbirth including tears and episiotomy
   - Lichen Sclerosus (most common in postmenopausal patients)
   - Lichen Planus
   - Previous vaginal surgery complications (excluding cosmetic procedures)
   - Radiotherapy to the genital area
   - Congenital conditions
   - Female genital mutilation (FGM)

3. **Eligibility criteria for provision of the intervention**
   Patients with persistently painful sexual intercourse due to vaginal scarring may be considered for Fenton's procedure if:
   - They have had FGM;
     OR
   - The scarring is the result of one of the following conditions:
     - Complications of childbirth including tears and episiotomy
     - Lichen sclerosus (most common in postmenopausal patients)
     - Lichen Planus
     - Previous vaginal surgery complications (excluding cosmetic procedures)
     - Radiotherapy to the genital area
     - Congenital conditions

     AND they have had appropriate conservative treatment which has not been successful, for example:
     - After childbirth - Perineal massage directed by a professional, the use of trainers and review by a Gynaecologist, to ensure that the anatomy has been appropriately restored.
     - For Lichen sclerosus – Potent topical steroid ointments, moisturisers, vaginal trainers, directed perineal massage and reassurance.

4. **Exclusions**
   This procedure will not be available to correct previous vaginal cosmetic surgery.

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for Fenton's procedure.

6. Compliance with NICE guidance

There is no relevant NICE guidance

7. References

7a. References included in original Suffolk/NEE policy/ies.

- Luesley D, Kilby M, 2015. Obstetrics and Gynaecology: and evidence-based text for MRCOG (p842). CRC Press.

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	Functional Electrical Stimulation
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Functional Electrical Stimulation
Included condition/ indication(s)	Foot drop of central neurological origin
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE101: The initial and continued use of Functional Electrical Stimulation for drop foot of central neurological origin
NEE CCG policy	Functional Electrical Stimulation

1. Interventions covered by this policy

Functional electrical stimulation (FES).

Functional electrical stimulation (FES) devices consist of a battery-operated stimulator, self-adhesive electrodes which are attached to the skin over the common peroneal nerve, and a footswitch which is placed in the shoe and activates the stimulator either via a lead or wirelessly. The electrical pulses delivered to the peroneal nerve activate the ankle dorsiflexors during the swing phase of gait, mimicking normal voluntary gait movement.

This policy applies both to patients new to FES and those requiring ongoing treatment beyond the life-expectancy of a current device.

2. Conditions to be considered for treatment under this policy

Foot drop of central neurological origin (for example in conditions such as stroke, multiple sclerosis, hereditary spastic paraparesis, Parkinson's disease, cerebral palsy, brain injury and spinal cord injury).

Foot drop is defined as the inability to activate the ankle dorsiflexors and lift the foot from the ground during the swing phase of gait. It results in weakness or lack of voluntary control of the ankle and foot dorsiflexors, causing the toes to drag and the foot to drop during the normal swing phase of gait. Foot drop can increase the risk of falls as well as the effort required to walk.

3. Eligibility criteria for provision of the intervention

Functional electrical stimulation for the treatment of foot drop of central neurological origin is considered a low priority procedure and will not usually be funded.

4. Exclusions

None.

5. Additional notes

Treatment for drop foot should be as part of an integrated rehabilitation programme, which aims to increase mobility and to reduce the risk of injury through falling. Approaches to treating foot drop include physiotherapy, orthotic devices such as ankle foot orthosis (AFO), electrical stimulation of the affected nerves, medication and surgery, such as ankle fusion or a tendon transfer procedure. These options can be used alone or in combination. First-line treatment is usually physiotherapy and/or the use of an AFO or other walking aid.

The Suffolk policy reviewed in 2017 (PE101) included an overview of evidence, including that published by NICE in their Medtech Innovation Briefing 56 (2016), and also considered NHS policies from other areas. It concluded that there was a lack of robust evidence from

high quality research supporting the use of FES in foot drop of central neurological origin. No guidance on this topic published since 2017 was identified, and while a number of new systematic reviews were identified none concluded that there was robust evidence of a therapeutic effect of FES in foot drop, and the evidence identified was generally not of good quality.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for FES. ECC Panels may wish to include the following in their considerations:

- If the patient has not used FES previously, is there evidence that a trial of FES would be the most appropriate step for them?
- If the panel approves a trial of FES, what time period will they set for the trial and how will they judge whether or not is has been of benefit to the patient?
- What measures of impact for the patient will they wish to consider? For example, objective assessments of function such as gait, walking speed and walking distance, and impact on activities of daily living, independence, and quality of life.
- Costs may include device, maintenance and replacement costs.

6. Compliance with NICE guidance

NICE Interventional Procedures Guidance 278 (2009) recommended that current evidence on the safety and efficacy (in terms of improving gait) of FES for drop foot of central neurological origin appeared adequate to support its use procedure provided that normal arrangements are in place for clinical governance, consent and audit. It recognised that interpretation of the evidence was difficult and that further evidence, particularly on efficacy, would be helpful

7. References

7a. References included in original Suffolk / North East Essex policy /policies.

- Graham J. Foot drop: explaining the causes, characteristics and treatment. *Br J Neurosci Nurs*. 2010;6(4):168-172. doi:10.12968/bjnn.2010.6.4.47792.
- Scotland HI, Lrp R, Uk T. Evidence Note. 2013;(49).
- National Institute for Health and Clinical Excellence. ODFS Pace and Pace XL functional electrical stimulation devices for treating drop foot. 2016: Medtech innovation briefing 56. https://www.nice.org.uk/advice/mib56
- Barrett C, Mann G, Taylor P, Strike P. A randomized trial to investigate the effects of functional electrical stimulation and therapeutic exercise on walking performance for people with multiple sclerosis. *PubMed*. 2009:15(4):493-504. http://www.ncbi.nlm.nih.gov/pubmed/19282417.
- Esnouf JE, Taylor PN, Mann GE, Barrett CL. Impact on activities of daily living using a functional electrical stimulation device to improve dropped foot in people with multiple sclerosis, measured by the Canadian Occupational Performance Measure. *Mult Scler*. 2010; 16(9):1141-1147. doi:10.1177/1352458510366013.
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- Wong J, Sultana I. FES evidence Brief v1.3. 2013.
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7b. Additional guidance referred to in production of ICS policy.

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Policy name	**Ganglion Excision**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical excision of ganglia
Included indication/ condition(s)	Ganglia
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T9: Ganglion
NEE CCG policy	Ganglion – surgical intervention

1. Interventions covered by this policy

Surgical excision of ganglia.

2. Conditions to be considered for treatment under this policy

Ganglia are cystic swellings containing jelly-like fluid which form around the wrists or in the hand. In most cases *wrist ganglia* cause only mild symptoms which do not restrict function, and many resolve without treatment within a year. Wrist ganglia rarely press on a nerve or other structure, causing pain and reduced hand function.

Ganglia in the palm of the hand (*seed ganglia*) can cause pain when carrying objects.

Ganglia which form just below the nail (*mucous cysts*) can deform the nail bed and discharge fluid, but occasionally become infected and can result in septic arthritis of the distal finger joint

3. Eligibility criteria for provision of the intervention

Surgical excision of ganglia should only be considered if the following criteria are met:

Wrist ganglia

- causing pain or tingling/numbness or concern (for example, regarding possible cancer) AND/OR there is restricted hand function
  AND
- Aspiration, if clinically appropriate, has been undertaken but has failed to resolve the symptoms.

Seed ganglia

- Causing pain
  AND
- Puncture/aspiration, if clinically appropriate, using a hypodermic needle has been undertaken but the ganglion has persisted or recurred

Ganglia below the nail (mucous cysts)

- There is recurrent spontaneous discharge of fluid
  OR
- There is significant nail deformity.

4. Exclusions

This policy does not cover:

- Suspected malignancy, when referral should be made through the appropriate (2 week wait) route.

5. Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by

NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for surgical excision of ganglia.

Conservative management is largely a matter of reassurance and asymptomatic ganglia should not be referred to secondary care. Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation. Aspiration of wrist ganglia may relieve pain and restore hand function, and "cure" a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly; a wide bore needle (minimum 16 gauge) is required as the contents are very viscous. Complication and recurrence are rare after aspiration and surgery for seed ganglia.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Greater Manchester EUR Policy Statement http://northwestcsu.nhs.uk/BrickwallResource/GetResource/3d84b326-c78d-40d9-9764-5e16f9318f64
- Best Bets: Best Evidence Topics: Is surgery more effective than aspiration with or without steroid injection in the management of ganglion cysts? http://www.bestbets.org/bets/bet.php?id=1945
- NHS choices http://www.nhs.uk/conditions/Excisionofganglion/Pages/Introduction.aspx
- British Society for Surgery of the Hand (BSSH) http://www.bssh.ac.uk/patients/conditions/20/ganglion_cysts

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

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Policy name	Gastroelectrical Stimulation
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Gastroelectrical stimulation
Included indication/ condition(s)	Idiopathic or diabetic gastroparesis
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Gastroelectrical stimulation

1. **Interventions covered by this policy**
   Gastroelectrical simulation.
   Electrical stimulation is delivered to the stomach muscle via an implanted system that consists of a neurostimulator which is placed in a pocket in the abdominal wall, and 2 leads with stimulating electrodes which are attached to the muscle of the stomach.

2. **Conditions to be considered under this policy**
   Intractable nausea and vomiting from idiopathic or diabetic gastroparesis.
   Gastroparesis is a chronic disorder in which the stomach empties more slowly than normal in the absence of mechanical obstruction.

3. **Eligibility criteria for provision of the intervention**
   Gastroelectrical simulation for use in intractable nausea and vomiting from idiopathic or diabetic gastroparesis is considered a low priority procedure and will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for gastroelectrical stimulation.
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

6. **Compliance with NICE guidance**
   NICE interventional procedures guidance (IPG 489) states that current evidence on the efficacy and safety of gastroelectrical stimulation for gastroparesis is adequate to support the use of this procedure with normal arrangements for clinical governance, consent and audit.
   NICE interventional procedures guidance makes recommendations on the safety and efficacy of a procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. Gastroelectrical stimulation is currently not funded by many NHS authorities.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies. None.
   7b. Additional guidance referred to in production of ICS policy.

   - National Institute for Health and Care Excellence, 2014. Interventional procedures guidance 489: Gastroelectrical stimulation for patients with gastroparesis. https://www.nice.org.uk/guidance/ipg489/
   - NHS website: Gastroparesis https://www.nhs.uk/conditions/gastroparesis/

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Policy name	**Grommets for Otitis Media with Effusion in Children**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical insertion of grommets
Included indication/ condition(s)	Persistent otitis media with effusion in children
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T7a: Grommets for otitis media with effusion in children
NEE CCG policy	Grommets/ adenoidectomy

1. **Interventions covered by this policy**
   Surgical insertion of grommets: these are tiny ventilation tubes which are inserted into the eardrum.

2. **Conditions to be considered for treatment under this policy**
   Otitis media with effusion (OME) (glue ear) in children aged under 12 years.

3. **Eligibility criteria for provision of the intervention**
   Insertion of grommets for the treatment of OME should only be considered in children aged under 12 years when **all** the following criteria are met (with the exception of children with Down's syndrome or Cleft Palate, see below):
   - The child has had persistent bilateral OME over a period of 3 months
     AND
   - The child has had specialist audiology and ENT assessment
     AND
   - The hearing level in the better ear is 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz
     OR
     The child has persistent bilateral OME with a hearing loss less than 25-30dbHL AND the impact of the hearing loss on the child's developmental, social or educational status is judged to be significant
     OR
     There is clinical and tympanographic evidence of persistent OME but the child cannot undergo standard assessment of hearing thresholds AND the impact of the hearing loss on the child's developmental, social or educational status is judged to be significant

   Children with Down's syndrome
   - The child has had specialist MDT assessment and in the opinion of the MDT will benefit from insertion of grommets.

   Children with Cleft Palate
   - The child has had specialist MDT assessment and in the opinion of the MDT will benefit from insertion of grommets.

   The persistence of the OME should be confirmed before surgery is carried out, with tympanometry as a minimum.

4. **Exclusions**
   This policy does not cover:

- Children aged 12 years and over and adults.
- Clinical conditions other than OME where grommets may be required, including recurrent otitis media, atrophic tympanic membranes, and to provide access to the middle ear for transtympanic instillation of medication
- Conditions requiring urgent referral, such as a child who has atypical otoscopic features accompanied by a persistent foul-smelling discharge suggestive of cholesteatoma, or a child who has excessive hearing loss suggestive of additional sensorineural deafness.

5. Additional notes

Referral may be made to the ECC Panel for children who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for grommets for otitis media with effusion.

This policy is based on 'Grommets for glue ear in children' in 'Evidence-based interventions: guidance for CCGs' published by NHS England, 2018, which is based on NICE CG60 'Otitis media with effusion in under 12s: surgery'. In December 2018 NICE took a decision to update this guidance, but the update has not yet been published.

Glue ear is very common in childhood, and in most cases it will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.

The risks of 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).

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NHS Choices. Available from: http://www.nhs.uk/Conditions/Glue-ear/Pages/Treatment.aspx
- West Suffolk Clinical Commissioning Group. Policy Thresholds. Grommets for otitis media with effusion in Children: Policy T7a. Available from: http://www.westsuffolkccg.nhs.uk/wp-content/uploads/2014/01/Evidence-Brief-T17a-Grommets-for-Otitis-Media-with-Effusion-in-children-2014.pdf
- NICE Surgical management of otitis media with effusion in children (CG60) Available from: https://www.nice.org.uk/guidance/cg60/chapter/1-Guidance
- Cochrane Database. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children 2010. Available from: http://www.cochrane.org/CD001801/ENT_grommets-ventilation-tubes-for-hearing-loss-associated-with-otitis-media-with-effusion-in-children
- Cochrane Database. Interventions for the prevention of post operative ear discharge after insertion of ventilation tubes (grommets) in children 2013. Available from: http://www.cochrane.org/CD001933/ENT_interventions-for-ear-discharge-associated-with-grommets-ventilation-tubes
- Rosenfeld, Shin, Schwartz et al. Clinical Practice Guideline: Otitis Media with Effusion (Update) 2016. Otolaryngology-Head and Neck Surgery. Available from: http://oto.sagepub.com/content/154/1_suppl/S1.full#T3

- Cambridge and Peterborough Clinical Commissioning Group. Grommets with or without adenoidectomy. 2014. Available from: http://www.cambsphn.nhs.uk/Libraries/Surgical_Threshold_Policies/GROMMETS_ADENOIDECTOMY_FEB_2014_V3.sflb.ashx
- Gloucestershire Clinical Commissioning Group. Policy: Grommet Insertion in Children. 2015.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2018. Otitis media with effusion in under 12s: surgery: 2018 surveillance decision https://www.nice.org.uk/guidance/cg60/resources/2018-surveillance-of-otitis-media-with-effusion-in-under-12s-surgery-nice-guideline-cg60-6604581853/chapter/Surveillance-decision?tab=evidence

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Policy name	Gynaecomastia Surgery
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Breast reduction surgery for gynaecomastia
Included indication/ condition(s)	Idiopathic gynaecomastia
Date produced	January 2021
Planned review date	January2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE 112: Breast reduction surgery for gynaecomastia PE 113: Breast reduction surgery for gynaecomastia related to use of antiandrogens as treatment for prostate cancer
NEE CCG policy	Gynaecomastia – Surgical intervention/ Breast reduction

1. **Interventions covered by this policy**
   Breast reduction surgery.

2. **Conditions to be considered for treatment under this policy**
   Idiopathic gynaecomastia

3. **Eligibility criteria for provision of the intervention**
   Surgical management of male gynecomastia is considered a low priority procedure and will not normally be funded.

4. **Exclusions**
   This policy does not cover:
   - Patients in whom breast or testicular cancer are suspected, who require further investigation and treatment if indicated
   - Patients in whom an underlying endocrine or liver abnormality are suspected, who require further investigation and treatment if indicated
   - Patients in whom medications or drugs known to increase the risk of gynaecomastia have been used.

5. **Additional notes**
   This policy is partially based on a recommendation in Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   True gynecomastia is benign enlargement of male breast tissue. It can be defined as the presence of >2cm palpable, firm, subareolar gland and ductal tissue. Gynecomastia is a common benign condition with up to 70% of boys developing pubertal gynecomastia and approximately 2/3 adult men having palpable breast tissue. It is separate from pseudo gynecomastia, also known as lipomastia, where breasts are larger due to increased adipose tissue. Gynecomastia often resolves spontaneously, especially in adolescence.

   In most cases a thorough history and physical examination, along with laboratory investigations, helps to exclude breast malignancy and any serious underlying endocrine or systemic disease, as well as to identify pseudo gynecomastia. Other possible underlying causes include treatments based on androgen deprivation, androgen receptor blockade

or oestrogen administration which are commonly used in the treatment of prostate cancer, other medications and drugs such as spironolactone, cimetidine, digoxin, cannabis or drugs used in bodybuilding. Patients may need to undergo further clinical evaluation for alternative treatments or medication adjustments as surgical intervention will not resolve the causative factors. Idiopathic gynaecomastia is when no underlying cause is identified.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery. The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria).

Surgery to correct unilateral or bilateral gynecomastia may be considered if the patient:

- Is aged 19 or over and is post pubertal (stable height for past 6 months)
  AND
- has BMI < 25 kg/m^2 with evidence that the patient's weight has been stable for 2 years
  AND
- Has breast enlargement on at least one side which is Grade III or above using Cordova's classification system (see Appendix)
  OR
  Has unilateral breast enlargement with a difference of at least 2 grades between the two sides (e.g. normal and Grade II).

IN ADDITION a clinician should have confirmed:

- The patient has true gynaecomastia (i.e. true breast tissue is present) not pseudo gynecomastia (adipose tissue)
- There is no suspicion of breast cancer or testicular cancer, an underlying cause such as an endocrine or liver abnormality, or the use of medications known to increase the risk of gynaecomastia (apart from the use of medication to treat prostate cancer in patients with this condition)
- The patient has been counselled regarding the risk of scarring, contour irregularities and moderate asymmetry following surgery, and is aware that revision surgery for such post-surgical cosmetic irregularities will not be funded by the CCG

ECC applications should be accompanied by clinical photographs.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

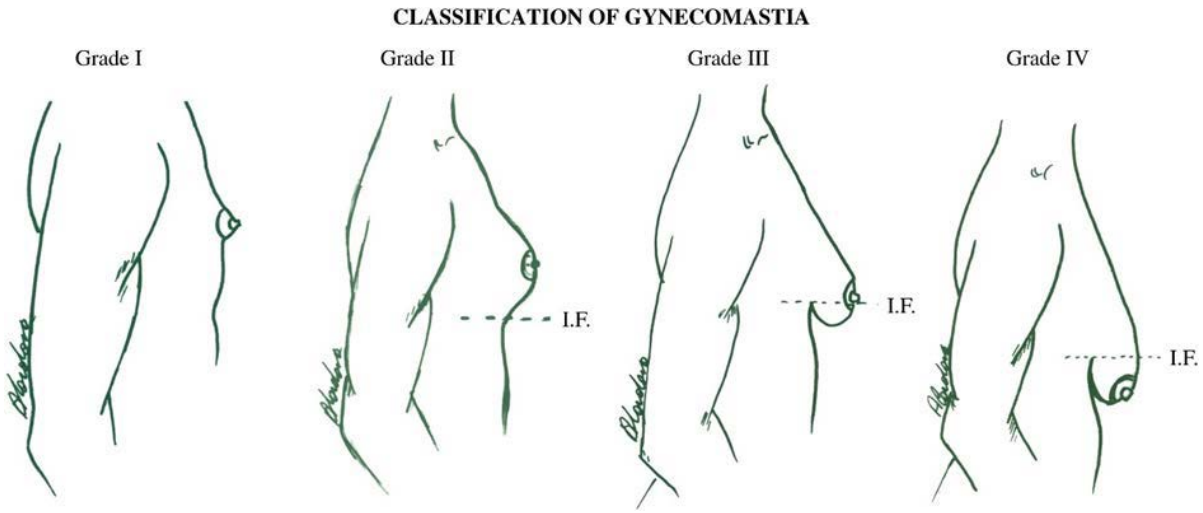
- Willet, A.M., Michell, J. M., Lee, M. J. R. Best practice diagnostic guidelines for patients presenting with breast symptoms. Department of Health. 2010.
- NHS Choices. What is gynecomastia http://www.nhs.uk/chq/Pages/885.aspx?CategoryID=61&SubCategoryID=614
- Narula HS, Carlson HE. Gynaecomastia--pathophysiology, diagnosis and treatment. Nat Rev Endocrinol. 2014 Nov; 10(11):684-98. Doi: 10.1038/nrendo.2014.139. Epub 2014 Aug 12.
- Adriana Cordova, Francesco Moschella Algorithm for clinical evaluation and surgical treatment of gynaecomastia Journal of Plastic, Reconstructive & Aesthetic Surgery Volume 61, Issue 1, Pages 41-49 (January 2008)
- British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) guidance for commissioners of plastic surgery http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
- NICE CG175 Diagnosis and Management Prostate Cancer https://www.nice.org.uk/guidance/cg175

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2019. Prostate cancer: diagnosis and management, NG131. https://www.nice.org.uk/guidance/ng131
- Cordova A, Moschella F, 2008. Algorithm for clinical evaluation and surgical treatment of gynaecomastia. JAPRAS 61; 1: 41-19 https://www.jprasurg.com/article/S1748-6815(07)00493-7/fulltext

Appendix. Classification of gynaecomastia

Based on Cordova & Moschella, 2008.



Grade I: increase in diameter and protrusion limited to the areolar region;
Grade II: areola-nipple complex above the inframammary fold (I.F.);
Grade III: areola-nipple complex at the same height as or about 1cm below the I.F.;
Grade IV: areola-nipple complex more than 1cm below the I.F

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Policy name	Haemorrhoids – Surgical Treatment
Policy type	Threshold Approval
Included intervention(s)	Surgical treatment of haemorrhoids
Included indication/ condition(s)	Haemorrhoids
Date produced	January 2021
Planned review date	January2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T50: Haemorrhoidectomy
NEE CCG policy	Haemorrhoid Surgery

1. **Interventions covered by this policy**
   Surgical treatment of haemorrhoids.

2. **Conditions to be considered for treatment under this policy**
   Haemorrhoids are abnormally swollen vascular mucosal cushions that are present in the anal canal. They are classed as external or internal, depending on their origin in relation to the dentate line **(which** is situated 2 cm from the anal verge). External haemorrhoids originate below the dentate line. Internal haemorrhoids arise above the dentate line and are graded by degree of prolapse; all grades may be accompanied by bleeding:
   Grade 1: project into the lumen of the anal canal but do not prolapse
   Grade 2: protrude beyond the anal canal on straining but spontaneously reduce when straining is stopped
   Grade 3: protrude outside the anal canal and reduce fully on manual pressure
   Grade 4: protrude outside the anal canal and cannot be reduced.

3. **Eligibility criteria for provision of the intervention**
   Surgical treatment should only be considered for haemorrhoids which are more severe and have not responded to non-operative measures, in patients who meet **both** the following criteria:
   - The patient has recurrent grade 3 or grade 4 combined internal/external haemorrhoids with
     persistent pain or bleeding
     OR
     The patient has irreducible and large external haemorrhoids
     AND
   - Conservative treatments, and outpatient procedures such as banding or injection have been considered and have been tried if clinically appropriate, but the patient's symptoms have not improved.

4. **Exclusions**
   This policy does not cover:
   - Lesions or symptoms that are suspicious of malignancy, which should be referred via the appropriate pathway
   - Patients with significant rectal bleeding, who should be referred for specialist examination

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for haemorrhoid surgery.

Haemorrhoids are common but only a small proportion of people affected seek medical attention. Often haemorrhoids (especially early stage) can be treated by lifestyle modification and conservative treatment such as eating more fibre, drinking more water, stool softeners, and using appropriate ointments for a limited time to stop itching. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or injection.

Haemorrhoid surgery can lead to complications. Pain and bleeding are common and pain may persist for several weeks. Urinary retention can occasionally occur and may require catheter insertion. Infection, iatrogenic fissuring (tear or cut in the anus), stenosis and incontinence (lack of control over bowel motions) occur more infrequently.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- SSAT Patient Care Guidelines, Surgical Management of Haemorrhoids .http://www.ssat.com/cgi-bin/hemorr.cgi
- [Haemorrhoids CKS]. 2016 [cited 23 May 2016]. Available from: http://cks.nice.org.uk/haemorrhoids
- Reese, G.E., von Roon, A.C. and Tekkis, P.P. (2009) Haemorrhoids. Clinical Evidence BMJ Publishing Group. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907769/pdf/2009-0415.pdf
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- Cataldo, P., Ellis, C.N., Gregorcyk, S. et al. (2005) Practice parameters for the treatment of haemorrhoids (revised).Diseases of the Colon & Rectum48(2), 189-194.
- Northwest London collaboration of clinical commissioning group. Haemorrhoidectomy. http://www.hounslowccg.nhs.uk/media/40064/21-Haemorrhoidectomy-v33.pdf
- Wakefield Clinical commissioning group. Clinical compact for haemorrhoids. https://www.wakefieldccg.nhs.uk/wp-content/uploads/2015/06/Clinical-Compact-for-Haemorrhoids-procedures-v0.3-final.pdf
- Herefordshire Clinical Commissioning Group Low Priority Treatment Policy 2015 http://tinyurl.com/h7a28ov
- Nottingham North East CCG http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2014/04/10.-Policy-for-Procedures-of-Low-Clinical-Value-PLCV-Version-D-March-2011-NNE.pdf

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2016. Clinical Knowledge Summary: Haemorrhoids. https://cks.nice.org.uk/haemorrhoids#!topicSummary

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Policy name	**Hallux Valgus (Bunions) or Hallux Rigidus Surgery**
Policy type	Threshold with prior approval
Included intervention(s)	Surgery for hallux valgus or hallux rigidus
Included condition/ indication(s)	Hallux valgus (bunions) Hallux rigidus
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T41. Hallux valgus (bunions) and hallux rigidus
NEE CCG policy	Bunions (hallux valgus) surgery Surgery for osteoarthritis or reduced mobility of the big toe (hallux rigidus)

1. **Interventions covered by this policy**
   Surgery for hallux valgus (bunions).
   Surgery for hallux rigidus. This may include, in selected patients, cheilectomy, arthrodesis, arthroplasty (Keller procedure), metatarsophalangeal joint replacement or osteotomy of the proximal phalanx (Moberg procedure).
   Surgery should be carried out as a day case procedure unless clinical circumstances dictate otherwise, and should not involve minimal access techniques.

2. **Conditions to be considered for treatment under this policy**
   Hallux valgus (bunion) is the deviation of the big toe (the hallux) away from the midline towards the lesser toes. The metatarsal head drifts towards the midline and this together with its overlying bursa and inflamed soft tissue is known as a bunion, which causes pain and rubbing on shoes. It is common in adults aged over 40 years (prevalence 28%).
   Hallux rigidus is the development of arthritic changes within the metatarsophalangeal joint causing stiffness, pain and deformity.
   Hallux valgus and rigidus are frequently accompanied by lesser toe changes such as hammer or claw toes and abnormal weight distribution under the lesser toes which can be painful. Deformity may contribute to impaired balance.
   Patients with diabetes and other causes of peripheral neuropathy are at increased risk of ulceration and infection as a result of hallux valgus deformity.

3. **Eligibility criteria for provision of the intervention**
   Patients with hallux valgus or hallux rigidus may be considered for surgery if they meet **all** the following criteria:
   - Appropriate conservative measures for a period of at least 6 months have failed to improve symptoms. Conservative measures may include:
     - Analgesia
     - Bunion pads/ appropriate footwear/ orthotics
     - Support to lose weight in patients with BMI>35 kg/m^2
     - Physiotherapy: support with balance, proprioception and core stability
     - Joint injection (if inflammation is suspected and there is no evidence of infection).

     AND
   - The patient has significant persistent pain which interferes with their normal functioning such as work, educational, domestic or carer activities;
     AND
   - The patient is willing to undergo surgery and understands the implications of surgery, including that they will be out of sedentary work for 2-6 weeks and physical work for

2-3 months, and that they will be unable to drive for 6-8 weeks (or 2 weeks if surgery is on the left foot and they drive an automatic car).

4. Exclusions

This policy does not cover:

- Children and young people (aged 18 and under).
- Complicated hallux valgus or hallux rigidus e.g. with impending or non-healing ulcer, or peripheral limb ischaemia. These should be managed as clinically appropriate on a case by case basis, including urgent referral if indicated.
- Surgical management using a synthetic cartilage implant (such as Cartiva).
- Surgery carried out using minimal access techniques.

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for surgery for hallux valgus or hallux rigidus.

The patient should be informed that the decision to have surgery is a dynamic process and a decision not to undergo surgery does not exclude them from having surgery at a future time point. Referral must not be made for prophylactic or cosmetic purposes.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

None

7b. Additional guidance referred to in production of ICS policy.

- British Orthopaedic Association/ Royal College of Surgeons (England) 2017. Commissioning guide: painful deformed great toe in adults.
- National Institute for Health and Care Excellence, 2007. Metatarsophalangeal joint replacement of the hallux. IPG 140. https://www.nice.org.uk/guidance/ipg140
- National Institute for Health and Care Excellence, 2010. Surgical correction of hallux valgus using minimal access techniques. IPG 332. https://www.nice.org.uk/guidance/ipg332

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Policy name	Hip Arthroscopy
Policy type	Threshold with prior approval
Included intervention(s)	Hip arthroscopy as a therapeutic intervention
Included condition/ indication(s)	Femoro-acetabular impingement, labral tears, loose bodies.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T48: Hip arthroscopy
NEE CCG policy	Hip arthroscopy

1. **Interventions covered by this policy**
   This policy covers the use of hip arthroscopy as a therapeutic intervention.

2. **Conditions to be considered for treatment under this policy**
   Femoro-acetabular impingement, which results from abnormalities of the femoral head or the acetabulum. It can be caused by jamming of an abnormally shaped femoral head into the acetabulum, or by contact between the acetabular rim and the femoral head–neck junction. Symptoms may include restriction of hip-joint movement, pain and 'clicking' of the hip, and are typically exacerbated by hip flexion or prolonged sitting.
   Labral tears; the labrum is the ring of cartilage that follows the outside rim of the socket of the hip joint, which may be torn due to trauma.
   Loose bodies within the hip joint.

3. **Eligibility criteria for provision of the intervention**
   Hip arthroscopy will be funded in the following conditions if the specified criteria are met, and none of the conditions listed below are present

   Femoro-acetabular impingement (FAI)

   - The patient has evidence of FAI as demonstrated by clinical assessment/radiological investigation
     AND
   - The patient has severe symptoms typical of FAI (hip pain that is worsened by flexion activities e.g. squatting or prolonged sitting), that significantly limit activities, with a duration of at least six months
     AND
   - The patient's symptoms have not improved with all available conservative treatment options including activity modification (e.g. restriction of athletic pursuits and avoidance of symptomatic motion), pharmacological intervention and physiotherapy
     AND
   - Other treatment options if clinically relevant and appropriate such as hip replacement or resurfacing have been considered and excluded
     AND
   - The patient is aged between 18 and 50 years, OR the patient is outside this age range and in the consultant's expert opinion this will be the best option for the patient.

   Labral tears

   - The patient has labral tears that have been identified by radiological investigation
     AND
   - There is no evidence of osteoarthritis or FAI in the joint

Loose bodies

- The patient has one or more loose bodies in the hip joint that have been identified by radiological investigation

Conditions in which hip arthroscopy will not be funded include the following:

- As a diagnostic intervention, for example when there are suspected loose bodies
- Advanced degenerative osteoarthritis (Tonnis grade 2 or more) or severe cartilage injury within the hip joint
- Joint space on plain radiograph <2mm wide along the length of the sourcil
- Patients who are candidates for total hip replacements
- Evidence of hip dysplasia or considerable protrusion
- Osteonecrosis with femoral head collapse
- Grade III or IV heterotopic bone formation
- Sepsis and accompanying osteomyelitis or abscess formation
- Joint ankyloses
- Generalised joint laxity e.g. Ehlers Danlos or Marfans Syndrome
- Osteogenesis Imperfecta

4. Exclusions

None

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hip arthroscopy.

Patients who meet criteria for funding must be added to the national non-arthroplasty hip registry: http://www.nahr.co.uk/

Arthroscopic femoro–acetabular surgery for hip impingement syndrome should only be carried out by surgeons with specialist expertise in arthroscopic hip surgery.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy /policies.

- http://orthoinfo.aaos.org/topic.cfm?topic=a00571 Accessed on 23/05/16
- Arthroscopic femoro–acetabular surgery for hip impingement syndrome NICE interventional procedure guidance [IPG408] Published date: September 2011
- Wall PDH, Brown JS, Parsons N, Buchbinder R, Costa ML, Griffin D. Surgery for treating hip impingement (femoroacetabular impingement). Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD010796. DOI: 10.1002/14651858.CD010796.pub2.
- Nord RM, Meislin RJ. Hip arthroscopy in adults. Bulletin of the NYU Hospital for Joint Diseases 2010; 68(2):97-102 97
- Moin Khan et. al. Arthroscopy Up to Date: Hip Femoroacetabular Impingement Arthroscopy: The Journal of Arthroscopic and Related Surgery, Vol 32, No 1 (January), 2016: pp 177-189
- Gupta A, Redmond JM, Stake CE, Dunne KF, Domb BG. Does Primary Hip Arthroscopy Result in Improved Clinical Outcomes?: 2-Year Clinical Follow-up on a Mixed Group of 738 Consecutive Primary Hip Arthroscopies Performed at a High-Volume Referral Center. Am J

Sports Med. 2016 Jan;44(1):74-82. doi: 10.1177/0363546514562563. Epub 2015 Jan 28.

- Park MS, Yoon SJ, Kim YJ, Chung WC. Hip arthroscopy for femoroacetabular impingement: the changing nature and severity of associated complications over time. Arthroscopy. 2014 Aug; 30(8):957-63. doi: 10.1016/j.arthro.2014.03.017. Epub 2014 May 14
- Niroopan et. Al. Hip Arthroscopy in Trauma: A Systematic Review of Indications, Efficacy, and Complications Arthroscopy April 2016Volume 32, Issue 4, Pages 692–703.e1
- Darren et. al. Efficacy of Hip Arthroscopy for the Management of Septic Arthritis: A Systematic Review, Arthroscopy: The Journal of Arthroscopic & Related Surgery Volume 31, Issue 7, July 2015, Pages 1358–1370
- Nusem I, Jabur MK, Playford EG. Arthroscopic treatment of septic arthritis of the hip. Arthroscopy. 2006 Aug; 22(8):902. e901-3
- Domb BG, Linder D, Finley Z, Botser IB, Chen A, Williamson J, Gupta A. Outcomes of hip arthroscopy in patients aged 50 years or older compared with a matched-pair control of patients aged 30 years or younger. Arthroscopy. 2015 Feb; 31(2):231-8. Doi: 10.1016/j.arthro.2014.08.030. Epub 2014 Nov 6.
- The National Non-Arthroplasty Hip Surgery Register (NAHSR) And Femoro-Acetabular Impingement surgery. https://www.britishhipsociety.com/uploaded/2011_NAHR_Archive/NAHSR%20and%20FAI%20surgery.pdf

7b. Additional guidance referred to in production of ICS policy.

- British Hip Society. The non-arthroplasty hip registry http://www.nahr.co.uk/
- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: pain arising from the hip in adults. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html

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Policy name	**Hip Injections**
Policy type	Threshold with prior approval
Included intervention(s)	Hip injection for diagnostics
Included condition/ indication(s)	Osteoarthritis, greater trochanteric pain syndrome
Date produced	31st March.2021
Planned review date	1st July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	None
NEE CCG policy	Removal of therapeutic element

1. Interventions covered by this policy

Hip injections comprising of both Steroid and Local Anaesthetic for use in both adults and children under the age of 18 years old.

2. Conditions to be considered for treatment under this policy

- Osteoarthritis
- Greater trochanteric pain syndrome

3. Eligibility criteria for provision of the intervention

Recommendation 1

As a diagnostic aid relating to Osteoarthritis and limited to the following instances;

- To introduce contrast medium to the joint as part of hip arthrogram
- Babies for hip arthrography

Recommendation 2

- Investigation into a possible infected hip such as inflammatory arthropathy in both adults and children.
- Investigation of infection in biological and replaced hips.

Recommendation 3

- Offering a peri-trochanteric corticosteroid injection adjunct to referral for physiotherapy in cases where conservative treatment options for Greater Trochanteric Pain Syndrome have not been successful.

4. Exclusions

Hip injection as a means of therapeutic intervention in Osteoarthritic conditions is not routinely supported. This policy is alignment with the most up to date published NICE guidelines and as such does not seek to offer intra-articular hyaluronan injections for the management of osteoarthritis or associated pain symptoms.
Use of Hyaluronic Acid and/or Platelet Rich Plasma is also not supported.

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5. Additional notes

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.

6. Compliance with NICE guidance

NICE CG177: Intra-articular injections in osteoarthritis

- 1.5.13 Do not offer intra-articular hyaluronan injections for the management of osteoarthritis. [2014]

NICE CKS

- Offering a peri-trochanteric corticosteroid injection and referral for physiotherapy
- There is strong evidence of a short-term benefit from peri-trochanteric corticosteroid injections for up to 3 months with the greatest effect at 6 weeks, however, recurrence of pain in the long term is common [Reid, 2015].
- The recommendation on physiotherapy is based on expert opinion as CKS found no clinical trials assessing the effect of physiotherapy on greater trochanteric pain syndrome [Reid, 2015].
- Peri-trochanteric corticosteroid injections may be most useful if used for pain relief in the short term to enable physiotherapy which will improve the long term prognosis [Reid, 2015]

7. References

1. Clinical Guideline NICE NG177, Osteoarthritis: care and management https://www.nice.org.uk/guidance/cg177
1. Greater trochanteric pain syndrome (trochanteric bursitis) Diagnosis and management
   NICE CKS https://cks.nice.org.uk/greater-trochanteric-pain-syndrome-trochanteric-bursitis#!topicSummary
2. British Orthopaedic Association Commissioning guide: Pain arising from the hip in adults; www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--pain-arising-from-the-hip-guide-2017.pdf

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Policy name	**Hip Replacement**
Policy type	Threshold with prior approval
Included intervention(s)	Hip replacement surgery
Included condition/ indication(s)	Osteoarthritis of the hip
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T18a: Hip replacement
NEE CCG policy	Hip replacement

1. Interventions covered by this policy

Hip replacement surgery

2. Conditions to be considered for treatment under this policy

Osteoarthritis of the hip

3. Eligibility criteria for provision of the intervention

Patients should only be referred for consideration of hip replacement surgery for osteoarthritis if:

- They experience joint symptoms that have a substantial impact on their quality of life, as demonstrated by:
  - Intense to severe persistent pain (defined in Appendix Table 1) leading to severe functional limitation (defined in Appendix Table 2) for a period of at least 3 months
    OR
  - moderate to severe functional limitation (defined in Appendix Table 2) affecting quality of life (in the opinion of the clinician(s) on the local CCG Hip Pathway) for a period of at least 3 months

AND

- they have completed 'Stage 2 – Preparation for Surgery' of the local CCG Hip pathway

AND

- they have completed all the following core treatments:
  - Patient education: such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment for at least 3 months

  AND
  - Activity and exercise: e.g. physiotherapy for at least 3 months

  AND
  - They have a BMI ≤35kg/m^2 (*see below)

  OR

  They have a BMI>35kg/m^2 and have evidence of participating in a weight management programme in line with Policy 'Weight management and smoking cessation prior to elective surgery'.

  AND
  - they have trialled appropriate pain relief for a minimum of 3 weeks: paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered first, Other treatment options, depending on response and the consideration of possible side-effects, may include oral NSAIDs, COX-2 inhibitors or opioids.

  AND

- if the patient currently smokes they should have been offered advice and support to help stop smoking as an opt-out, in line with Policy ** 'Weight management and smoking cessation prior to elective surgery'

* Patients whose BMI is >30 but ≤35kg/m^2 should be advised that there is evidence that the outcomes of joint replacement surgery are better in people whose BMI is ≤30, and be offered support to lose weight.

Clinical exceptions to this policy (patients who are not required to meet the above criteria) are:

- Patients whose pain is so severe and/or mobility is so compromised that they are in immediate danger of losing their independence, and joint replacement would help prevent this.
- Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

Second joint replacement

If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

4. Exclusions

This policy does not apply to:

- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.
- Patients with a recent history of trauma or an injury
- Patients for whom hip replacement is being considered for indications other than osteoarthritis

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hip replacement.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance, except with respect to the following:
NICE Clinical Guideline 177 recommends that 'Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. However, in acknowledgement of the evidence of increased risk of post-operative complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review, and some of which was published since NICE completed their review (Pozzobon et al, 2019)) and with metabolic syndrome (Glance et al, 2010), and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54.

- Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502.
- The International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2006. http://www.idf.org/webdata/docs/MetS_def_update2006.pdf.
- National Institute for Health and Care Excellence. Osteoarthritis: Care and management in adults (NICE CG177). 2014. https://www.nice.org.uk/guidance/cg177/evidence/full-guideline-191761309.
- National Institute for Health and Care Excellence. Osteoarthritis (NICE QS87). 2015. https://www.nice.org.uk/guidance/qs87.
- British Orthopaedic Association, Royal College of Surgeons, British Hip Society. *Commissioning Guide: Pain Arising from the Hip in Adults*. 2013. http://www.boa.ac.uk/pro-practice/pain-arising-from-the-hip-in-adults-commissioning-guide/.
- Glance L, Wissler R, Mukamel D, et al. Perioperative outcomes among patients with the modified metabolic syndrome who are undergoing noncardiac surgery. *Anesthesiology*. 2010;113(4):859-872.

7b. Additional guidance referred to in production of ICS policy.

- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: pain arising from the hip in adults. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018;**8:**e017689. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf

Appendix

Table 1: Classification of Pain Level *

Pain Level	
Slight	Sporadic pain. (May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain. (May be daily and occurs 50-75% of one's day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature. (Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches).
Severe	Continuous pain. (Occurs 100% of the time) Pain when resting. Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).

*Based on: Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54

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Table 2: Classification of Functional Limitations**

Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care. Walking capacity of between half and one hour. Aids such as a cane are needed occasionally.
Severe	Largely or wholly incapacitated. Walking capacity of less than half an hour. Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.

**Based on: Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502

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Policy name	Hip Resurfacing
Policy type	Threshold with prior approval
Included intervention(s)	Hip resurfacing arthroplasty
Included condition/ indication(s)	Osteoarthritis of the hip
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Hip resurfacing

1. **Interventions covered by this policy**
   Hip resurfacing arthroplasty. This involves removing and replacing the surface of the femoral head with a hollow metal hemisphere, which fits into a metal cup fixed into the acetabulum.

2. **Conditions to be considered for treatment under this policy**
   Osteoarthritis of the hip.

3. **Eligibility criteria for provision of the intervention**
   Patients may be funded for hip resurfacing if they would otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements. Patient selection for total hip replacement or resurfacing arthroplasty depends on various factors, including but not limited to patient characteristics such as age, gender, activity and underlying hip physiology

   Patients should only be referred for consideration of hip resurfacing surgery for osteoarthritis if:
   - They experience joint symptoms that have a substantial impact on their quality of life, as demonstrated by:
     - intense to severe persistent pain (defined in Appendix Table 1) leading to severe functional limitation (defined in Appendix Table 2) for a period of at least 3 months

     OR
     - moderate to severe functional limitation (defined in Appendix Table 2) affecting quality of life (in the opinion of the clinician(s) on the local CCG Hip Pathway) for a period of at least 3 months

   AND
   - there is a clear rationale why hip resurfacing is considered more appropriate than hip replacement for this patient

   AND
   - they have completed 'Stage 2 – Preparation for Surgery' of the local CCG Hip pathway

   AND
   - they have completed all the following core treatments:
     - Patient education: such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment for at least 3 months

     AND
     - Activity and exercise: e.g. physiotherapy for at least 3 months

     AND
     - They have a BMI ≤35kg/m^2 (*see below)

     OR

     They have a BMI>35kg/m^2 and have evidence of participating in a weight

management programme in line with Policy 'Weight management and smoking cessation prior to elective surgery'.

AND

- they have trialled appropriate pain relief for a minimum of 3 weeks: paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered first, Other treatment options, depending on response and the consideration of possible side-effects, may include oral NSAIDs, COX-2 inhibitors or opioids.

AND

- if the patient currently smokes they should have been offered advice and support to help stop smoking as an opt-out, in line with Policy 'Weight management and smoking cessation prior to elective surgery'

* Patients whose BMI is >30 but ≤35kg/m^2 should be advised that there is evidence that the outcomes of joint replacement surgery are better in people whose BMI is ≤30, and be offered support to lose weight.

Clinical exceptions to this policy (patients who are not required to meet the above criteria) are:

- Patients whose pain is so severe and/or mobility is so compromised that they are in immediate danger of losing their independence, and joint resurfacing would help prevent this.

Second joint resurfacing

If more than one joint resurfacing is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint resurfacing and another joint resurfacing is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

4. Exclusions

This policy does not apply to:

- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.
- Patients with a recent history of trauma or an injury
- Patients for whom hip resurfacing is being considered for indications other than osteoarthritis

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hip resurfacing.

Prostheses for hip resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. Clinicians may be more likely to offer resurfacing arthroplasty to men than to women because higher revision rates have been observed in women, which may be associated with women tending to have smaller hips.

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6. Compliance with NICE guidance

This policy complies with relevant NICE guidance, except with respect to the following: NICE Clinical Guideline 177 recommends that 'Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. However, in acknowledgement of the evidence of increased risk of post-operative complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review, and some of which was published since NICE completed their review (Pozzobon et al, 2019)) and with metabolic syndrome (Glance et al, 2010), and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

7. References

7a. References included in original Suffolk/NEE policy/ies.

- http://www.nice.org.uk/guidance/ta304/resources/guidance-total-hip-replacementandresurfacing-arthroplasty-for-endstage-arthritis-of-the-hip-review-of-technologyappraisalguidance-2-and-44-pdf

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2014. Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip. Technology appraisal guidance TA304 www.nice.org.uk/guidance/ta304
- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: pain arising from the hip in adults. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018;**8:**e017689. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf

Appendix

Table 1: Classification of Pain Level *

Pain Level	
Slight	Sporadic pain. (May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain. (May be daily and occurs 50-75% of one's day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature. (Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches).
Severe	Continuous pain. (Occurs 100% of the time) Pain when resting. Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).

*Based on: Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54

Table 2: Classification of Functional Limitations**

Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care. Walking capacity of between half and one hour. Aids such as a cane are needed occasionally.
Severe	Largely or wholly incapacitated. Walking capacity of less than half an hour. Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.

**Based on: Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502

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Policy name	Hysterectomy for Heavy Menstrual Bleeding
Policy type	Threshold with prior approval
Included intervention(s)	Hysterectomy
Included indication/ condition(s)	Heavy menstrual bleeding.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T14: Hysterectomy for heavy menstrual bleeding
NEE CCG policy	Hysterectomy for heavy menstrual bleeding

1. **Interventions covered by this policy**
   Hysterectomy is the surgical removal of the uterus.

2. **Conditions to be considered for treatment under this policy**
   Heavy menstrual bleeding.

3. **Eligibility criteria for provision of the intervention**
   Hysterectomy should be considered as a treatment for heavy menstrual bleeding only when:
   - Other treatment options have failed or are contraindicated (further details in section 5 below); these may include consideration of:

     for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis
     - an LNG-IUS
     - pharmacological treatments (hormonal or non-hormonal)
     - surgical interventions (endometrial ablation, or, for women with submucosal fibroids, hysteroscopic removal)

     for women with fibroids of 3 cm or more in diameter
     - an LNG-IUS
     - pharmacological treatments (hormonal or non-hormonal)
     - uterine artery embolization, for patients who meet criteria in the relevant policy
     - myomectomy

   AND
   - there is a wish for amenorrhoea (no periods)

   AND
   - the woman (who has been fully informed) requests it

   AND
   - the woman no longer wishes to retain her uterus and fertility

4. **Exclusions**
   This policy does not apply to:
   - Children and young people (aged 18 and under)
   - Post-menopausal, inter-menstrual or post-coital bleeding.

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018, which is based on NICE NG88 ‘Heavy menstrual bleeding: diagnosis and management’.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Please refer to policy that covers Uterine Artery Embolisation
Please refer to policy that covers Dilatation and curettage for heavy menstrual bleeding

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hysterectomy.

Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if the ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.

The following is a summary of **recommendations on the management of heavy menstrual bleeding** in NICE NG88 (see the guidance for full details).

When agreeing treatment options for heavy menstrual bleeding with women, consider: 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.

For women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis

- An LNG-IUS (levonorgestrel-releasing intrauterine system) as first line
- Non-hormonal pharmacological treatments: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs)
- Hormonal pharmacological treatments: combined hormonal contraception, cyclical oral progestogens

If these are declined or unsuccessful, or symptoms are severe, consider referral to specialist care for:

- Investigations to diagnose the cause of HMB, if needed,
- Pharmacological options not already tried
- Surgical options: second-generation endometrial ablation, hysterectomy, or (for women with submucosal fibroids), hysteroscopic removal may be considered

for women with fibroids of 3 cm or more in diameter

Consider referral to specialist care to undertake additional investigations and discuss treatment options. These may include:

- Non-hormonal pharmacological treatments: tranexamic acid and/or NSAIDs, which can be continued for as long as they are found to be beneficial
- Hormonal pharmacological treatments: LNG-IUS, combined hormonal contraception, cyclical oral progestogens
- Uterine artery embolization
- Surgical: second-generation endometrial ablation, myomectomy, hysterectomy

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6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy /policies.

- NICE guidelines [CG44] Heavy menstrual bleeding: assessment and management https://www.nice.org.uk/guidance/cg44
- Royal College Obstetricians and Gynecologists Publication standards for gynaecology https://www.rcog.org.uk/globalassets/documents/guidelines/wprgynstandards2008.pdf
- Nice Quality Statement QS47 Heavy Menstrual Bleeding https://www.nice.org.uk/guidance/qs47
- http://www.westsuffolkccg.nhs.uk/wp-content/uploads/2014/09/T36-Uterine-Artery-Embolisation-Threshold-Policy1.pdf
- NHS Shared decision making tool HMB http://sdm.rightcare.nhs.uk/pda/menorrhagia/
- Lethaby A, Hussain M, Rishworth JR, Rees MC. Progesterone or progestogen-releasing intrauterine systems for heavy menstrual bleeding. Cochrane Database of Systematic Reviews 2015, Issue 4
- Marjoribanks J, Lethaby A, Farquhar C. Surgery versus medical therapy for heavy menstrual bleeding. Cochrane Database of Systematic Reviews 2016, Issue 1
- National Institute for Health and Care Excellence, 2018. Heavy menstrual bleeding: diagnosis and management. NG88. www.nice.org.uk/guidance/ng88 (replaces CG44)

7b. Additional guidance referred to in production of ICS policy

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

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Policy name	Knee Arthroscopy in conditions other than Osteoarthritis
Policy type	Threshold with prior approval
Included intervention(s)	Knee arthroscopy
Included condition/ indication(s)	Various conditions involving internal derangement of the knee joint, or continuing diagnostic uncertainty
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T35: Knee arthroscopy
NEE CCG policy	Knee arthroscopy

1. Interventions covered by this policy

Knee arthroscopy involves the insertion of an arthroscope attached to a video camera through a small incision, with further intervention as clinically indicated.

2. Conditions to be considered for treatment under this policy

Internal derangement of the knee joint: meniscal tear, articular cartilage pathology, synovial pathology, impingement or patellofemoral maltracking.
Continuing diagnostic uncertainty

3. Eligibility criteria for provision of the intervention

Therapeutic knee arthroscopy

Therapeutic knee arthroscopy may be considered in the following circumstances, when the specified criteria apply.

- There is clear evidence of *internal joint derangement*, as demonstrated by a competent clinical examination and/or MRI scan. Internal joint derangement may be: meniscal tear, articular cartilage pathology, synovial pathology, impingement (amenable to treatment e.g. by notchplasty, removal of cyclops lesion or excision of infrapatellar fat pad) or patellofemoral maltracking

AND

- Where clinically appropriate a trial of at least three months' conservative treatment has failed and not addressed the symptoms. Conservative treatment may include adequate analgesia, physiotherapy/ exercise programmes, and losing weight if necessary.

Diagnostic knee arthroscopy

Knee arthroscopy should not usually be considered a diagnostic tool. It may be considered when there is continuing diagnostic uncertainty and:

- The diagnostic uncertainty has not been resolved by competent clinical examination and non-invasive investigations (e.g. MRI)

OR

- there are valid clinical reasons why it is not possible to carry out non-invasive investigations such as MRI

4. Exclusions

This policy does not cover:

- Patients undergoing urgent treatment due to acute trauma
- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.
- Arthroscopy carried out in conjunction with open surgery

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5. Additional notes

Please refer to the policy that covers 'Knee arthroscopy in osteoarthritis'.
All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.
Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee arthroscopy.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Onyema C, Oragui E, White J, Khan W. Evidence-based practice in arthroscopic knee surgery. Journal of perioperative practice 2011; 21(4): 128-34
- Allum R. Complications of arthroscopy of the knee. Journal of Bone and Joint Surgery 2002; 84(7): 937
- NICE. IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. National Institute for Health and Clinical Excellence Interventional Procedures Programme, August 2007.
- NICE CG177 Osteoarthritis: the care and management of osteoarthritis in adults. National Institute for Health and Clinical Excellence (NICE), Feb 2014.
- Kirkley A et al. A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee. The New England Journal of Medicine. 2008 Sep 11;359(11):1097-107
- Sing DC, B.S. TFL, Feeley BT, , M.D. ALZ. Is Obesity a Risk Factor for Adverse Events After Knee Arthroscopy? J Arthrosc Relat Surg. 2016;32(7):1346–1353. http://www.arthroscopyjournal.org/article/S0749-8063 (16)00047-5/abstract. (Accessed 13/09/16)
- HEALTH EVIDENCE REVIEW COMMISSION (HERC). COVERAGE GUIDANCE: KNEE ARTHROSCOPY FOR OSTEOARTHRITIS.; 2014. http://www.oregon.gov/oha/herc/CoverageGuidances/Knee-Arthroscopy-11-13-14.pdf.
- Werner BC,, MD MTB, , MD WMN, , PhD JAB. Total Knee Arthroplasty Within Six Months After Knee Arthroscopy Is Associated With Increased Postoperative Complications. J Arthroplasty. 2015;30(8):1313–1316. http://www.arthroplastyjournal.org/article/S0883-5403(15)00134-5/fulltext.
- NICE: National Institute for Health and Care Excellence. Arthroscopic radiofrequency chondroplasty for discrete chondral defects of the knee. IPG493. https://www.nice.org.uk/guidance/ipg493. Published 2014.
- Moin Khan M, Nathan Evaniew M, Asheesh Bedi M, Olufemi R. Ayeni, MD MSc Mohit Bhandari MP, Wales YJB for E and. Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. Can Med Assoc J. 2014;186(14):1057-1064. http://www.cmaj.ca/content/186/14/1057.abstract?sid=c688377f-060c-43fe-817b-ffd7727df795.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

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Policy name	Knee Arthroscopy for patients with Osteoarthritis
Policy type	Threshold with prior approval
Included intervention(s)	Arthroscopic knee washout (lavage and debridement)
Included condition/ indication(s)	Osteoarthritis of the knee
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T35: Knee arthroscopy
NEE CCG policy	Knee arthroscopy

1. **Interventions covered by this policy**
   Arthroscopic washout (lavage) of the knee involves the insertion of an arthroscope attached to a video camera through a small incision. Saline is introduced via an arthroscopic cannula to wash out the joint. Washout expels any loose debris through the cannula. Debridement involves using instruments to remove damaged cartilage or bone, and this is often performed at the same time as washout.

2. **Conditions to be considered for treatment under this policy**
   Osteoarthritis of the knee, which can cause symptoms including pain, stiffness and mechanical locking.

3. **Eligibility criteria for provision of the intervention**
   Arthroscopic washout (lavage) with or without debridement of the knee should only be considered for patients who have osteoarthritis of the knee who have a clear history of mechanical locking.

4. **Exclusions**
   This policy does not cover:
   - Patients with osteoarthritis of the knee with other symptoms such as morning joint stiffness or 'giving way', or X-ray evidence of loose bodies, in the absence of mechanical locking
   - Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.

5. **Additional notes**
   This policy is based on 'Evidence-based interventions: guidance for CCGs' published by NHS England in November 2018.

   Please refer to the policy that covers 'Knee arthroscopy in conditions other than osteoarthritis'.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee arthroscopy.

   Conservative treatments such as adequate analgesia, exercise programmes, and losing weight if necessary, can help in the management of the symptoms of knee osteoarthritis.

Where symptoms do not resolve after nonoperative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Onyema C, Oragui E, White J, Khan W. Evidence-based practice in arthroscopic knee surgery. Journal of perioperative practice 2011; 21(4): 128-34
- Allum R. Complications of arthroscopy of the knee. Journal of Bone and Joint Surgery 2002; 84(7): 937
- NICE. IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. National Institute for Health and Clinical Excellence Interventional Procedures Programme, August 2007.
- NICE CG177 Osteoarthritis: the care and management of osteoarthritis in adults. National Institute for Health and Clinical Excellence (NICE), Feb 2014.
- Kirkley A et al. A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee. The New England Journal of Medicine. 2008 Sep 11; 359(11):1097-107
- Sing DC, , B.S. TFL, Feeley BT, , M.D. ALZ. Is Obesity a Risk Factor for Adverse Events After Knee Arthroscopy? J Arthrosc Relat Surg. 2016; 32(7):1346–1353. http://www.arthroscopyjournal.org/article/S0749-8063 (16)00047-5/abstract. (accessed 13/09/16)
- HEALTH EVIDENCE REVIEW COMMISSION (HERC). COVERAGE GUIDANCE: KNEE ARTHROSCOPY FOR OSTEOARTHRITIS. 2014. http://www.oregon.gov/oha/herc/CoverageGuidances/Knee-Arthroscopy-11-13-14.pdf.
- Werner BC,, MD MTB, , MD WMN, , PhD JAB. Total Knee Arthroplasty Within Six Months After Knee Arthroscopy Is Associated With Increased Postoperative Complications. J Arthroplasty. 2015;30(8):1313–1316. http://www.arthroplastyjournal.org/article/S0883-5403 (15)00134-5/fulltext.
- NICE: National Institute for Health and Care Excellence. Arthroscopic radiofrequency chondroplasty for discrete chondral defects of the knee. IPG493. https://www.nice.org.uk/guidance/ipg493. Published 2014.
- Moin Khan M, Nathan Evaniew M, Asheesh Bedi M, Olufemi R. Ayeni, MD MSc Mohit Bhandari MP, Wales YJB for E and. Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. Can Med Assoc J. 2014; 186(14):1057-1064. http://www.cmaj.ca/content/186/14/1057.abstract?sid=c688377f-060c-43fe-817b-ffd7727df795.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

Policy name	Knee Replacement
Policy type	Threshold with prior approval
Included intervention(s)	Knee replacement surgery
Included condition/ indication(s)	
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T18b: Knee replacement PE118: Patella resurfacing as part of primary total knee replacement
NEE CCG policy	Knee replacement

1. Interventions covered by this policy

Knee replacement surgery

2. Conditions to be considered for treatment under this policy

Osteoarthritis of the knee

3. Eligibility criteria for provision of the intervention

Patients should only be referred for consideration of knee replacement surgery for osteoarthritis if:

- They experience joint symptoms that have a substantial impact on their quality of life, as demonstrated by:
  - intense to severe persistent pain (defined in Appendix Table 1) leading to severe functional limitation (defined in Appendix Table 2) for a period of at least 3 months

  OR
  - moderate to severe functional limitation (defined in Appendix Table 2) affecting quality of life (in the opinion of the clinician(s) on the local CCG Hip Pathway) for a period of at least 3 months

AND

- they have completed 'Stage 2 – Preparation for Surgery' of the local CCG Knee pathway

AND

- they have completed all the following core treatments:
  - Patient education: such as elimination of damaging influence on knees, activity modification (avoid impact and excessive exercise) and lifestyle adjustment for at least 3 months

  AND
  - They have received at least one additional non-operative therapy: e.g. manual therapy (e.g. physiotherapy), supports and braces, shock absorbing shoes or insoles, local heat and cold therapy. Intra-articular corticosteroid injections may also be provided (when facility is available in primary/intermediate care)

  AND
  - They have a BMI ≤35kg/m^2 (*see below)

  OR

  They have a BMI>35kg/m^2 and have evidence of participating in a weight management programme in line with Policy 'Weight management and smoking cessation prior to elective surgery'

  AND
  - they have trialled appropriate pain relief for a minimum of 3 weeks: paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be

considered first, Other treatment options, depending on response and the consideration of possible side-effects, may include oral NSAIDs, COX-2 inhibitors or opioids.

AND

- if the patient currently smokes they should have been offered advice and support to help stop smoking as an opt-out, in line with Policy 'Weight management and smoking cessation prior to elective surgery'

* Patients whose BMI is >30 but ≤35kg/m^2 should be advised that there is evidence that the outcomes of joint replacement surgery are better in people whose BMI is ≤30, and be offered support to lose weight.

Clinical exceptions to this policy (patients who are not required to meet the above criteria) are:

- Patients whose pain is so severe and/or mobility is so compromised that they are in immediate danger of losing their independence, and joint replacement would help prevent this.
- Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

Second joint replacement

If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

4. Exclusions

This policy does not apply to:

- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.
- Patients with a recent history of trauma or an injury
- Patients for whom knee replacement is being considered for indications other than osteoarthritis

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Patella resurfacing is considered a low priority procedure and should not currently be offered as part of primary total knee replacement. This position may be reviewed after the publication of NICE guidance on joint replacement which is due to be published in March 2020.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee replacement.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance, except with respect to the following:
NICE Clinical Guideline 177 recommends that 'Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. However, in acknowledgement of the evidence of increased risk of post-operative

complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review, and some of which was published since NICE completed their review (Pozzobon et al, 2019)) and with metabolic syndrome (Glance et al, 2010), and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991; 20:48-54.
- Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502.
- The International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2006. http://www.idf.org/webdata/docs/MetS_def_update2006.pdf.
- National Institute for Health and Care Excellence. Osteoarthritis: Care and management in adults (NICE CG177). 2014. https://www.nice.org.uk/guidance/cg177/evidence/full-guideline-191761309.
- National Institute for Health and Care Excellence. Osteoarthritis (NICE QS87). 2015. https://www.nice.org.uk/guidance/qs87.
- British Orthopaedic Association, Royal College of Surgeons. *Commissioning Guide: Painful osteoarthritis of the knee*; 2013. http://www.boa.ac.uk/pro-practice/painful-osteoarthritis-of-the-knee-commissioning-guide-2/.
- Glance L, Wissler R, Mukamel D, et al. Perioperative outcomes among patients with the modified metabolic syndrome who are undergoing noncardiac surgery. *Anesthesiology*. 2010;113(4):859-872.
- Swan, J. D., Stoney, J. D., Lim, K., Dowsey, M. M., & Choong, P. F. The need for patella resurfacing in total knee arthroplasty: a literature review. ANZ journal of surgery. 2010; 80(4): 223-233.
- Hsu RW. The management of the patella in total knee arthroplasty. Chang Gung Med J. 2006 Sep-Oct; 29(5):448-57.
- Shuzhen L, Yueping C, Wei S, Jinmin Z, Shunqing H, and Xiangping L. Systematic review of patella resurfacing in total knee arthroplasty. Int Orthop. 2011 Mar; 35(3): 305–316.
- Sandiford NA, Alao U, Salamut W, Weitzel S, Skinner JA. Patella Resurfacing during Total Knee Arthroplasty: Have We Got the Issue Covered? Clin Orthop Surg. 2014 Dec; 6(4): 373–378

7b. Additional guidance referred to in production of ICS policy.

- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: painful osteoarthritis of the knee. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018; **8:e017689**. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf
- National Institute for Health and Care Excellence, October 2019. Joint replacement (primary): hip, knee and shoulder. Draft for consultation. https://www.nice.org.uk/guidance/GID-NG10084/documents/draft-guideline
- National Institute for Health and Care Excellence, October 2019. Joint replacement (primary): hip, knee and shoulder. Evidence review for patella resurfacing. https://www.nice.org.uk/guidance/GID-NG10084/documents/evidence-review-12

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Table 1: Classification of Pain Level *

Pain Level	
Slight	Sporadic pain. (May be daily but comes and goes 25% or less of one's day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.
Moderate	Occasional pain. (May be daily and occurs 50-75% of one's day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense	Pain of almost continuous nature. (Occurs 75-100% of one's day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches).
Severe	Continuous pain. (Occurs 100% of the time) Pain when resting. Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).

*Based on: Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54

Table 2: Classification of Functional Limitations**

Functional Limitations	
Minor	Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care. Walking capacity of between half and one hour. Aids such as a cane are needed occasionally.
Severe	Largely or wholly incapacitated. Walking capacity of less than half an hour. Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required.

**Based on: Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502

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Policy name	**Labiaplasty and Vaginoplasty**
Policy type	Threshold with prior approval
Included intervention(s)	Surgery to alter the size or appearance of the labia or vagina
Included indication/ condition(s)	Patients requesting surgery to alter the size or appearance of the labia or vagina
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T33: Labiaplasty
NEE CCG policy	Vaginal Labia Reduction/Refashioning

1. **Interventions covered by this policy**
   Surgery to refashion, reduce in size or repair the labia or vagina.

2. **Conditions to be considered for treatment under this policy**
   Patients requesting surgery to alter the size or appearance of the labia or vagina.

3. **Eligibility criteria for provision of the intervention**
   Labiaplasty
   Referral for surgery to the labia may be considered if patients meet one of the following criteria:
   - They have another medical condition (such as cancer or congenital malformation) which has caused labial hypertrophy, and there is a clinical indication for Labiaplasty

   OR
   - Repair to the labia is required following trauma, including traumatic birth injury

   Vaginoplasty
   Referral for vaginoplasty may be considered if patients meet one of the following criteria:
   - They have congenital absence or significant developmental/endocrine abnormalities of the vaginal canal

   OR
   - Repair of the vaginal canal is required after trauma, including traumatic birth injury

4. **Exclusions**
   This policy does not cover:
   - Suspected malignancy, when referral should be made through the appropriate (2 week wait) route
   - Surgery to alter the appearance of the labia or vagina for cosmetic reasons
   - Hymenorrhaphy.

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy ‘Weight management and smoking cessation prior to elective surgery’.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement ‘Cosmetic interventions: general principles’.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for Labiaplasty or Vaginoplasty. An ECC will only be accepted if it is supported by a consultant gynaecologist who has performed and documented a clinical examination and confirms that there is a defined clinical need.

The labia vary widely in size and appearance and there is no standard definition of what constitutes hypertrophy. Assessment tends to focus on functionality, for example if a patient finds her labia chafe uncomfortably against her clothes, limit her participation in activities like horse riding or cycling, or interfere with her sexual function.

The number of labial reduction procedures undertaken by the NHS has increased five-fold over the last decade. The Royal College of Obstetricians and Gynaecologists considers that there is a lack of high quality evidence supporting the use of Labiaplasty, and the College reports no data exist on the efficacy of Labiaplasty for the treatment of functional problems. Labiaplasty carries risks of bleeding, wound infection, scarring, damage to sensitivity and diminished sexual function.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- http://reference.medscape.com/article/1372175-overview#a0102
- Goodman MP. Female genital cosmetic and plastic surgery: a review. J Sex Med. 2011 Jun; 8(6):1813-25
- http://www.rcog.org.uk/files/rcog-orp/RCOG%20FGCS%20Ethical%20opinion%20paper.pdf
- ACOG Committee Opinion 'Vaginal "Rejuvenation" and Cosmetic Vaginal Procedures', 378, (September 2007).
- http://www.bbc.co.uk/news/health-18947106
- http://www.theguardian.com/lifeandstyle/2009/nov/20/cosmetic-vulva-surgery
- http://blog.wellcome.ac.uk/2012/07/20/new-short-film-centrefold-tackles-the-ethics-of-labiaplasty/

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Laser Hair Removal for Excessive Hair Growth including Hirsutism**
Policy type	Threshold with prior approval
Included intervention(s)	Laser hair removal
Included condition/ indication(s)	Hair which is considered to require removal because of its quantity and/or its location.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T38: Laser hair removal for excessive hair growth including hirsutism
NEE CCG policy	Hirsutism / Hair Depilation

1. Interventions covered by this policy

Laser hair removal.

2. Conditions to be considered for treatment under this policy

Facial hirsutism in women (including transgender women), which has not responded to other specified treatments.
Intractable pilonidal sinus disease.
Abnormally located hair resulting from reconstructive surgery.

3. Eligibility criteria for provision of the intervention

Laser hair removal for excessive or inappropriate hair growth will be funded in the following conditions if the specified criteria are met:

For the treatment of *facial hirsutism* in women (including transgender women undergoing gender reassignment) who have a Ferriman-Gallwey score of 3 or 4[2] in either individual facial area where:

- Eflornithine has been tried for 4 months if clinically appropriate but has failed and is stopped as a result

AND

- medical treatment such as combined oral contraceptive and/or antiandrogen therapy has been tried for at least 6 months, usually in the secondary care setting, or is not clinically appropriate or is contraindicated[3]

AND

- if the woman is obese (BMI >30kg/m^2) and has polycystic ovary syndrome, she has received support with weight management including the offer of referral to a weight management programme.

OR

Those undergoing treatment for intractable pilonidal sinus disease

OR

Those who have undergone reconstructive surgery leading to abnormally located hair.

4. Exclusions

This policy does not cover children and young people (aged 18 and under).

[2] Hirsutism is assessed using the Ferriman-Gallwey score (see appendix).

[3] See the Faculty of Sexual and Reproductive Healthcare UK Medical Eligibility Criteria for Contraceptive Use https://www.fsrh.org/ukmec/

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5. Additional notes

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Hirsutism is defined as excessive hair growth of terminal hair in a male pattern of growth in women. It occurs in 5-15% of women, with 70-80% of these women being diagnosed with polycystic ovary syndrome (PCOS). If appropriate, women should be investigated for underlying causes and treatment offered if indicated. There is evidence that if obese women with PCOS lose weight there is likely to be some improvement in their symptoms, including hirsutism.

Eflornithine cream e.g. Vaniqa should only be prescribed for those patients with an underlying medical condition associated with facial hair such as PCO or transgender women undergoing gender reassignment.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NICE Clinical Knowledge Summaries. Hirsutism. January 2010. Accessed from: http://cks.nice.org.uk/hirsutism on 20/12/2016
- Haedersdal M, Gøtzsche PC. Laser and photoepilation for unwanted hair growth. Cochrane Database of Systematic Reviews. 2006. Issue 4. Art. No.: CD004684
- Hamzavi I, Tan E, Shapiro S, Harvey l. A randomized bilateral vehicle-controlled study of eflornithine cream combined with laser treatment versus laser treatment alone for facial hirsutism in women. J Am Acad Dermatol 2007; 57(1): pp 54-59
- Smith et al. Eflornithine cream combined with laser therapy in the management of unwanted facial hair growth in women: a randomized trial. Dermatol Surg. 2006; 32(10):pp1237-43.
- Sonino et al. Quality of life of hirsute women. Postgrad Med J (1993).69, pp186-189
- Hahn et al. Clinical and psychological correlates of quality-of-life in polycystic ovary syndrome. European Journal of Endocrinology (2005), 153, pp 853- 860
- Clayton et al. A randomised controlled trial of laser treatment among hirsute women with polycystic ovary syndrome. Dermatological surgery and laser. 2005. pp986-99
- Drosdzol et al. Quality of life, mental health and self-esteem in hirsute adolescent females. J Psychosom Obstet Gynaecol. 2010; 31(3),pp168-175

7b. Additional guidance referred to in production of ICS policy.

- NICE Clinical Knowledge Summary (revised December 2014). https://cks.nice.org.uk/hirsutism
- Faculty of Sexual and Reproductive Healthcare, 2017. UK Medical Eligibility Criteria for Contraceptive Use https://www.fsrh.org/ukmec/
- Kolouri O, Conway G, 2009. Management of hirsutism. *BMJ.* **338**, b847. https://www.bmj.com/bmj/section-pdf/186179?path=/bmj/338/7698/Clinical_Review.full.pdf
- Lavery S, Mackie M, Kownacki S, Smith R, Scanlon M, Conway G, Messenger A, 2005. Medical management of facial hirsutism. The outcomes of a guidelines working party. https://pdfs.semanticscholar.org/cc30/4480ae30d504727db69d29dd74073774e84c.pdf
- Martin K, Anderson R, Chang R, Ehrmann D, Lobo R, Murad H, Pugeat M, Rosenfield R, 2018. Evaluation and Treatment of Hirsutism in Premenopausal Women: An Endocrine Society Clinical Practice Guideline *J Clin Endocrinol Metab*, 103(4):1233–1257 https://academic.oup.com/jcem/article/103/4/1233/4924418

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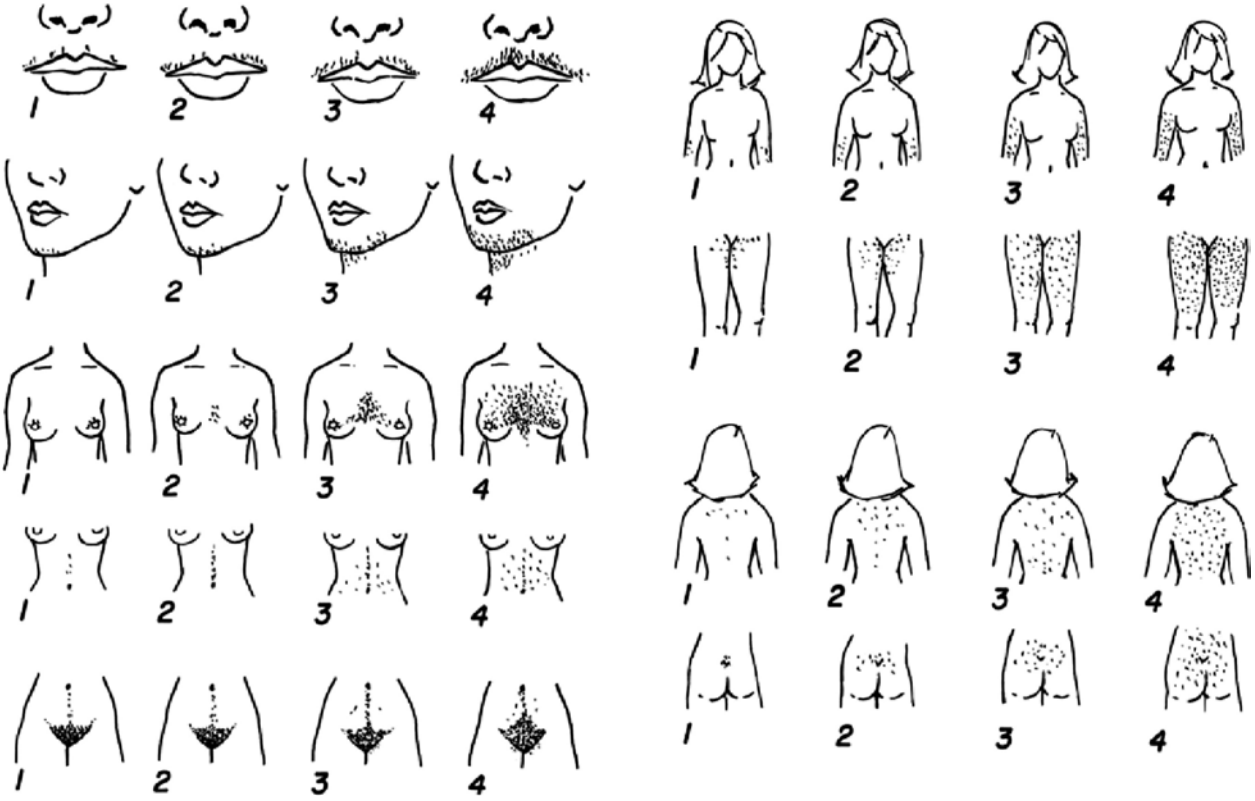
Appendix: Ferriman-Gallwey hirsutism scoring system. From: Martin et al, 2018.



Ferriman–Gallwey hirsutism scoring system. Each of the nine body areas most sensitive to androgen is assigned a score from 0 (no hair) to 4 (frankly virile). These separate scores are summed to provide a total hormonal hirsutism score. Generalized hirsutism (score ≥8) is abnormal in the general US population, whereas locally excessive hair growth (score <8) is a common normal variant. The normal score is lower in some Asian populations and higher in Mediterranean populations

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Policy name	Laser Treatment for Rosacea
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Laser therapy
Included condition/ indication(s)	Acne rosacea
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Laser treatment for rosacea

1. **Interventions covered by this policy**
   Laser therapy

2. **Conditions to be considered for treatment under this policy**
   Acne rosacea. This is a chronic, inflammatory skin condition that can affect the cheeks, nose, eyes, chin, and forehead. It may be characterised by recurrent episodes of facial flushing, persistent erythema, telangiectasia, papules, pustules, and/or associated eye symptoms (ocular rosacea).

3. **Eligibility criteria for provision of the intervention**
   Laser treatment for rosacea is considered a low priority intervention and will not usually be funded.

4. **Exclusions**
   None

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for laser treatment for rosacea.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None

   7b. Additional guidance referred to in production of ICS policy.
   - National Institute for Health and Care Excellence, 2018. Clinical Knowledge Summaries: Acne Rosacea https://cks.nice.org.uk/rosacea-acne

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Policy name	**Lymphoedema Services**
Policy type	Threshold with prior approval
Included intervention(s)	Referral to community lymphoedema services to access the full lymphoedema pathway Referral to the alternative lymphoedema pathway
Included condition/ indication(s)	True lymphoedema Cancer-related lymphoedema
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Lymphoedema services (including treatment for lymphorrhoea)

1. **Interventions covered by this policy**
   Referral to community lymphoedema services to access the full lymphoedema pathway.
   Referral to the alternative lymphoedema pathway providing advice on skin care, exercise, weight management and garments.

2. **Conditions to be considered for treatment under this policy**
   True lymphoedema in patients with BMI<60 kg/m^2
   Cancer-related lymphoedema.
   Lymphoedema is a progressive chronic condition that occurs as a result of an inadequate or compromised lymphatic system. This may be a primary/congenital abnormality or due to trauma such as DVT, cellulitis, cancer or cancer treatments.

3. **Eligibility criteria for provision of the intervention**
   Referral to the community lymphoedema service for access to the full lymphoedema pathway
   Referral to the community lymphoedema service for access to the full lymphoedema pathway may be considered for patients meeting the following criteria:
   - The patient has cancer-related lymphoedema

   OR
   - The patient has a clear diagnosis of true lymphoedema with lymphorrhoea (wet legs)

   OR
   - The patient has a clear diagnosis of true lymphoedema

   AND
   - The patient has a BMI≤40 kg/m^2 OR the patient's BMI is >40 kg/m^2 only because they have developed lymphoedema secondary to surgery

   AND
   - A review of medication has been performed to exclude medication known to cause or exacerbate oedema

   AND
   - A DVT has been ruled out

   AND
   - Any active cellulitis has been successfully treated

   AND
   - The patient has maximised all available conservative management options, including limb elevation, weight management and exercise.

   Referral to the alternative lymphoedema pathway
   Referral to the alternative lymphoedema pathway providing advice on skin care, exercise, weight management and garments may be considered for patients meeting the following

criteria:

- The patient has a clear diagnosis of true lymphoedema

AND

- The patient has a BMI>40 kg/m^2 and <60 kg/m^2, which is not considered to be due to lymphoedema secondary to surgery

AND

- A review of medication has been performed to exclude medication known to cause or exacerbate oedema

AND

- A DVT has been ruled out

AND

- Any active cellulitis has been successfully treated

AND

- The patient has maximised all available conservative management options, including limb elevation, weight management and exercise

AND

- The patient has evidenced a commitment to a significant weight loss regime (referrals should not be made where agreement cannot be achieved between the referrer and the patient).

4. Exclusions

This policy does not apply to:

- People with oedema secondary to obesity (not true lymphoedema)
- Patients with complex conditions
- Patients requiring treatment from a specialist provider, including as an inpatient.

5. Additional notes

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphoedema.

Effective management of lymphoedema has been shown to significantly reduce the incidence of cellulitis and the possible need for hospital admission both of which are common problems encountered with lymphoedema. By improving health and independence, effective lymphoedema management can minimise the demands of increasing immobility and discomfort that would otherwise be made on health and social services.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral to lymphoedema services. This may include patients:

- With a BMI of ≥60 kg/m^2
- With large skin folds at risk of infection
- Requiring a complex treatment plan from a specialist provider
- Requiring intensive inpatient therapy

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy/ies.

- British Lymphology Society. Alternative treatment pathway for BMI >40

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7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2017. Liposuction for chronic lymphoedema. IPG588 https://www.nice.org.uk/guidance/ipg588
- National Institute for Health and Care Excellence, 2017. Advanced breast cancer: diagnosis and treatment. CG 81 https://www.nice.org.uk/guidance/cg81
- National Institute for Health and Care Excellence, 2018. Early and locally advanced breast cancer. NG101 https://www.nice.org.uk/guidance/ng101
- NHS Lymphoedema https://www.nhs.uk/conditions/lymphoedema/

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Policy name	**Male Circumcision**
Policy type	Threshold with prior approval
Included intervention(s)	Male Circumcision
Included condition/ indication(s)	Various conditions of the foreskin
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T8. Male Circumcision
NEE CCG policy	Circumcision

1. Interventions covered by this policy

Male circumcision (surgery to remove the foreskin).

2. Conditions to be considered for treatment under this policy

Inability to retract the foreskin, anatomical abnormality of the foreskin or other conditions associated with recurrent inflammation, infection or dermatological disease.

3. **Eligibility criteria for provision of the intervention**

Circumcision will only be commissioned when the patient has one of the following indications as confirmed by an appropriate specialist clinician:

- Phimosis (inability to retract the foreskin due to a narrow prepucial ring)
- Recurrent paraphimosis (inability to pull forward a retracted foreskin)
- Recurrent balanitis (inflammation of the glans) or balanoposthitis (inflammation of the glans and prepuce)
- Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)
- Dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required
- Recurrent febrile urinary tract infections due to an anatomical abnormality
- In children, the procedure will also be considered for ballooning of the foreskin or spraying of urine

Circumcision carried out for cultural or lifestyle reasons (including religious and ritual practices) is considered a low priority procedure and will not usually be funded.

4. Exclusions

This policy does not cover:

- Suspected penile malignancy, when referral should be made through the appropriate (2 week wait) route.
- Traumatic foreskin injury where the foreskin cannot be salvaged.

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery.

Nearly all boys are born with an unretractable foreskin, which as part of normal

development gradually becomes retractile without the need for any intervention. By the age of 16, only 1% of boys have an unretractable foreskin. There are a number of non-invasive alternatives to treating retraction difficulties before circumcision is considered, such as treatment with topical steroids or manual stretching of the prepuce under local anaesthetic.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- NHS Choices. Circumcision in adults. Available from: http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx
- Royal College of Surgeons. Commissioning guide: Foreskin conditions. 2013. Available from: Foreskin Conditions - Commissioning Guide
- Moreno G, Corbalán J, Peñaloza B, Pantoja T. Topical corticosteroids for treating phimosis in boys. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD008973. DOI: 10.1002/14651858.CD008973.pub2
- Liu, Yang, Chen et al. Is steroids therapy effective in treating phimosis? A meta-analysis. Int Urol Nephrol. 2016 Mar; 48(3):335-42. Doi : 10.1007/s11255-015-1184-9
- http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2015/13%20January/Agenda%20Item%2004.2%20-%20SCPG%20Overview%20Report.pdf
- Bedfordshire and Hertfordshire Priorities Forum Statement. Circumcision. May 2015. Available from: http://www.enhertsccg.nhs.uk/sites/default/files/documents/May2015/guidance-08-circumcision-updated-may15.pdf
- Male Circumcision Policy. Planned Procedure Thresholds. Hounslow Clinical Commissioning Group. Available from: http://www.hounslowccg.nhs.uk/news-and-publications/publications.aspx?n=2010
- Zhu, Jia, Dai et al. Relationship between circumcision and human papillomavirus infection: a systemic review and meta-analysis. Asian J Androl. 2016 March. Abstract available from: http://www.ncbi.nlm.nih.gov/pubmed/26975489
- Singh-Grewal D,Macdessi J, Craig J. Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child. 2005 Aug;90(8):853-8
- Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The Lancet. 2007;369 (9562): 643–56

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Nasal Surgery including Septorhinoplasty and Rhinoplasty**
Policy type	Threshold with prior approval / exceptional clinical circumstances
Included intervention(s)	Septorhinoplasty, septoplasty, rhinoplasty
Included indication/ condition(s)	Symptomatic nasal airway obstruction
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	CS1: Septorhinoplasty PE108: Rhinoplasty
NEE CCG policy	Nasal surgery (including Rhinoplasty and Septorhinoplasty)

1. Interventions covered by this policy

Nasal surgery is any procedure performed on the external or internal structures of the nose, septum or turbinate to improve abnormal function, reconstruct congenital or acquired deformities, or to enhance appearance.

Septoplasty is a surgical procedure that corrects nasal septum defects or deformities, by alteration, splinting, or partial removal of obstructing supporting structures.

Rhinoplasty is a surgical procedure to reshape the nose. Bone or cartilage may be removed, tissue grafted from another part of the body, or synthetic material implanted to alter the shape of the nose.

Septorhinoplasty is a procedure combining rhinoplasty with major repair of the nasal septum.

2. Conditions to be considered for treatment under this policy

Symptomatic nasal airway obstruction.

3. Eligibility criteria for provision of the intervention

Rhinoplasty carried out to alter the appearance of the nose is considered a low priority procedure and will not usually be funded.

Patients may be considered for nasal surgery if they meet the following criteria. If septorhinoplasty is proposed, there should be documentation from an ENT surgeon confirming that septoplasty alone would not improve function.

- They have deviation of the septum and/or bones of the nose (including post-traumatic deformity) which results in documented continuous nasal airway obstruction causing significant symptoms which interfere with work, educational, domestic or caring responsibilities*****
  AND
  They have had at least 3 months medical treatment, including when appropriate, nasal steroids or immunotherapy which has not improved the symptoms

OR

- The surgery is being undertaken as part of the treatment for congenital abnormalities e.g. cleft lip and palate

OR

- The patient suffers from severe anosmia and/or recurrent epistaxis and an appropriate specialist has discussed the likely impact of surgery with the patient and confirmed that there is a strong possibility that surgery will improve symptoms

*****Obstruction should be demonstrated by:

At least 50% of both nares or 25% of one nare and 75% of the other as documented via imaging such as a CT scan or via endoscopy,
OR
If imaging or endoscopic assessment is not feasible the patient should have a score of 65 or more in the Nasal Obstruction Symptom Evaluation (NOSE) questionnaire (see Appendix).

4. Exclusions

This policy does not cover:

- Procedures undertaken as an emergency

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Asymptomatic septal or nasal deviation does not require treatment. The potential complications of septorhinoplasty include septal perforation, failure to completely improve breathing due to swollen membranes as is seen in allergic patients, post-operative bleeding, nasal crusting and re-obstruction due to improper healing and scarring creating intranasal synechiae (adhesions).

Referral may be made to the ECC panel for patients who do not meet the above criteria in whom there are considered to be exceptional circumstances supporting the need for surgery. The following are offered as advice to potential refers and ECC panels - The ECC panel may consider surgery to alter the appearance of the nose for patients who:

- Are aged over 18
- Have severe nasal deformity
- Have psychological symptoms for which they have undergone assessment and had pharmacological interventions which have not been helpful, and surgical intervention is considered likely to alleviate the psychological manifestations.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Aetna Clinical Policy Bulletin: Septoplasty and Rhinoplasty. March 2011. http://www.aetna.com/cpb/medical/data/1_99/0005.html
- *Rhinoplasty Reduction and Augmentation*, British Association of Aesthetic Plastic Surgeons (BAAPS), 2016, Available ONLINE at http://baaps.org.uk/procedures/rhinoplasty-reduction Accessed: 10/10/2016
- Moore M, Eccles R. *Objective evidence for the efficacy of surgical management of the deviated septum as a treatment for chronic nasal obstruction: a systematic review. Clinical otolaryngology* 2011 Apr1;36(2):106-13.
- *Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery* (NHS Modernisation Agency) London British Association for Plastic Reconstructive and Aesthetic Surgeons (BAPRAS). 2014 Available ONLINE at http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn2 Accessed 11/10/2016
- Brunton G, Paraskeva N, Caird J, Bird KS, Kavanagh J, Kwan I, Stansfield C, Rumsey N, Thomas J. *Psychosocial predictors, assessment, and outcomes of cosmetic procedures: a systematic rapid evidence assessment*. Aesthetic plastic surgery. 2014 Oct 1; 38(5):1030-40.
- Parrilla C, Artuso A, Gallus R, Galli J, Paludetti G. *The role of septal surgery in cosmetic*

rhinoplasty. Acta Otorhinolaryngologica Italica. 2013 Jun; 33(3):146.

7b. Additional guidance referred to in production of ICS policy.

- Lipan MJ, Most SP, 2013. Development of a Severity Classification System for Subjective Nasal Obstruction *JAMA Facial Plast Surg*.15(5):358-361. doi:10.1001/jamafacial.2013.344 https://jamanetwork.com/journals/jamafacialplasticsurgery/fullarticle/170983

Appendix

Nasal Obstruction Symptom Evaluation (NOSE) questionnaire
(Lipan MJ, Most SP, 2013).
https://jamanetwork.com/journals/jamafacialplasticsurgery/fullarticle/1709837

Over the past 1 month, how much of a problem were the following conditions for you? Please circle the most correct response

	Not a problem	Very mild problem	Moderate problem	Fairly bad problem	Severe problem
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through my nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

The sum of the scores is multiplied by 5 to give a score out of 100.
The following categories have been proposed based on a study of 345 adult patients, but no specific threshold was set for likely benefit from intervention.

Score range	**Obstruction**
5-25:	Mild
30-50:	Moderate
55-75:	Severe
80-100:	Extreme

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Policy name	**Nipple Inversion**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical correction of nipple inversion
Included condition/ indication(s)	Nipple inversion which is affecting the patient's ability to breastfeed.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE115. Nipple Inversion
NEE CCG policy	88. Nipple Inversion

1. Interventions covered by this policy

Surgical correction of nipple inversion.

2. Conditions to be considered for treatment under this policy

Nipple inversion (the nipple does not protrude from the areola but is retracted inwards).

3. Eligibility criteria for provision of the intervention

Surgical correction of nipple inversion will only be commissioned when the patient meets **all** the following criteria:

- The patient is unable to breastfeed their baby due to inverted nipples

AND

- The patient has received expert breastfeeding support and all non-surgical measures such as the use of a suction device have failed to resolve the problem with breastfeeding

AND

- In the view of the consultant surgeon a surgical correction is likely to alleviate this problem

Surgical correction of nipple inversion which is expected only to improve appearance, with no impact on function, will not be funded.

4. Exclusions

This policy does not cover:

- Acquired nipple inversion when the presentation indicates that investigation of a possible underlying cause (such as malignancy) is required.

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Nipple inversion may be congenital or acquired, and can affect one breast or both. Benign acquired nipple inversion may be gradual and happen over several years. When nipple inversion occurs rapidly, the underlying cause can be inflammation, postsurgical changes, or an underlying malignancy and this should be investigated appropriately.
As babies' breastfeed rather than nipple feed, the consensus view is that in most cases women with flat or inverted nipples will be able to breastfeed with expert support and guidance in breastfeeding technique

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6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Nicholson BT, Harvey JA, Cohen MA. Nipple-areolar complex: normal anatomy and benign and malignant processes. Radiographics. 2009 Mar-Apr; 29(2):509-23. Doi: 10.1148/rg.292085128
- Inverted nipple surgery Nuffield Health https://www.nuffieldhealth.com/treatments/inverted-nipple-surgery
- La Leche league international Inverted or Flat nipples https://www.llli.org/breastfeeding-info/inverted-flat-nipples/
- NHS choices Breastfeeding http://www.nhs.uk/conditions/pregnancy-and-baby/Pages/benefits-breastfeeding.aspx
- Australian Breast Feeding Association Inverted or Flat Nipples https://www.breastfeeding.asn.au/bfinfo/inverted-and-flat-nipples
- NHS Modernisation Agency Action on Cosmetic Surgery http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
- Lancashire North CCG http://www.lancashirenorthccg.nhs.uk/download/policies/commissioning/Policy%20Number%2039%20Surgical%20Correction%20of%20Breast%20Nipple%20Inversion.pdf
- Wakefield CCG https://www.wakefieldccg.nhs.uk/wp-content/uploads/2015/05/WCCG-Specialist-Plastics-Policy-V0.5.pdf
- Somerset CCG www.somersetccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=5493
- Gloucestershire CCG www.gloucestershireccg.nhs.uk/wp-content/uploads/.../Other-breast-procedures.doc
- Greater Manchester Clinical Commissioning Group - Current Breast Surgery Commissioning Criteria northwestcsu.nhs.uk/BrickwallResource/.../afc97dbc-3bc8-4196-833b-b3a5c176ca70

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2006 (updated 2015). Postnatal care up to 8 weeks after birth (CG37). https://www.nice.org.uk/guidance/CG37

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Policy name	**Penile Prostheses**
Policy type	Exceptional clinical circumstances
Included intervention(s)	Penile prostheses
Included indication/ condition(s)	Erectile dysfunction
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	
NEE CCG policy	Penile implants

1. **Interventions covered by this policy**
   Penile prostheses include either inflatable or malleable implants, which are inserted under general anaesthetic.

2. **Conditions to be considered for treatment under this policy**
   Erectile dysfunction

3. **Eligibility criteria for provision of the intervention**
   The management of erectile dysfunction with a penile prosthesis is considered a low priority procedure and will not usually be funded.

4. **Exclusions**
   This policy does not cover:
   - Management of erectile dysfunction which is a consequence of treatment for cancer, including prostate cancer and penile cancer.

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.
   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for a penile prosthesis.

6. **Compliance with NICE guidance**
   This policy complies with relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk / North East Essex policy / ies.
   None
   7b. Additional guidance referred to in production of ICS policy.

   - National Institute for Health and Care Excellence, 2019. Prostate cancer: diagnosis and management. NG131. https://www.nice.org.uk/guidance/ng131
   - British Society for Sexual Medicine, 2017. Guidelines on the management of erectile dysfunction in men. http://www.bssm.org.uk/wp-content/uploads/2018/09/BSSM-ED-guidelines-2018-1.pdf

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Policy name	**Pinnaplasty in Children**
Policy type	Threshold with prior approval
Included intervention(s)	Pinnaplasty
Included indication/ condition(s)	Prominent ears
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T46: Pinnaplasty in children
NEE CCG policy	Pinnaplasty/ otoplasty

1. **Interventions covered by this policy**
   Referral to secondary care for consideration of pinnaplasty.

2. **Conditions to be considered for treatment under this policy**
   Prominent ears.

3. **Eligibility criteria for provision of the intervention**
   Patients may be referred to secondary care for consideration of pinnaplasty if they meet **all** the following criteria (with the exception of patients in whom correction of ear prominence is required to better support a hearing aid, see below):
   - Over the age of 5 but under the age of 18 years.

   AND
   - The patient (not the parents alone) desires surgical correction*.

   AND
   - In the professional opinion of the GP the prominence is of such a severity that it presents as disfigurement.

   AND
   - There is supporting documented evidence from a health professional and the child's school that the health and wellbeing of the child is being adversely affected despite all reasonable steps being taken to address the issue (for example, low attendance rate at school and/or poor educational performance which are considered to be a consequence of the protruding ears).

   AND
   - It is the opinion of the child's health professional that the adverse impact on the child's health and wellbeing is likely to be remedied through correction of the deformity.

   Patients in whom correction of ear prominence is required to better support a hearing aid
   - Patients may be referred for consideration of pinnaplasty if correction of ear prominence is required to better support a hearing aid.

   * Referrals should not be made for children who appear indifferent or opposed to the idea of surgery. Parents requesting surgery for their child in order to prevent psychological distress should be advised that referral should wait until their child specifically requests treatment.

4. **Exclusions**
   This policy does not cover:
   - Children aged 5 years and under
   - Adults aged 18 years and over

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer

to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for pinnaplasty.

The age range included in this policy is based on the Royal College of Surgeons guidance. A systematic review of 28 studies reported the following pooled proportions of complications following surgery for correction of prominent ears: haematoma and/or bleeding incidence 2.5%, infection 0.8%, skin/wound healing problems 3%, suture-related problems 1.8%, scarring 1.6%, pain and itching 13% and revision surgeries/recurrence 5%.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Royal College of Surgeons (2012). Commissioning Guide: Pinnaplasty [online] Available at: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/pinnaplasty-commisioning-guide/

7b. Additional guidance referred to in production of ICS policy.

- Sadhra SS, Motahariasl S, Hardwicke JT, 2017. Complications after prominent ear correction: A systematic review of the literature. J Plast Reconstr Aesthet Surg 70(8):1083-1090. https://www.jprasurg.com/article/S1748-6815(17)30211-5/fulltext

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Policy name	**Reversal of Sterilisation**
Policy type	Exceptional clinical circumstances
Included intervention(s)	Surgical reversal of sterilisation
Included indication/ condition(s)	Patients requesting reversal of a permanent sterilisation procedure
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE105: Reversal of female sterilisation
NEE CCG policy	Reversal of sterilisation

1. **Interventions covered by this policy**
   Surgical reversal of male sterilisation (vasectomy) or female sterilisation (occlusion or interruption of the fallopian tubes).

2. **Conditions to be considered for treatment under this policy**
   Patients requesting reversal of a permanent sterilisation procedure.

3. **Eligibility criteria for provision of the intervention**
   Reversal of male or female sterilisation are considered low priority procedures and will not usually be funded.

4. **Exclusions**
   None

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Please refer to the policy that covers vasectomy under General Anaesthetic.
   Please refer to the policy that covers female sterilisation.

   Reversal of both male and female sterilisation can be technically difficult and the rates of success in restoring fertility are not high. Factors which influence this include the patient's age, the method used in the original operation, and the length of time that has passed since it was carried out.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for reversal of sterilisation. The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria).
   Reversal of male or female sterilisation:
   - There has been a death of the only existing child of the patient from their current or any previous relationships
   - There has been remarriage following death of spouse, and there are no living children for both partners

   AND for reversal of male sterilisation:
   - Loss of unborn child when vasectomy had taken place during the pregnancy AND the couple has no living children from the current or any previous relationships.

   AND for reversal of female sterilisation:

- Loss of the infant when sterilisation had taken place during or after delivery AND the couple has no living children from the current or any previous relationships

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NHS Conditions, reversal of sterilisation on the NHS, Available at: http://www.nhs.uk/Conditions/contraception-guide/Pages/sterilisation-reversal-NHS.aspx Accessed: 17.10.2016.
- Royal College of Obstetricians and Gynaecologists (RCOG). *Male and female sterilisation. London* (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2004 Jan. 114 p. (Evidence-based Clinical Guideline; no. 4)
- NICE Clinical Knowledge Summaries *Hysteroscopic sterilisation by tubal cannulation and placement of intrafallopian implants,* National Institute of Care and Excellence (NICE), September 2009: https://www.nice.org.uk/guidance/ipg315, Accessed: 4/09/2016
- Faculty of Sexual and Reproductive Healthcare (FSRH), *Clinical Guidelines, Male and Female Sterilisation,* FSRH, Royal College of Obstetricians & Gynaecologists, 2014 Available from: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-summary-sep-2014.*pdf (*Accessed: 19.09.2016)
- Prabha S; Burnett LC; Hill R. Reversal of sterilisation at Glasgow Royal Infirmary. *Journal of Family Planning and Reproductive Health Care* 2002; 29: 32–33
- Kolettis et al (2002) Outcomes for vasectomy reversal performed after obstructive intervals of at least 10 years. Urology. 2002 Nov; 60(5):885-8.
- National Guidelines Clearing House, *Male and Female Sterilisation*, Revised Sept 2014, https://www.guideline.gov/summaries/summary/48788/male-and-female-sterilisation, Accessed 05/09/2016

7b. Additional guidance referred to in production of ICS policy.

- Royal College of Obstetricians and Gynaecologists, 2016. Female Sterilisation: Consent Advice. https://www.rcog.org.uk/globalassets/documents/guidelines/consent-advice/consent-advice-3-2016.pdf

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Policy name	**Rhinophyma**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Treatment for rhinophyma
Included condition/ indication(s)	Rhinophyma
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Rhinophyma

1. **Interventions covered by this policy**
   Referral for treatment for rhinophyma.

2. **Conditions to be considered for treatment under this policy**
   Rhinophyma. This is a progressive skin condition that affects the nose, which becomes red, swollen and bumpy. It is most commonly seen in association with acne rosacea.

3. **Eligibility criteria for provision of the intervention**
   Referral for treatment of rhinophyma is considered a low priority intervention and will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for referral for treatment of rhinophyma.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None
   7b. Additional guidance referred to in production of ICS policy.

   - British Association of Dermatologists, 2017. Rhinophyma https://www.bad.org.uk/shared/get-file.ashx?id=2045&itemtype=document
   - NHS Modernisation Agency/ British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS), 2014. Information for Commissioners of Plastic Surgery Services. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
   - National Institute for Health and Care Excellence, 2018. Clinical Knowledge Summaries: Acne Rosacea https://cks.nice.org.uk/rosacea-acne

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Policy name	**Scar Revision**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical revision of scars
Included condition/ indication(s)	Scars resulting from trauma or surgery
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T53. Surgical revision of scars
NEE CCG policy	Scar revision

1. **Interventions covered by this policy**
   Surgical revision of scars.

2. **Conditions to be considered for treatment under this policy**
   Scars resulting from trauma or surgery which are interfering with function.

3. **Eligibility criteria for provision of the intervention**
   Scar revision will only be commissioned when the patient meets **all** the following criteria:
   - The scar is causing a demonstrable functional problem

   AND
   - The functional problem is likely to be resolved with surgical revision of the scar

   AND
   - At least 18 months have elapsed since the original surgery or trauma which caused the scar

   Surgical revision of scars which is expected only to improve appearance, with no impact on function, will not be funded.

4. **Exclusions**
   This policy does not cover:
   - Scars resulting from burns
   - Scars which are being revised post-operatively for clinical reasons

5. **Additional notes**
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Most scars gradually improve over time without surgical intervention, and some non-surgical interventions can help improve appearance. Keloid scars may recur and are sometimes worse after revision.

6. **Compliance with NICE guidance**
   No relevant NICE guidance

7. **References**
   7a. References included in original Suffolk/NEE policy / policies.
   - Greater Manchester EUR Policy statement, Surgical revision of scarring, June 2015
   - Hull CCG General Commissioning Policy – Scar Revision Surgery and Resurfacing February

2016
- Lisa O'Brien, Daniel J Jones, Silicone gel sheeting for preventing and treating hypertrophic and keloid scars, The Cochrane Library, 2013 https://doi.org/10.1002/14651858.CD003826.pub3
- Emedicine article: Scar revision accessed online 24/06/2016 via http://emedicine.medscape.com/article/2250161-overview#a11
- Kerwin LY, El Tal AK, Stiff MA, Fakhouri TM., Scar prevention and remodelling: a review of the medical, surgical, topical and light treatment approaches. Int J Dermatol. 2014 Aug;53(8):922-36. doi: 10.1111/ijd.12436. Epub 2014 Apr 2.
- Gold MH, Berman B, Clementoni MT, Gauglitz GG, Nahai F, Murcia C. Updated international clinical recommendations on scar management: part 1--evaluating the evidence. Dermatol Surg. 2014 Aug;40(8):817-24. doi: 10.1111/dsu.0000000000000049.
- Uebelhoer NS, Ross EV, Shumaker PR, Ablative fractional resurfacing for the treatment of traumatic scars and contractures. Semin Cutan Med Surg. 2012 Jun; 31(2):110-20. doi:10.1016/j.sder.2012.03.005.
- Krakowski AC, Goldenberg A, Eichenfield LF, Murray JP, Shumaker PR. Ablative fractional laser resurfacing helps treat restrictive paediatric scar contractures. Paediatrics. 2014 Dec; 134(6):e1700-5. doi: 10.1542/peds.2014-1586. Epub 2014 Nov 3.
- Douglas Leventhal, MD; Maxwell Furr, BS; David Reiter, MD, DMD Treatment of Keloids and Hypertrophic Scars A Meta-analysis and Review of the Literature, *Arch Facial Plast Surg.* 2006;8(6):362-368.
- Juckett G, and Hartmann-Adams H, Management of Keloids and Hypertrophic Scars *Am Fam Physician.* 2009 Aug 1; 80(3):253-260.
- Mid Essex CCG Policy Statement – Scar revision 12th February 2016
- South Central and West Commissioning Support Unit, Individual Funding Requests Policy, 23rd September 2015

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Shoulder Arthroscopy for conditions other than pure Subacromial Shoulder Impingement**
Policy type	Threshold with prior approval
Included intervention(s)	Shoulder arthroscopy
Included condition/ indication(s)	Rotator cuff tear, Superior labrum anterior posterior (SLAP) tear, Adhesive capsulitis, Non-traumatic shoulder joint instability, Traumatic shoulder joint instability
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T49: Shoulder arthroscopy
NEE CCG policy	Shoulder arthroscopy

1. **Interventions covered by this policy**
   Shoulder arthroscopy to investigate and treat a number of different conditions, excluding pure subacromial shoulder impingement.

2. **Conditions to be considered for treatment under this policy**
   - Rotator cuff tear.
   - Superior labrum anterior posterior (SLAP) tear.
   - Adhesive capsulitis
   - Non-traumatic shoulder joint instability
   - Traumatic shoulder joint instability

3. **Eligibility criteria for provision of the intervention**
   Shoulder arthroscopy should be considered as part of the management of the following conditions in the following circumstances:

   Rotator cuff tear **as demonstrated by clinical symptoms and radiological imaging, either:**
   - Full thickness rotator cuff tear

   OR
   - Partial thickness rotator cuff tear which has not responded to 3 months of conservative management*

   Superior labrum anterior posterior (SLAP) tear **as demonstrated by clinical symptoms and radiological imaging, either:**
   - Significant SLAP tear

   OR
   - Minor (type I #) SLAP tear which has not responded to 3 months of conservative management*

   Adhesive capsulitis **demonstrated by clinical symptoms**
   - Which has not responded to 3 months of conservative management* including corticosteroid injection if clinically appropriate

   Non-traumatic shoulder joint instability
   - Which has not responded to 6 months of conservative management including a structured physiotherapy programme*****

   AND

- If there is a clear target for surgical intervention

Traumatic shoulder joint instability

- When arthroscopy is considered clinically appropriate alongside relevant conservative management*****

***Conservative management**

The conservative management to be attempted prior to referral may include the following:

- Activity modification
- Physiotherapy
- Oral analgesics, including NSAIDs if appropriate
- Steroid injection to the affected part of the joint where clinically appropriate

Type 1 SLAP tear was described as **'**The superior labrum had marked fraying with a degenerative appearance, but the peripheral labral edge remained firmly attached to the glenoid, and the attachment of the biceps tendon to the labrum was intact'. (Snyder et al, 1990)

4. Exclusions

This policy does not cover:

- The use of shoulder arthroscopy for diagnostic purposes.
- Patients with 'red flag' conditions requiring urgent referral, such as a history of acute trauma, signs suggestive of an unreduced dislocation, or symptoms or signs suggestive of tumour or infection.

5. Additional notes

Please refer to the policy that covers 'Arthroscopic shoulder decompression' in pure subacromial shoulder impingement.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for shoulder arthroscopy.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Coghlan JA, Buchbinder R, Green S, Johnston RV, Bell SN, Surgery for rotator cuff disease, Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005619. DOI: 10.1002/14651858.CD005619.pub2
- NICE CKS revised April 2015 accessed online via http://cks.nice.org.uk/shoulder-pain#!scenariorecommendation on 01/06/2016
- Woo Hyung Lee et al, Clinical Outcomes of Conservative Treatment and Arthroscopic Repair of Rotator Cuff Tears: A Retrospective Observational Study, Ann Rehabil Med 2016; 40(2):252-262 pISSN: 2234-0645 eISSN: 2234-0653 http://dx.doi.org/10.5535/arm.2016.40.2.252
- Baums et. al. Functional outcome and general health status in patients after arthroscopic release in adhesive capsulitis. Knee Surg Sports Traumatol Arthrosc. 2007 May; 15(5):638-44.
- Snow M, Boutros I, Funk L. Posterior arthroscopic capsular release in frozen shoulder. Arthroscopy. 2009 Jan; 25(1):19-23.

- Fernandes MR. Arthroscopic treatment of adhesive capsulitis of the shoulder with minimum follow up of six years. Acta Ortop Bras. 2015 Mar-Apr; 23(2): 85–89. doi: 10.1590/1413-78522015230200613 PMCID: PMC4813413
- Wei Dong et. al. Treatments for Shoulder Impingement Syndrome. A PRISMA Systematic Review and Network Meta-Analysis, Medicine, Volume 94, Number 10, March 2015
- Longo et. al. Humeral Avulsion of the Glenohumeral Ligaments: A Systematic Review. Arthroscopy. 2016 May 12. pii: S0749-8063(16)00248-6. doi: 10.1016/j.arthro.2016.03.009

7b. Additional guidance referred to in production of ICS policy.

- British Orthopaedic Association, 2014. Subacromial shoulder pain commissioning guide. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Snyder SJ, Karzel RP, Del Pizzo W, Ferkel RD, Friedman MJ, 1990. SLAP lesions of the shoulder. *Arthroscopy*; 6(4):274-9. https://www.arthroscopyjournal.org/article/0749-8063(90)90056-J/pdf
- British Elbow and Shoulder Society, 2019. BESS/BOA patient care pathways: Atraumatic shoulder instability https://mail.bess.org.uk/application/files/4115/5783/7706/Atraumatic_Shoulder_Instability.pdf
- British Elbow and Shoulder Society, 2015. BESS/BOA patient care pathways: Traumatic anterior shoulder instability https://www.bess.org.uk/application/files/1914/8127/3404/Traumatic_Anterior_Instability.pdf
- British Elbow and Shoulder Society, 2015. BESS/BOA patient care pathways: Frozen shoulder https://www.boa.ac.uk/uploads/assets/221d74d9-2db0-40c6-ae113e5b1bef68e5/frozen%20shoulder.pdf

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Policy name	Sleep Systems (for posture)
Policy type	Threshold with prior approval
Included intervention(s)	Sleep positioning systems
Included condition/ indication(s)	Patients with or at risk of severe postural deformity
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Sleep systems (for posture)

1. **Interventions covered by this policy**
   Sleep positioning systems are commercially-available, individualized, lying support systems that may contain one or more component parts. They aim to help the patient maintain a posture overnight which may be beneficial for example in reducing joint problems, improving comfort and promoting the quality and quantity of sleep.

2. **Conditions to be considered for treatment under this policy**
   Patients who have severe postural deformity.
   Patients who are at risk of severe postural deformity which may cause the following:
   - Dislocations of the hip or other joints
   - Muscle spasm and altered muscle tone
   - Effects on the respiratory system that impact on the patient's quality of life
   - Effects to the digestive system that impact on the patient's quality of life

3. **Eligibility criteria for provision of the intervention**
   The provision of sleep positioning systems may be considered for patients with or at risk of severe postural deformity.

4. **Exclusions**
   This policy does not apply to sleep positioning systems for obstructive sleep apnoea.

5. **Additional notes**
   Where replacement parts to an existing sleep system are required, patients should meet with the policy criteria above and funding requests should be accompanied by an up to date quote for the equipment.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for sleep positioning systems.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None

   7b. Additional guidance referred to in production of ICS policy.

   - Blake SF, Logan S, Humphreys G, Matthews J, Rogers M, Thompson-Coon J, Wyatt K, Morris C, 2015. Sleep positioning systems for children with cerebral palsy. Cochrane database of systematic reviews. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009257.pub2/epdf/full

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Policy name	Snoring Surgery in Adults
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Surgical procedures to the soft palate
Included indication/ condition(s)	Snoring in adults
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE119: Treatment for soft palate snoring
NEE CCG policy	Laser treatment for soft palate Snoring and sleep apnoea

1. **Interventions covered by this policy**
   Surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (uvulopalatopharyngoplasty, laser assisted uvulopalatoplasty, radiofrequency ablation of the palate, soft palate implants).

2. **Conditions to be considered for treatment under this policy**
   Snoring in the absence of obstructive sleep apnoea (OSA) in adults.

3. **Eligibility criteria for provision of the intervention**
   Surgical procedures on the soft palate for simple snoring in the absence of OSA in adults are low priority procedures and will not usually be funded.

4. **Exclusions**
   This policy does not apply to:
   - children and young people (aged 18 and under)
   - patients with features suggestive of a head and neck cancer

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery for simple snoring.

   Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore; as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner.

   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).

Snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

Patients complaining of simple snoring should be counselled without referral to secondary care. Advice should be given on the following where appropriate:

- Weight reduction if BMI is above 30kg/m^2
- Smoking cessation, including offer of referral for smoking cessation support
- Reducing or stopping evening alcohol intake.
- Using ear plugs whilst asleep
- Self-training to alter their sleep position to avoid lying on back
- Obtaining a mandibular advancement device to be worn at night from their orthodontist
- The treatment of nasal congestion (rhinitis)

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- National Institute for Health and Clinical Excellence. Radiofrequency ablation of the soft palate for snoring (IPG476). January 2014. Available from: http://guidance.nice.org.uk/IPG476 (accessed on 22/12/2016).
- Parker RJ, Hardinge M, Jeffries C. Primary care 10-minute consultation: Snoring. BMJ. 2005; 331:1063.
- Bridgman S A *et al*. Surgery for Obstructive Sleep Apnoea (Cochrane Review). In: *The Cochrane Library,* Issue 2, 2000. Oxford: Update Software. Available from: http://www.update-software.com/abstracts/ab001004.htm (22/12/2016).
- National Institute for Health and Clinical Excellence. Soft-palate implants for simple snoring (IPG240). November 2007. Available from: http://www.nice.org.uk/Guidance/IPG240 (accessed on 22/12/2016).
- Han S, Kern R. Laser-assisted uvulopalatoplasty in the management of snoring and obstructive sleep apnea syndrome. Minerva Med. 2004; 95(4):337-45.
- Madani M. Complications of laser-assisted uvulopalatopharyngoplasty (LA-UPPP) and radiofrequency treatments of snoring and chronic nasal congestion: a 10-year review of 5,600 patients. J Oral Maxillofac Surg. 2004; 62(11):1351-62.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2015. Clinical Knowledge Summaries: Obstructive Sleep Apnoea Syndrome. https://cks.nice.org.uk/obstructive-sleep-apnoea-syndrome#!topicSummary
- British snoring and sleep apnoea association. Epworth Sleepiness Scale
- https://britishsnoring.co.uk/sleep_apnoea/epworth_sleepiness_scale.php
- Johns MW, 1991. A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. *Sleep,* 14(6):540—545 https://britishsnoring.co.uk/pdf/epworth.pdf?PHPSESSID=chg0jdmkht13c0vt69ai3fjds5

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Policy name	**Specialist Fertility Services including Assisted Conception**
Policy type	Threshold with prior approval
Included intervention(s)	Level 3 fertility services
Included indication/ condition(s)	Infertility
Date produced	20th October 2021
Planned review date	20th October 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T39: Fertility
NEE CCG policy	12: Assisted conception using IVF/ICS/IUI for infertility

1. Interventions covered by this policy

Three levels of fertility treatment services are provided:
Level 1 services, primary care: initial assessment and investigation and referral to the next level if necessary.
Level 2 services, secondary and specialist care: specialist investigations, drug treatment and monitoring, other interventions as indicated
Level 3 services, tertiary specialist care: further specialist investigations and treatment including assisted conception

This policy covers **Level 3 fertility services**, the key procedures being:
In Vitro Fertilisation (IVF): ovarian stimulation, the collection of the resulting eggs and fertilisation with sperm in the lab. If fertilisation is successful, the embryo is allowed to develop for between two and six days and is then transferred back to the woman's womb. Any remaining good quality embryos can be frozen to use later on in a frozen embryo transfer if the first transfer is unsuccessful.
Intracytoplasmic sperm injection (ICSI): instead of mixing the sperm with the eggs, IVF with ICSI involves injecting a single sperm into each mature egg, which maximises the chance of fertilisation.

2. Conditions to be considered for treatment under this policy

Infertility is defined in this policy as failure to conceive after frequent unprotected intercourse for 3 years in couples of reproductive age in the absence of known reproductive pathology.
For a woman of reproductive age who is using artificial insemination (AI) to conceive (with either partner or donor sperm) infertility is defined as failure to conceive after 12 documented cycles of treatment over a 3-year period.

3. Eligibility criteria for provision of the intervention

Patients should **only** be referred for level 3 fertility services if they meet **all** of the following criteria at the time of referral (or **all applicable** criteria for same sex couples, also see below*). The number of cycles and number of embryos to be transferred depend on age and number of previous cycles of IVF (see below**).

- They meet the definition of infertility and its duration above appropriate to their situation
- Age of female partner: between 23 and 42 years inclusive
- Age of male partner: between 23 years and less than 55 years

- Women aged 23-39 should have self-funded no more than 2 cycles of IVF previously; women aged 40-42 inclusive should not have had any self-funded cycles of IVF previously (see below**).
- They met the criteria in the Policy 'Subfertility investigation and treatment in secondary care' and have completed further assessments and investigations indicated. As a minimum these should have included:

  Female:
  - Laparoscopy and/or hysteroscopy and/or hysterosalpingogram or ultrasound scan where appropriate
  - Rubella antibodies; the woman must be rubella immune
  - Chlamydia screening
  - Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
  - HIV status
  - AMH (anti-Mullerian hormone), which should be >5.4 pmol - Women referred for IVF assessment shall be offered an ovarian reserve test as per NICE guidance to identify and exclude those with low chance of conception. GPs should ensure the patient meets all of the initial criteria within the referral form in the first instance prior to the AMH request being sent to the Fertility Unit. Ovarian reserve testing should only be conducted within the overall context of a fertility assessment carried out by a specialist centre.

  Male*:*
  - Preliminary Semen Analysis and appropriate investigations where abnormal (including genetic analysis if indicated)
  - Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
  - HIV status

- BMI of female partner is 19 or more and less than 30 kg/m^2 at referral and throughout treatment
- BMI of male partner is less than 30 kg/m^2 at referral and throughout treatment
- Both partners are non-smokers at the time of referral from secondary care to specialist fertility services and throughout treatment. Smoking status should be ascertained by carbon monoxide testing in secondary care and specialist IVF services.
- Neither partner has undergone sterilisation in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)
- There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance.
- Both partners are registered with a GP Practice within Ipswich and East Suffolk, West Suffolk or North East Essex CCGs and were eligible for NHS care for at least 12 months prior to the referral from primary to secondary care.
- Neither couple has a living child from the current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships.

Same sex couples (female)

- A woman who is using AI to conceive should meet the definition of infertility and its duration above. Fertile same sex couples will not be funded for assisted conception methods under this policy. Couples are encouraged to maximise opportunities within AI cycles by exploring the option of both partners undergoing AI.
- Same sex couples will be required to meet relevant eligibility criteria above.
- CCGs will not routinely fund donor sperm, but will fund the associated IVF/ICSI treatment in line with the eligibility criteria within this policy, providing the sperm meets the criteria set out by the treating provider unit.

- The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement to NHS funded fertility treatment, in line with the criteria for heterosexual couples, and will not be eligible for additional cycles with their partner or any future partners.

Same sex couples (male)

- Same sex male couples will not be able to access fertility treatment within their relationship but will be eligible for appropriate investigation where there is evidence of subfertility. Surrogacy is not commissioned as part of this policy.

***Female partner age, previous cycles of IVF, number of cycles*[4] *and number of embryos transferred*:

Age 23 years or more and less than 40 years:

- will be eligible for TWO full cycles (for women who have self-funded no or one previous cycle of IVF); or ONE full cycle (for women who have self-funded two previous cycles of IVF). If the woman reaches the age of 40 years during treatment, the current cycle will be completed, but no further cycles will be offered.
- one embryo will be transferred during each cycle to reduce the risk of multiple pregnancies. A maximum of four embryo transfers (fresh plus frozen) will be funded. All frozen embryos should be used before a fresh cycle is funded. Where couples have previously self-funded a cycle then the couples must utilise the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again.

Age 40 years to 42 years inclusive:

- will be eligible for ONE full cycle providing all the following criteria are met:
  - Never previously had IVF treatment
  - There is no evidence of low ovarian reserve
  - There has been a discussion of the additional implications of IVF and pregnancy at this age
- Up to two embryos may be transferred during each cycle. A maximum of two embryo transfers (one fresh plus one frozen) will be funded.

4. Exclusions

This policy does not cover:

- Gamete storage, preimplantation genetic diagnosis and intrauterine insemination
- Couples with a known clinical cause of absolute infertility which precludes any possibility of natural conception, and who meet other eligibility criteria, will have immediate access to NHS funded assisted reproduction services
- Treatment may be denied on other medical ground not explicitly covered in this policy

5. Additional notes

- Read in conjunction with the subfertility investigation and treatment in secondary care.
- Read in conjunction with the cryopreservation of sperm, oocytes or embryos for patients about to undergo treatments which pose a risk to their fertility.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral for specialist fertility services.

[4] A full cycle comprises one round of ovarian stimulation and the transfer of resultant fresh embryo(s). Where an excess of embryos is available following a fresh cycle, these embryos may be frozen for future use, and subsequently thawed and transferred to the patient as a frozen cycle within the 'full cycle'.

It is expected that 84% of couples in the general population having regular unprotected intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment (NCCWCH 2013).

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- Unexplained infertility (no identified male or female cause) (25%)
- Ovulatory disorders (25%)
- Tubal damage (20%)
- Factors in the male causing infertility (30%)
- Uterine or peritoneal disorders (10%).

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. It is estimated that infertility affects 1 in 7 heterosexual couples in the UK (NICE, 2017).

Criteria – additional information

Women with a **BMI** over 30 kg/m^2 take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. The RCOG advises that losing weight will increase the chances of conception. NICE CG156 also recommends that 'men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility'. Couples who require it should be offered advice and support to achieve weight loss, and should be informed of the weight criterion in relation to NHS funded assisted reproduction services at the earliest appropriate opportunity in their progress through infertility investigations in primary care and secondary care.

Women with a low BMI are also likely to have reduced fertility and NICE recommend that 'women who have a BMI of less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception'.

Criteria for minimum maternal and paternal **age** in this policy have been set with reference to the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. The upper age limit of 42 years for women accessing infertility services is recommended by NICE.

There is significant association between reduced fertility and **smoking** in both men and women, and there are also risks associated with smoking and passive smoking during pregnancy. Couples who smoke will not be eligible for NHS funded specialist assisted reproduction assessment or treatment, and should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary care and secondary care, provided with information about the negative impacts of smoking, and offered support to stop.

NICE CG156 gives advice on initial **assessment and investigation** of patients with concerns regarding fertility. Prior to referral to level 2 or 3 services all patients should have been given advice about increasing the chances of conception (NICE CG 156 section 1.2) including with respect to the timing of sexual intercourse, lifestyle including smoking, alcohol and healthy weight, and offered initial assessment and investigations including semen analysis, review of menstrual cycle and maternal blood testing to determine

ovulation.

Patients undergoing male or female **sterilisation** should have provided informed consent and been counselled that the procedures are regarded as permanent and irreversible.

The Human Fertilisation and Embryology (HFE) Act 1990 states that 'a woman shall not be provided with treatment services unless account has been taken of the **welfare of any child** who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth'.

Treatment components – additional information

Couples will not be allowed to pay for any **additional interventions** as part of the treatment within a cycle of NHS fertility treatment. This includes, but is not limited to, any drugs (including drugs prescribed by the couple's GP), recommended treatment that is outside the scope of the service specification agreed with the Secondary or Tertiary Provider or experimental treatments. Where a patient meets the CCG eligibility criteria, but agrees to commence treatment on a privately funded basis, they may not retrospectively apply for any associated payment relating to the private treatment.

The CCG will fund **embryo storage** as part of assisted conception treatment for one year only. Patients must be counselled by the clinician and infertility counsellor to this effect. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple. If any fertility treatment results in a live birth, then the couple will no longer be considered childless and will not be eligible for further NHS funded fertility treatments, including the implantation of any stored embryos.

Egg, sperm and embryo storage for patients undergoing cancer treatments are covered under separate arrangements.

Egg donation where no other treatment is available will be available to women who have undergone premature ovarian failure (longer than six months amenorrhoea and AMH greater than 5.4 pmol due to an identifiable pathological or iatrogenic cause, before the age of 40 years, or to avoid transmission of inherited disorders to a child where the couple meets the other eligibility criteria. The patient may be able to provide an egg donor; alternatively, the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.

Donor insemination may be indicated where:

- the male partner is likely to pass on an inheritable genetic condition;
- severe rhesus incompatibility has been a problem because of the male partner's homozygous status;
- the male partner does not produce suitable sperms (quantity or quality) and, therefore, ICSI is not possible

Anovulatory women can have ovulation induction prior to donor insemination. A maximum of six cycles of donor insemination will be funded followed by IVF with donor sperm if all other eligibility criteria are met. The need to prevent transmission of sexually transmitted diseases (including HIV) by donor insemination has led to the mandatory quarantine of donor sperm for six months by cryopreservation prior to its use in the UK.

Due to poor clinical evidence, **intra uterine insemination** (IUI) will only be offered in exceptional circumstances.

Interventions to prevent the **transmission of blood borne viruses** in fertile

serodiscordant couples (for example, where one partner has HIV or Hepatitis C) where all other criteria are met is commissioned from specialist centres. Sperm washing will not be offered for men with Hepatitis B.

Surrogacy (including part funding) is not commissioned as part of this policy. As advised by the Department of Health 2018.

6. Compliance with NICE guidance

NICE CG 156 states that women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination), should be offered 3 full cycles of IVF, with or without ICSI.

The decision to maintain waiting times as per the previous policy (i.e. 3 years rather than 2) for women with unexplained fertility was made based upon moderate to low quality evidence presented by NICE and the difficulties in justifying additional spend in constrained NHS resources. The decision to reduce the number of cycles from 3 to 2 was made to partially mitigate the extra resource needed to increase the age limit. The decision to include access for women aged 40-42 who meet specific criteria was based on high to low quality evidence presented by NICE but recognizes the improved success rates of IVF. NICE CG156 also recommend that IUI can be used in some circumstances.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Clinical threshold policy: Infertility. March 2014.
- National institute for clinical and health excellence. Fertility: assessment and treatment for people with fertility problems. Clinical guideline 156. February 2013.
- Kidd SA, Eskenazi B, Wyrobek AJ “Effects of male age on semen quality and fertility: a review of the literature” Fertil Steril (2001); 75(2): 237
- De La Rochebrochard E, de Mouzon J, Thepot f, Thonneau P “Fathers over 40 and increased failure to conceive: the lessons of invitro fertilisation in France” (2006); 85(5):1420

7b. Additional guidance referred to in production of ICS policy

- Human fertilisation and embryology authority, 2019. Commissioning guidance for fertility treatment. https://www.hfea.gov.uk/media/2920/commissioning-guidance-may-2019-final-version.pdf
- National Institute for Health and Care Excellence, 2017. Fertility problems: assessment and treatment (CG156) updated September 2017. https://www.nice.org.uk/guidance/cg156
- http://www.fertilityfairness.co.uk/wp-content/uploads/2018/10/England-FertilityFairness_FOI_2018.pdf
- JAMA 10/10/17 Steiner and Pritchard Biomarkers of ovarian reserve and infertility among older women of reproductive age.
- AJOG Ovarian reserve testing, user guide August 2017. Tal,Seifer

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Policy name	**Spinal Surgery for Non-Acute Lumbar Conditions**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical discectomy, spinal decompression surgery
Included condition/ indication(s)	Low back pain and radicular pain/ sciatica
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T17: Spinal surgery for acute (sic) lumbar conditions PE117: Spinal surgery
NEE CCG policy	Spinal surgery for non-acute lumbar conditions

1. Interventions covered by this policy

Spinal decompression and/or surgical discectomy.

2. Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

Most low back pain and radicular pain improves over time with conservative treatments. This policy considers the surgical management of severe low back pain and radicular pain for which non-surgical treatments have failed.

3. Eligibility criteria for provision of the intervention

Spinal decompression and/or surgical discectomy will be considered as clinically indicated in patients with severe low back pain and radicular pain in whom:

- Imaging findings are concordant with the patient's symptoms (for example, indicating intervertebral disc prolapse or spinal stenosis)

AND

- Conservative approaches to management have not improved pain or function. These should have included:
  - advice and information, encouragement to continue usual activities and take appropriate exercise
  - pain management including adequate analgesia with anti-neuropathic medication
  - manual therapies (including physiotherapy)
  - psychological interventions as part of a treatment package
  - a combined physical and psychological treatment programme, where appropriate.

AND for patients with chronic low back pain:

- If they meet the criteria in the relevant policy (**Diagnostic medial branch block +/- radiofrequency denervation**), they should have been assessed for suitability for radiofrequency denervation and received the intervention if considered appropriate, but this has not resolved the problem.

AND for patients with radicular pain:

- If they meet the criteria in the relevant policy (**Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica))**, they should have been considered for nerve root block/ epidural and received the intervention if appropriate, but this has not resolved the problem.

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4. Exclusions

This policy does not cover:

- children and young people (aged 16 and under)
- patients with back pain due to acute conditions such as fracture or dislocation
- patients with 'red flag' conditions requiring urgent referral, such as an abnormal or progressive neurological deficit, associated sphincter problems, symptoms or signs suggestive of tumour or infection.

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

The risk of surgical site infection in spinal surgery has been shown to be higher in patients who are older and have a higher BMI.

Spinal Stenosis is a condition that develops as a result of narrowing of the spinal canal leading to compression of the nerve roots. This is a result of age related changes. The vast majority of patients present with back & leg symptoms resulting in a reduced walking distance. Spinal stenosis may cause sciatica.

The following specific interventions will not be routinely funded as NICE states that current evidence on their safety and efficacy does not appear adequate for them to be used without special arrangements for consent and for audit or research purposes:

- Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica
- Endoscopic laser foraminoplasty
- Percutaneous endoscopic laser thoracic discectomy
- Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica
- Therapeutic endoscopic division of epidural adhesions

Spinal fusion for chronic low back pain should only be offered as part of a randomised controlled trial (NICE, 2016).

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for spinal surgery.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC

Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- National Institute for Health and Clinical Excellence. Clinical Guideline (CG) 88 (2009) Early management of persistent non-specific low back pain
- Phillips M, Slosar P, Youssef J, Andersson G, Papatheofanis F. Lumbar Spine Fusion for Chronic Low Back Pain Due to Degenerative Disc Disease. SPINE, Volume 38, Number 7, pp E409- E422. 2013
- Chou R. Low back pain (chronic). Clinical Evidence, 2010, vol./is. 2010/, 1462-3846;1752-8526 (2010)
- National Spinal Taskforce. Commissioning spinal services – getting the service back on track. A guide for commissioners of spinal services.
- NHS Commissioning Board. Clinical Commissioning Policy Statement: Spinal Surgery for Chronic, Non-specific Low Back Pain. December 2012
- Kovacs F, Urrutia G, Alarcon JD. Surgery versus Conservative Treatment for Symptomatic Lumbar Spinal Stenosis: A Systematic Review of Randomised Controlled Trials. Spine. 2011 36(20), E1335-1351
- Gibson JNA, Waddell G. Surgical interventions for lumbar disc prolapse. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD001350. DOI: 10.1002/14651858.CD001350.pub4
- Peul W, van Houwelinger H, van den Hout W, Brand R, Eekhof J et al. Surgery versus Prolonged Conservative Treatment for Sciatica. The New England Journal of Medicine (2007); 356(22); 2245-56
- Jarrett M, Orlando J. Grimmer-Somers K. The effectiveness of land based exercise compared to decompressive surgery in the management of lumbar spinal-canal stenosis: a systematic review. BMC Musculoskeletal Disorders. 2012, 13:30
- Klemencsics I, Lazary A, Szoverfi Z, Bozsodi A, Eltes P, Varga PP. Risk factors for surgical site infection in elective routine degenerative lumbar surgeries. The Spine Journal. 2016 Aug 9, S1529-9430(16)30869-5. DOI: 10.1016
- National Institute for Clinical Excellence. IPG570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: guidance. December 2016. Available from URL: https://www.nice.org.uk/guidance/ipg570 [accessed December 2016]
- National Institute for Clinical Excellence. IPG31 Endoscopic laser foraminoplasty: guidance. December 2003. Available from URL: https://www.nice.org.uk/guidance/ipg31 [accessed December 2016]
- National Institute for Clinical Excellence. IPG061 Percutaneous endoscopic laser thoracic discectomy: guidance. May 2004. Available from URL: https://www.nice.org.uk/guidance/ipg61 [accessed December 2016]
- National Institute for Clinical Excellence. IPG544 Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica: guidance. January 2016. Available from URL: https://www.nice.org.uk/guidance/ipg544 [accessed December 2016]
- National Institute for Clinical Excellence. IPG333 Therapeutic endoscopic division of epidural adhesions: guidance. February 2010. Available from URL: https://www.nice.org.uk/guidance/ipg333 [accessed December 2016]

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7b. Additional guidance referred to in production of ICS polic

- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59
- (This replaces CG88)
- National Institute for Health and Care Excellence, 2013 (updated 2019). Neuropathic pain in adults: pharmacological management in non-specialist settings (CG173) https://www.nice.org.uk/guidance/cg173
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf
- National Institute for Health and Care Excellence, 2017. Lateral interbody fusion in the lumbar spine for low back pain (IPG 574) https://www.nice.org.uk/guidance/ipg574
- National Institute for Health and Care Excellence, 2018. Transaxial interbody lumbosacral fusion for low back pain (IPG620) https://www.nice.org.uk/guidance/ipg620

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Policy name	Standing Frames (Bespoke)
Policy type	Threshold with prior approval
Included intervention(s)	Bespoke standing frame
Included condition/ indication(s)	Patients with a neurological condition Patients who have sustained a spinal cord injury
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Standing frames (bespoke)

1. **Interventions covered by this policy**
   A standing frame is an individualized piece of equipment with a rigid frame and a wide base that supports a person in the standing position.

2. **Conditions to be considered for treatment under this policy**
   Patients who have a neurological condition and patients who have sustained a spinal cord injury who meet at least one of the criteria below.

3. **Eligibility criteria for provision of the intervention**
   The provision of a bespoke standing frame may be considered for patients with a neurological condition and patients who have sustained a spinal cord injury who meet at least one of the following criteria:
   - The patient is at risk of hip and knee contractures
   - The patient requires a standing frame to compensate for the loss of muscle control
   - The standing frame is the only way the patient can be supported in an upright position
   - Supported standing would benefit other bodily functions and bone integrity
   - There is evidence that a standing frame would benefit neuro-rehabilitation producing achievable outcomes for the patient in line with evidence-based interventions
   - The patient has severe learning disabilities and/or co-morbidities that require continual postural and positioning management to prevent deterioration which could have an impact on respiratory and musculoskeletal health.
   - Where a significant deterioration in posture is likely to increase risk of hospital admission and decrease life expectancy.

   Evidence will be required that a trial of the suggested standing frame has proved of significant benefit to the patient in line with evidence based achievable outcomes.

4. **Exclusions**
   None.

5. **Additional notes**
   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for a bespoke standing frame.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None

7b. Additional guidance referred to in production of ICS policy.

- Goodwin J, Lecouturier J, Basu A, Colver A, Crombie S, Smith J, Howel D, McColl E, Parr J R, Kolehmainen N, Roberts A, Miller K & Cadwgan J, 2018. Standing frames for children with cerebral palsy: a mixed-methods feasibility study. *Health Technology Assessment* Volume: 22, Issue: 50.
- https://www.journalslbrary.nihr.ac.uk/hta/hta22500#/full-report
- Paleg GS, Smith BA, Glickman LB, 2013. Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs. *Pediatr Phys Ther* 25:232–47. https://doi.org/10.1097/PEP.0b013e318299d5e7

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Policy name	**Subfertility Investigation and Treatment in Secondary Care**
Policy type	Threshold with prior approval
Included intervention(s)	Level 2 fertility services
Included indication/ condition(s)	Subfertility
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T34: Subfertility in secondary care
NEE CCG policy	-

1. Interventions covered by this policy

Three levels of fertility treatment services are provided:
Level 1 services, primary care: initial assessment and investigation and referral to the next level if necessary.
Level 2 services, secondary and specialist care: specialist investigations, drug treatment and monitoring, other interventions as indicated
Level 3 services, tertiary specialist care: further specialist investigations and treatment including assisted conception
This policy covers Level 2 fertility services.

2. Conditions to be considered for treatment under this policy

Subfertility is defined in this policy as failure to conceive after frequent unprotected intercourse for 1 year in couples of reproductive age in the absence of known reproductive pathology.
For a woman of reproductive age who is using artificial insemination (AI) to conceive (with either partner or donor sperm) subfertility is defined in this policy as failure to conceive after 6 documented cycles of treatment over at least a 12-month period.
Same sex male couples will be eligible for further investigation of male factor infertility where there is evidence of subfertility, for example failure to conceive through AI as above.

3. Eligibility criteria for provision of the intervention

Patients should **only** be referred for level 2 subfertility investigation and treatment if they meet **all** of the following criteria (or **all applicable** criteria for same sex couples):

- They meet the definition of subfertility above appropriate to their situation

AND

- BMI of female partner is 19 or more and less than 30 kg/m^2

AND

- Age of female partner is between 23 and 42 years inclusive

AND

- BMI of male partner is less than 30 kg/m^2

AND

- Age of male partner is between 23 years and less than 55 years

AND

- If either or both partners smoke they have taken part in and completed a recognised supportive smoking cessation programme. They have been informed that both partners will need to be non-smokers in order to access Level 3 fertility services, should they require them

AND

- Initial assessment and investigations have been initiated in primary care (semen test, blood tests to determine ovulation and lifestyle advice) as clinically appropriate, in line with NICE CG156

AND

- Neither partner has undergone sterilisation in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)

AND

- There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance

AND

- Both partners are registered with a GP Practice within Ipswich and East Suffolk, West Suffolk or North East Essex CCGs and were eligible for NHS care for at least 12 months prior to the referral from primary to secondary care

4. Exclusions

This policy does not cover:

- Couples with a known clinical cause of absolute infertility
- Patients about to undergo treatment which will affect their fertility, such as some cancer treatments

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Please refer to the policy that covers specialist fertility services including assisted conception.
Please refer to the policy that covers cryopreservation of sperm, oocytes or embryos for patients about to undergo treatments which pose a risk to their fertility.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for subfertility investigation and treatment in secondary care.

It is expected that 84% of couples in the general population having regular unprotected intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment (NCCWCH 2013).

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- Unexplained infertility (no identified male or female cause) (25%)
- Ovulatory disorders (25%)
- Tubal damage (20%)
- Factors in the male causing infertility (30%)
- Uterine or peritoneal disorders (10%)

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. It is estimated that infertility affects 1 in 7 heterosexual couples in the UK (NICE, 2017).

Criteria – additional information

Women with a **BMI** over 30 kg/m^2 take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. The RCOG advises that losing weight will increase the chances of conception. NICE CG156 also recommends that 'men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility'. Couples who require it should be offered advice and support to achieve weight loss, and should be informed of the weight criterion in relation to NHS funded assisted reproduction services at the earliest appropriate opportunity in their progress through infertility investigations in primary care and secondary care.

Women with a low BMI are also likely to have reduced fertility and NICE recommend that 'women who have a BMI of less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception'.

Criteria for minimum maternal and paternal **age** in this policy have been set with reference to the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. The upper age limit of 42 years for women accessing infertility services is recommended by NICE.

There is significant association between reduced fertility and **smoking** in both men and women, and there are also risks associated with smoking and passive smoking during pregnancy. Couples who smoke will not be eligible for NHS funded specialist assisted reproduction assessment or treatment, and should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary care and secondary care, provided with information about the negative impacts of smoking, and offered support to stop.

NICE CG156 gives advice on initial **assessment and investigation** of patients with concerns regarding fertility. Prior to referral to level 2 or 3 services all patients should have been given advice about increasing the chances of conception (NICE CG 156 section 1.2) including with respect to the timing of sexual intercourse, lifestyle including smoking, alcohol and healthy weight, and offered initial assessment and investigations including semen analysis, review of menstrual cycle and maternal blood testing to determine ovulation.

Patients undergoing male or female **sterilisation** should have provided informed consent and been counselled that the procedures are regarded as permanent and irreversible.

The Human Fertilisation and Embryology (HFE) Act 1990 states that 'a woman shall not be provided with treatment services unless account has been taken of the **welfare of any child** who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth'.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

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7b. Additional guidance referred to in production of ICS policy.

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- National Institute for Health and Care Excellence, 2017. Fertility problems: assessment and treatment (CG156) updated September 2017. https://www.nice.org.uk/guidance/cg156

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Policy name	**Surgical Repair of Hernias - Elective**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical repair of hernias
Included condition/ indication(s)	Inguinal hernias, Incisional hernias, Umbilical hernias
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T32. Surgical treatment of hernias
NEE CCG policy	Hernia – elective surgical repair

1. Interventions covered by this policy

Elective surgical repair of hernias, which may involve open or laparoscopic techniques.

2. Conditions to be considered for treatment under this policy

A hernia is defined as a protrusion through a weakness in the abdominal wall of a sac of peritoneum, often containing intestine or other abdominal contents. It usually presents as a lump and patients may experience pain or discomfort that can limit daily activities. A hernia is reducible if the lump disappears when the patient is reclining or when the contents are manually pushed back within the abdominal cavity. If a hernia becomes irreducible the blood supply of the contents may be compromised, and a hernia may present as a surgical emergency should the bowel strangulate or become obstructed.

An *inguinal hernia* is a protrusion of the contents of the abdominal cavity or preperitoneal fat through a defect in the groin area, and may be indirect (following the inguinal canal) or direct (due to defect or weakness in the fascia in the inguinal area).
An *incisional hernia* results from the protrusion of abdominal contents through a defect caused during surgery.
An *umbilical hernia* protrudes through the umbilicus and a paraumbilical hernia protrudes above or below the umbilical ring.

3. Eligibility criteria for provision of the intervention

For patients with asymptomatic or minimally symptomatic inguinal, incisional or umbilical hernias, a watchful waiting approach is recommended, under informed consent. If the patient is a smoker, stop smoking support must be offered and details of local smoking cessation support given to the patient. Other conservative measures include avoiding heavy lifting.

For *inguinal hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation or wind symptoms that interfere with work or activities of daily living

OR

- The hernia is difficult or impossible to reduce

OR

- The hernia is an inguino-scrotal hernia

OR

- The hernia increases in size month on month

OR

- There is a history of incarceration

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

For *umbilical hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation that interfere with work or activities of daily living

OR

- The hernia increases in size month on month

OR

- To avoid incarceration or strangulation of bowel

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

For *incisional hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation that interfere with work or activities of daily living

AND

- Appropriate conservative management has been tried first, e.g. weight reduction where appropriate, and this has not resolved the symptoms

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

4. Exclusions

This policy does not cover:

- Children and young people aged 16 and under
- Femoral hernias; all patients with a suspected femoral hernia should be referred to secondary care due to the risk of strangulation
- Hernias where emergency treatment might be required, for example suspected strangulation

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Watchful waiting is advocated as an acceptable option for men with asymptomatic or minimally symptomatic inguinal hernias. The European Hernia Society guidelines (Simons et al, 2009) base this recommendation on the findings of two randomised controlled trials. Watchful waiting was not defined but in one trial men were given written instructions to watch for hernia symptoms and contact their physician if problems developed; in addition, they were examined at 6 months and yearly after enrolment (Fitzgibbons et al, 2006). A large cohort study of patients with incisional and umbilical hernias concluded that watchful waiting is also safe for patients with these conditions (Kokotovic et al, 2016).

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

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7. References

7a. References included in original Suffolk/NEE policy / policies.

- National Institute for Health and Care Excellence (2004) Laparoscopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence.
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7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Tattoo Removal**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Interventions to remove tattoos.
Included indication/ condition(s)	Unwanted tattoo.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE104: Tattoo removal
NEE CCG policy	Tattoo removal

1. **Interventions covered by this policy**
   Interventions to remove tattoos, usually laser, surgical excision or dermabrasion.

2. **Conditions to be considered under this policy**
   Unwanted tattoo.

3. **Eligibility criteria for provision of the intervention**
   Interventions to remove unwanted tattoos are considered low priority procedures and will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for tattoo removal. This may include the following conditions which are offered as examples to potential referrers and ECC panels (note: these are **not** referral criteria):
   - If the tattoo is on the face and is seriously impairing psychosocial functioning
   - If the tattoo is the result of trauma which was inflicted under severe duress (i.e. a "rape tattoo") and is seriously impairing psychosocial functioning
   - If the tattoo is on the face and the patient was a child and considered not Gillick competent at the time of the tattooing

   In circumstances such as the examples above, evidence should be provided in the form of a psychiatrist's report on the difficulties of psychosocial functioning and its impact on the patient, and that removal of the tattoo could alleviate the problems with psychosocial functioning.
   - If there is severe allergic reaction and/or repeated infection as a result of the tattoo **and** all other treatment options have failed **and** the removal of the tattoo is clinically indicated in the view of an expert clinician

6. **Compliance with NICE guidance**
   No relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy / policies.
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- Care Quality Commission, Gillick Competency Guidelines, 2016, Available at http://www.cqc.org.uk/content/nigels-surgery-8-gillick-competency-and-fraser-guidelines Accessed. 14/10/2016
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7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica)**
Policy type	Threshold with prior approval
Included intervention(s)	Epidural injection or nerve root block
Included condition/ indication(s)	Radicular pain (sciatica)
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T42: Therapeutic epidural injections for persistent (chronic) radicular pain
NEE CCG policy	Spinal injections (therapeutic) for pain related to the lumbar spine

1. Interventions covered by this policy

An epidural injection is the injection of local anaesthetic and steroid into the epidural space (the space within the spinal canal, outside the dura mater, which contains the spinal nerve roots, fat, connective tissue and blood vessels).
A nerve root block is an injection which targets a specific lumbar nerve.

2. Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

This policy applies to the use of epidural injection or nerve root block in people with radicular pain.

3. Eligibility criteria for provision of the intervention

Therapeutic epidural injection or nerve root block will be considered for the following patients with radicular pain:

Patients with radicular pain which is severe and acute

- The patient has severe, acute radicular pain (present for a period of less than 3 months)

AND

- the pain has not responded to conservative therapy. This may have included:
  - Advice and information, encouragement to continue usual activities and take appropriate exercise
  - Pain management including adequate analgesia with anti-neuropathic medication
  - Manual therapies (including physiotherapy)
  - Psychological interventions as part of a treatment package
  - A combined physical and psychological treatment programme, where appropriate.

OR

Patients with moderate or severe radicular pain

- The patient has moderate or severe radicular pain

AND

- the patient wishes to avoid, or is not suitable for surgery

AND

- The patient is not able to participate effectively in conservative pain management, or the pain has not responded to conservative therapy. This may have included:
  - Advice and information, encouragement to continue usual activities and take appropriate exercise
  - Pain management including adequate analgesia with anti-neuropathic medication
  - Manual therapies (including physiotherapy)
  - Psychological interventions as part of a treatment package
  - A combined physical and psychological treatment programme, where appropriate

Repeat injection (up to a total of 3 injections in 6 months) may be commissioned for patients with moderate or severe radicular pain meeting the above criteria if:

- a specialist pain clinician taking account of multi-disciplinary team assessment, concludes that benefits outweigh harms

AND

- The patient has been clinically assessed as having a substantial and sustained benefit from their first injection

AND

- The patient has been assessed as continuing to be unable to benefit from conservative management.

4. Exclusions

This policy does not cover:

- Children and young people (aged 16 and under)
- Conditions of a non-mechanical nature, including;
  - Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
  - Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
  - Neurological disorders (including cauda equina syndrome or mononeuritis)
  - Adolescent scoliosis
- Conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
- Other conditions including pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.
- Neurogenic claudication in people who have central spinal canal stenosis.

5. Additional notes

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for therapeutic epidural injection or root block.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, tr igger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Manchikanti L et al. (2013) An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician, 04 2013, vol./is. 16/2 Suppl (S49-283), 1533-3159;2150-1149 (2013 Apr)
- Chou R; Atlas SJ; Stanos SP; Rosenquist RW (2009) nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice Guideline. Spine, May 2009, vol./is. 34/10(1078-93), 0362-2436;1528-1159 (2009 May 1)
- Cleeland C (1991) Brief Pain Inventory. Pain Research Group.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

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Policy name	**Therapeutic Spinal Injection for Non-Specific Low Back Pain without Radiculopathy**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Spinal injection of local anaesthetic and steroid
Included condition/ indication(s)	Non-specific low back pain without radiculopathy
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T42: Therapeutic epidural injections for persistent (chronic) radicular pain
NEE CCG policy	Spinal injections (therapeutic) for pain related to the lumbar spine

1. Interventions covered by this policy

The following injections:

- 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.

2. Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain (radiculopathy) is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

This policy applies to the use of the above injections in patients with non-specific low back pain, without radiculopathy.

3. Eligibility criteria for provision of the intervention

The therapeutic spinal injections specified above should not be offered to patients with non-specific low back pain without radiculopathy.

4. Exclusions

This policy does not cover:

- Children and young people (aged 16 and under)
- Conditions of a non-mechanical nature, including;
  - Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
  - Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
  - Neurological disorders (including cauda equina syndrome or mononeuritis)
  - Adolescent scoliosis

- Conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
- Other conditions including pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.

5. Additional notes

This policy is based on 'Evidence-based interventions: guidance for CCGs' published by NHS England in November 2018.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for the specified spinal injections.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Manchikanti L et al. (2013) An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician, 04 2013, vol./is. 16/2 Suppl(S49-283), 1533-3159;2150-1149 (2013 Apr)
- Chou R; Atlas SJ; Stanos SP; Rosenquist RW (2009) Nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice guideline. Spine, May 2009, vol./is. 34/10(1078-93), 0362-2436;1528-1159 (2009 May 1)
- Cleeland C (1991) Brief Pain Inventory. Pain Research Group.

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

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Policy name	**Tier 3 Weight Management**
Policy type	Threshold with prior approval
Included intervention(s)	Referral to Tier 3 specialist weight management service
Included indication/ condition(s)	Obesity
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Tier 3 weight management

1. **Interventions covered by this policy**
   Referral to Tier 3 specialist multidisciplinary weight management service.

2. **Conditions to be considered for treatment under this policy**
   Obesity: BMI ≥40kg/m^2, or BMI ≥35kg/m^2 with obesity-related comorbidities.

3. **Eligibility criteria for provision of the intervention**
   Patients who are obese may be referred to the Tier 3 specialist multidisciplinary weight management service if they meet **both** the following criteria:
   - They have completed a course of treatment at a Tier 2 service (or equivalent) but have not achieved or maintained adequate, clinically beneficial weight loss

   AND
   - They have **one** of the following:
     - BMI ≥40kg/m^2

     OR
     - BMI ≥35kg/m^2

     AND
     Obesity-related comorbidity such as metabolic syndrome, hypertension, obstructive sleep apnoea, functional disability or infertility OR a condition such as learning disability which means they need additional support
     AND
     Specialist advice is needed regarding overall patient management

4. **Exclusions**
   This policy does not cover:
   - Children and young people (aged 18 and under)
   - Patients who have undergone bariatric surgery within the last 12 months
   - Patients who are known to have an eating disorder
   - Pregnant women

5. **Additional notes**
   All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

   Please refer to policy that covers Bariatric surgery
   Please refer to policy that covers body contouring procedures

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral for Tier 3 weight management.

Tier 2 weight management services are multidisciplinary and multi-component; that is, they address dietary intake, physical activity levels and behaviour change. They aim for long-term lifestyle changes to support weight loss and prevent future weight regain. Tier 3 services provide more intensive interventions which may include pharmacological treatment, and consideration of surgery if appropriate.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

None

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2014. Weight management: lifestyle services for overweight or obese adults. PH53 https://www.nice.org.uk/guidance/ph53
- National Institute for Health and Care Excellence, 2014. Obesity: identification, assessment and management. CG189 https://www.nice.org.uk/guidance/cg189

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Policy name	**Tinnitus**
Policy type	Threshold with prior approval
Included intervention(s)	Referral to secondary care for tinnitus
Included indication/ condition(s)	Tinnitus
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Tinnitus treatment

1. **Interventions covered by this policy**
   Referral to secondary care for investigation and further management of tinnitus.

2. **Conditions to be considered for treatment under this policy**
   Tinnitus is the perception of sound in the absence of sound from the external environment. It may be described as a ringing, hissing, buzzing, sizzling, whistling, or humming, and can be constant or intermittent, and unilateral or bilateral.

3. **Eligibility criteria for provision of the intervention**
   Referral to secondary care may be considered for people with tinnitus if they have one of the following:
   - Unilateral tinnitus (persistent over 2 months)
   - Objective or pulsatile tinnitus.
   - Tinnitus associated with unilateral or asymmetric hearing loss.
   - Tinnitus associated with persistent otalgia or otorrhoea that does not resolve with routine treatment.
   - Tinnitus with vestibular symptoms (for example dizziness, vertigo).
   - Tinnitus of uncertain cause.
   - Persistent tinnitus (lasting 6 months or more)
   - Tinnitus causing distress despite primary care management.

4. **Exclusions**
   This policy does not cover the following conditions which should be referred as an emergency:
   - Sudden onset pulsatile tinnitus.
   - Tinnitus in association with significant neurological symptoms and/or signs (for example facial weakness).
   - Tinnitus associated with severe vertigo.
   - Tinnitus secondary to head trauma.
   - Tinnitus associated with unexplained sudden hearing loss.

5. **Additional notes**
   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral to secondary care for tinnitus.

   Around 10% of adults in the UK experience prolonged tinnitus. The impact on individuals varies from minimal impact to an association with impaired concentration, social isolation, insomnia, anxiety, depression and (rarely) suicide.

Most commonly, tinnitus is associated with disorders causing hearing loss, such as age-related hearing loss, noise-induced hearing loss, Meniere's disease, impacted wax and otosclerosis. It **can also be associated with ototoxic drugs such as v**alproate, loop diuretics, aspirin and nonsteroidal anti-inflammatory drugs, antimalarials and some antibiotics, and with e**ar infections, neurological disorders such as** acoustic neuroma and multiple sclerosis, metabolic disorders such as thyroid disorders and diabetes, **psychological disorders and trauma to the head or neck. Most tinnitus is mild in severity and improves over time** but in some cases it can persist for many years (especially when there is a co-existing sensorineural hearing loss).

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

None

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2017. Clinical Knowledge Summaries: Tinnitus https://cks.nice.org.uk/tinnitus#!topicSummary

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Policy name	**Temporomandibular Joint Replacement**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Temporomandibular joint replacement
Included indication/ condition(s)	Temporomandibular joint disorders
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Temporomandibular Joint Replacement

1. **Interventions covered by this policy**
   Prosthetic replacement of the temporomandibular joint.
   This involves replacing both the skull base component of the joint (the fossa or socket) and the mandibular component (the condyle) with prostheses.

2. **Conditions to be considered under this policy**
   Temporomandibular joint disorders include inflammatory and degenerative arthritis, trauma, infection and complications of surgery. Severe disease may cause pain and difficulty opening and closing the mouth.

3. **Eligibility criteria for provision of the intervention**
   Temporomandibular joint replacement will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for temporomandibular joint replacement. This may include patients with severe disease causing pain and difficulty opening and closing the mouth, with an inability to eat a normal diet or problems with dentistry or anaesthesia. Contra-indications would include active or chronic infection, patient conditions where there is insufficient quantity or quality of bone to support the components, systemic disease with increased susceptibility to infection, previous partial temporomandibular joint reconstruction, known allergic reaction to any materials used in the components, patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions, skeletally immature patients, and patients with severe hyper-functional habits (e.g. clenching, grinding etc.).

   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Conservative treatments for disorders of the temporomandibular joint include rest, non-steroidal anti-inflammatory drugs, bite splints and physiotherapy. Other surgical approaches include arthroscopic surgery, re-modelling of the joint surface and removal and replacement of the intra-articular disc.

6. **Compliance with NICE guidance**
   NICE IPG 500 states that 'Current evidence on the efficacy and safety of total prosthetic replacement of the temporomandibular joint is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit'. The procedure should be carried out in specialist units by clinicians with specific

training and experience.

NICE interventional procedures guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS.

7. References

7a. References included in original Suffolk/NEE policy/ies.

None.

7b. Additional guidance referred to in production of ICS policy.

- NHS. Temporomandibular disorder. https://www.nhs.uk/conditions/temporomandibular-disorder-tmd/
- National Institute for Health and Care Excellence, 2014. Total prosthetic replacement of the temporomandibular joint. IPG 500. https://www.nice.org.uk/guidance/ipg500

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Policy name	**Temporomandibular Joint Retainers and Appliances**
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Temporomandibular joint retainers and appliances
Included indication/ condition(s)	Temporomandibular disorders
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Temporalmadibular Joint Retainers and Appliances

1. **Interventions covered by this policy**
   Temporomandibular joint retainers and appliances.

2. **Conditions to be considered under this policy**
   Temporomandibular disorders may include pain and joint dysfunction.

3. **Eligibility criteria for provision of the intervention**
   Temporomandibular joint retainers and appliances are considered low priority interventions and will not usually be funded.

4. **Exclusions**
   None.

5. **Additional notes**
   Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for temporomandibular joint retainers and appliances.

6. **Compliance with NICE guidance**
   There is no relevant NICE guidance.

7. **References**
   7a. References included in original Suffolk/NEE policy/ies.
   None.

   7b. Additional guidance referred to in production of ICS policy.
   - NHS. Temporomandibular disorder. https://www.nhs.uk/conditions/temporomandibular-disorder-tmd/

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Policy name	**Tonsillectomy**
Policy type	Threshold with prior approval
Included intervention(s)	Surgical procedures to remove the tonsils +/- adenoids
Included indication/ condition(s)	Recurrent sore throat due to tonsillitis Sleep apnoea in children
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T13: Tonsillectomy
NEE CCG policy	Tonsillectomy

1. Interventions covered by this policy

Surgical procedures to remove the tonsils or adenoids and tonsils.

2. Conditions to be considered for treatment under this policy

Recurrent sore throats, which are due to acute tonsillitis, in adults and children.
Obstructive sleep apnoea (OSA) in children.

3. Eligibility criteria for provision of the intervention

Recurrent sore throat

Surgery for the treatment of recurrent severe episodes of sore throat should only be considered when the following criteria are met:

- Sore throats are due to acute tonsillitis

AND

- The episodes are disabling and prevent normal functioning

AND

- There have been the following numbers of documented, clinically significant, adequately treated sore throats in the specified time periods:
  - Seven or more in the preceding year

  OR
  - Five or more in each of the preceding two years

  OR
  - Three or more in each of the preceding three years.

IN ADDITION

In patients with the following medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the ongoing management, tonsillectomy may be considered beneficial at a lower threshold than the criteria set out above, after specialist assessment.

- Acute and chronic renal disease resulting from acute bacterial tonsillitis.
- As part of the treatment of severe guttate psoriasis.
- Metabolic disorders where periods of reduced oral intake could be dangerous to health.
- PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Obstructive sleep apnoea in children

Adenotonsillectomy should be considered for children (aged 12 months–18 years inclusive) with:

- clinical features of adenotonsillar hypertrophy

AND

- features of OSA such as
  - Snoring and pauses in breathing, which may be followed by a gasp or snort
  - Restlessness and sudden arousals from sleep, laboured breathing, unusual sleep posture (for example head bent backwards), and bedwetting
  - Daytime symptoms such as changes in behaviour (for example irritability), poor concentration, decreased performance at school, tiredness and sleepiness, failure to gain weight or grow, and mouth breathing

AND

- Sleep studies which support the diagnosis of OSA

4. Exclusions

This policy does not apply to tonsillectomy which may be required as a treatment for the following conditions:

- Suspected cancer (e.g. asymmetry of tonsils), when referral should be made through the appropriate (2 week wait) route
- Recurrent quinsy
- Emergency presentations (e.g. treatment of parapharyngeal abscess)

5. Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018, which is based on the 2010 SIGN guideline.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for tonsillectomy.

Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person's ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.

The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267,159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- West Suffolk Clinical Commissioning Group. Clinical Thresholds. Tonsillectomy T13. Available from: http://www.westsuffolkccg.nhs.uk/clinical-area/clinical-thresholds-lpps/
- SIGN. Management of sore throat and indications for tonsillectomy. April 2010. Available

from: https://www.sign.ac.uk/assets/sign117.pdf
- NICE Clinical Knowledge Summaries. Sore Throat- acute. Scenario: Management of acute sore throat. Available from: http://cks.nice.org.uk/sore-throat-acute#!scenario
- ENT guide. Commissioning guide Tonsillectomy 2013 Available from: https://entuk.org/sites/default/files/files/Tonsillectomy_Commissioning%20guide_Published.pdf
- Burton, Glasziou, Chong, Vnenekamp. Surgical removal of the tonsils (tonsillectomy) for chronic or recurrent acute tonsillitis. 2014. Cochrane Database. Available from: http://www.cochrane.org/CD001802/ENT_surgical-removal-of-the-tonsils-tonsillectomy-for-chronic-or-recurrent-acute-tonsillitis
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- Buskens, Van Staaij et al. Adenotonsillectomy or watchful waiting in patients with mild to moderate symptoms of throat infections or adenotonsillar hypertrophy. Arch Otolaryngol Head and Neck Surg. 2007; 133(11):1083-1088.
- Cambridge and Peterborough Clinical Commissioning Groups. Tonsillectomy Referral Proforma for GP. Available from: http://www.cambridgeshireandpeterboroughccg.nhs.uk/CATCH/tonsils.htm
- South, Central and West Commissioning Support Unit. Tonsillectomy- referral for Assessment. 2015. Available from: https://www.southgloucestershireccg.nhs.uk/media/medialibrary/2015/12/tonsillectomy_policy.pdf
- Powell S, Kubba H, O'Brien C, Tremlett M Paediatric obstructive sleep apnoea. BMJ. 2010 Apr 14;340:c1918. doi: 10.1136/bmj.c1918.
- Hodges S, Wailoo M P, Tonsillar enlargement and failure to thrive, BMJ Vol 295, 1987..

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2015. Clinical Knowledge Summaries: Obstructive Sleep Apnoea Syndrome. https://cks.nice.org.uk/obstructive-sleep-apnoea-syndrome#!topicSummary

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Policy name	Trigger Finger - Surgical Release
Policy type	Threshold with prior approval
Included intervention(s)	Surgical release of trigger finger.
Included indication/ condition(s)	Trigger Finger
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T9 – Trigger Finger
NEE CCG policy	Trigger Finger – Surgical Intervention

1. **Interventions covered by this policy**
   Surgical release of trigger finger.

2. **Conditions to be considered for treatment under this policy**
   Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain, and loss and unreliability of hand function.

3. **Eligibility criteria for provision of the intervention**
   Surgical release of trigger finger should only be considered if **one** of the following criteria is met:
   - the triggering has persisted or recurred after non-operative treatment, which included:
     - two steroid injections

     WITH OR WITHOUT
     - splinting of the affected finger for 3-12 weeks

   OR
   - the finger is permanently locked in the palm

   OR
   - the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods

   OR
   - the patient is diabetic

4. **Exclusions**
   This policy does not cover:
   - Children and young people (aged 18 and under)

5. **Additional notes**
   This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.
   All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

   Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for trigger finger release.

   Mild cases which cause no loss of function require no treatment or avoidance of activities

which precipitate triggering and may resolve spontaneously. Treatment with steroid injections usually resolves troublesome trigger fingers within 1 week (strong evidence) but the problem may recur, especially in diabetics. There is only weak evidence for splinting. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NHS Choices. Conditions: Trigger Finger. Updated September 2015. Available from: http://www.nhs.uk/Conditions/Trigger-finger/Pages/Introduction.aspx
- West Suffolk Clinical Commissioning Group. Clinical Threshold Policy. Trigger Finger. Available from: http://www.westsuffolkccg.nhs.uk/wp-content/uploads/2014/09/WSCCG-T9-checklist-Common-Hand-Trigger-finger.pdf
- Hull Clinical Commissioning Group. Clinical Commissioning Policies. Tendinopathies (Secondary Care). Available from: http://hullccg.nhs.uk/policies
- The British Society for Surgery of the Hand. Hand Disorders: Trigger finger/thumb. Available from: http://www.bssh.ac.uk/patients/conditions/18/trigger_fingerthumb
- North and West Reading Clinical Commissioning Group. Thames Valley Priorities Committee Policy Proposals: Orthopaedic hand policies - Carpal tunnel syndrome, Dupuytrens contracture and Trigger finger. Available from: http://www.nwreadingccg.nhs.uk/about-us/18-your-north-and-west-reading-ccg/427-governing-body-meeting-in-public-15-september-2015
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- NHS England. Interim Clinical Commissioning Policy: Trigger Finger (stenosing tenosynovitis) Surgery. November 2013. Available from: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC034.pdf
- South, Central and West Commissioning Support Unit. Trigger Finger (stenosing tenosynovitis) Surgery. Policy Statement. Available from: https://www.southgloucestershireccg.nhs.uk/media/medialibrary/2015/12/trigger_finger_policy_.pdf
- Huisstede, Hoogvliet et al. Multidisciplinary consensus guideline for managing trigger finger: results from the European Hand guide Study. Phys Ther. 2014 Oct;94(10):1421-33. doi: 10.2522/ptj.20130135. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24810861
- Kerrigan CL, Stanwix MG. Using evidence to minimize the cost of trigger finger care. J Hand Surg Am. 2009;34(6):997-1005. Available from: https://www.researchgate.net/publication/26705949_Using_Evidence_to_Minimize_the_Cost_of_Trigger_Finger_Care

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- British Society for Surgery of the Hand, 2016. Evidence based management of adult trigger digits https://www.bssh.ac.uk/_userfiles/pages/files/professionals/BEST%20Guidelines/BEST%20trigger%20finger%20PUBLISHED(1).pdf

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Policy name	**Urinary Incontinence and Symptomatic Pelvic Organ Prolapse in Secondary Care (Treatment of Female)**
Policy type	Threshold with prior approval
Included intervention(s)	Referral to secondary care for women with urinary incontinence Surgery for women with pelvic organ prolapse
Included indication/ condition(s)	Female urinary incontinence Symptomatic pelvic organ prolapse
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T31: Treatment of female urinary incontinence and symptomatic pelvic organ prolapse in secondary care
NEE CCG policy	-

1. Interventions covered by this policy

Referral to secondary care for further investigation and treatment of female urinary incontinence. Surgical intervention for women with symptomatic pelvic organ prolapse.

2. Conditions to be considered for treatment under this policy

***Female urinary incontinence* (UI).** This can be divided into:
Stress incontinence: involuntary leakage of urine associated with increased intra-abdominal pressure.
Urge incontinence: the involuntary leakage of urine accompanied by or immediately preceded by urgency. Urgency with or without urge incontinence can be described as overactive bladder syndrome (OAB).
Mixed urinary incontinence: a combination of stress and urge incontinence.

Pelvic organ prolapse: symptoms include a feeling of pelvic heaviness, bulge or lump coming down from the vagina and backache; it can also be associated with bladder dysfunction.

3. Eligibility criteria for provision of the intervention

Female urinary incontinence

Referral to secondary care for investigation and treatment of female urinary incontinence will only be considered when **both** the following criteria are met (note: Mixed UI should be treated according to the dominant symptom):

- The patient has had a trial of initial conservative treatment, which should be:
  - ***Stress or mixed UI***: the patient has undergone a minimum of 3 months supervised pelvic floor training (comprising at least 8 contractions performed 3 times a day), without satisfactory resolution of symptoms
    OR
  - ***Urge or mixed UI***: the patient has undergone a minimum of 6 weeks bladder training with the addition of at least 4 weeks treatment with an anticholinergic drug if appropriate, without satisfactory resolution of symptoms

AND

- There is documented evidence that the patient has received lifestyle advice where applicable regarding reducing caffeine intake, appropriate fluid intake, smoking cessation and weight loss if BMI >30kg/m^2

Pelvic Organ Prolapse

Surgical treatment for symptomatic pelvic organ prolapse will only be considered when **all** the following criteria are met:

- the patient has both pelvic organ prolapse AND urinary or faecal incontinence

AND

- there is documented evidence that the patient has received lifestyle advice where applicable regarding minimising heavy lifting, avoiding constipation and weight loss if BMI >30kg/m^2

AND

- there is documented evidence that the patient has had a trial of conservative measures where applicable such as topical vaginal oestrogens in women with vaginal atrophy, and supervised pelvic floor muscle training

AND

- a trial of a pessary has either failed to satisfactorily relieve symptoms, OR is unacceptable to the patient

4. Exclusions

This policy does not cover:

- Children and young people (aged 18 and under)
- Women with symptoms suspicious of malignancy (for example visible haematuria, microscopic haematuria in the over 50s, mass arising from urinary tract) who should be referred via the appropriate pathway
- Women with recurrence of symptoms or de novo symptoms following surgical treatment of urinary incontinence or pelvic organ prolapse[5]

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral to secondary care for investigation and treatment of female urinary incontinence or surgical treatment for pelvic organ prolapse.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- NHS England Specialist services https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-e/e09/
- McClurg D, Pollock A, Campbell P, Hazelton C, Elders A, Hagen S, Hill DC. Conservative interventions for urinary incontinence in women: an Overview of Cochrane systematic reviews (Protocol). Cochrane Database of Systematic Reviews 2016, Issue 9.
- Royal college of Obstetricians and Gynecologists Pelvic Organ Prolapse 2013 https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-pelvic-organ-prolapse.pdf
- NICE CG171 Urinary incontinence in women: Management https://www.nice.org.uk/guidance/cg171?unlid=64214263620168245424
- NICE clinical knowledge summaries http://cks.nice.org.uk/incontinence-urinary-in-women
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[5] This is commissioned by NHS England as part of Complex Gynaecology: Recurrent Prolapse and Urinary Incontinence https://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-recur-pro-urina-incon.pdf

Womens Health 2014; 6: 83–94.

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2019. Urinary incontinence and pelvic organ prolapse in women: management. NG123 https://www.nice.org.uk/guidance/ng123 (replaces CG 171)

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Policy name	Uterine Artery Embolisation
Policy type	Threshold with prior approval
Included intervention(s)	Uterine artery embolisation
Included indication/ condition(s)	Uterine fibroids Adenomyosis
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T36: Uterine artery embolisation in non-operative treatment of fibroids
NEE CCG policy	Fibroid embolisation/ Uterine artery embolisation

1. Interventions covered by this policy

Uterine artery embolisation involves the insertion of a catheter into the femoral artery, and manipulation under fluoroscopic guidance. Small embolisation particles are injected through the catheter into the arteries supplying the target areas, with the aim of causing thrombosis and consequent infarction.

2. Conditions to be considered for treatment under this policy

Uterine fibroids, also known as uterine leiomyomas or uterine myomas, are benign tumours of smooth muscle cells and fibrous tissue that develop within the wall of the uterus. They may be asymptomatic or may cause symptoms such as heavy menstrual bleeding, incontinence, a feeling of pelvic pressure, or pain.

Adenomyosis is a benign condition characterised by the presence of ectopic endometrial glands and stroma within the myometrium. It frequently occurs coincidentally with fibroids. Adenomyosis may cause no symptoms but some women with adenomyosis experience heavy, prolonged menstrual bleeding with severe cramps, pelvic pain and discomfort.

3. Eligibility criteria for provision of the intervention

Women with symptomatic uterine fibroids or adenomyosis should only be considered for uterine artery embolisation if they meet all the following criteria:

- Their fibroids (if applicable) are 3cm or more in diameter

AND

- Conservative management (including hormonal and non-hormonal pharmacological approaches) has been considered and is either not appropriate or has been unsuccessful

AND

- There has been a discussion with the patient on the effects of the procedure compared with other possible interventions, and in particular they are aware that:
  - symptoms may not be relieved or could return
  - while it is possible that fertility may be retained, the effects of the procedure on fertility and on pregnancy are uncertain

4. Exclusions

None.

5. Additional notes

Please refer to policy that covers Hysterectomy for heavy menstrual bleeding
Please refer to policy that covers Dilatation and curettage for heavy menstrual bleeding

Uterine artery embolisation should only be carried out by radiologists with the appropriate training and competence.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for uterine artery embolisation.

Current evidence on uterine artery embolisation for fibroids and for adenomyosis shows that the procedure is efficacious for symptom relief in the short and medium term for a substantial proportion of patients (NICE 2010, NICE 2013). It may therefore be more appropriate for women who are likely to be nearing the menopause and who will gain sufficient short-term relief, while avoiding major surgery. There are no major safety concerns.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- National Institute for Health and Care Excellence, 2010. Uterine Artery Embolisation for Fibroids. IPG367 http://nice.org.uk/guidance/ipg367

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2018. Heavy menstrual bleeding: diagnosis and management. NG88. www.nice.org.uk/guidance/ng88
- National Institute for Health and Care Excellence, 2013. Uterine Artery Embolisation for Adenomyosis. IPG473 http://nice.org.uk/guidance/ipg473

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Policy name	Varicose Vein Interventions
Policy type	Threshold with prior approval
Included intervention(s)	Endothermal ablation, foam sclerotherapy or surgery
Included indication/ condition(s)	Varicose veins
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T6: Varicose veins
NEE CCG policy	Varicose veins

1. **Interventions covered by this policy**
   Interventions for varicose veins, including:
   - endothermal ablation (laser ablation or radiofrequency ablation)
   - ultrasound-guided foam sclerotherapy
   - surgery (ligation and stripping)

2. **Conditions to be considered for treatment under this policy**
   Varicose veins are dilated, often palpable subcutaneous veins with reversed blood flow, most commonly found in the legs. They may be asymptomatic, cause mild symptoms, or more troublesome symptoms such as pain, aching or itching. Possible complications include changes in skin pigmentation, bleeding, venous ulceration or deep vein thrombosis.

3. **Eligibility criteria for provision of the intervention**
   Patients with varicose veins may be referred for further assessment and consideration of an interventional procedure if they have **one** of the following:
   - Symptomatic primary or recurrent varicose veins; i.e. veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching)

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

   OR
   - Superficial vein thrombophlebitis (characterised by the appearance of hard painful veins) and suspected venous incompetence

   OR
   - A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks)

   OR
   - A healed venous leg ulcer.

4. **Exclusions**
   This policy does not cover:
   - Children and young people (aged 18 and under)
   - People with bleeding varicose veins, who should be referred to a vascular service immediately
   - Treatment of varicose veins during pregnancy

5. **Additional notes**
   This policy is based on ‘Varicose vein interventions’ in ‘Evidence-based interventions:

guidance for CCGs' published by NHS England, 2018, which is based on NICE CG168 'Varicose veins: diagnosis and management'.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.
All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for varicose vein interventions.

The interventional procedures covered by this policy have been shown to be clinically and cost effective for the specified indications compared to no treatment or treatment with compression hosiery, which should not be offered unless interventional treatment is unsuitable (for example, during pregnancy). NICE recommend that treatments should be considered in the following order for people with confirmed varicose veins and truncal reflux: first endothermal ablation; if this is unsuitable, foam sclerotherapy; if this is unsuitable, surgery.

Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. The rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%. Recurrence can occur due to the development of further venous disease that will benefit from further intervention.

6. Compliance with NICE guidance

This policy complies with relevant NICE guidance.

7. References

7a. References included in original Suffolk / NEE policy / policies.

- NICE clinical guidance CG168 https://www.nice.org.uk/guidance/cg168
- NICE Obesity guidance https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations
- Foti D & Kanazawa L. Activities of daily living. In: Pendleton H & Shultz-Krohn (eds) Pedretti's Occupational Therapy: Practice Skills for Physical Dysfunction. 7th edition. United states. Elsevier mosby; 2008 p157-159.
- NHS choices varicose veins http://www.nhs.uk/Conditions/Varicose-veins/Pages/Causes.aspx
- Royal college of surgeons 2013 Commissioning guide Varicose veins http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins/view?searchterm=commissioning+guide+varico
- NICE clinical knowledge summaries Varicose veins http://cks.nice.org.uk/varicose-veins#!backgroundsub
- NICE quality standard 67 Varicose veins in the legs (August 2014) https://www.nice.org.uk/guidance/qs67
- Dorset CCG policy http://www.dorsetccg.nhs.uk/Downloads/aboutus/Policies/Clinical/Policies%20from%20Sept%202014/Criteria%20Based%20Access%20Protocol%20-%20Varicose%20veins.pdf
- Gloucestershire CCG policy www.gloucestershireccg.nhs.uk/wp-content/uploads/2015/08/Varicose-veins.doc
- South East London CCGs' policy http://www.lewishamccg.nhs.uk/about-us/Who-weare/Governing%20Body%20papers/Enc%2020.1%20SE%20London%20Treatment%20Access%20Policy.pdf

7b. Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

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Policy name	Vasectomy under General Anaesthetic
Policy type	Threshold with prior approval
Included intervention(s)	Vasectomy carried out under general anaesthetic (GA)
Included condition/ indication(s)	Men requesting a permanent sterilisation procedure
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T12: Vasectomy under general anaesthetic
NEE CCG policy	Vasectomies

1. **Interventions covered by this policy**
   Vasectomy carried out under general anaesthetic.

2. **Conditions to be considered for treatment under this policy**
   Men requesting a permanent sterilisation procedure for whom it is not appropriate to carry out vasectomy under local anaesthetic.

3. **Eligibility criteria for provision of the intervention**
   Men requesting vasectomy should only be referred for the procedure to be carried out under GA if:
   - They have a previous documented adverse reaction to local anaesthesia

   OR
   - They have scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or manipulation of the spermatic cord through the skin difficult to achieve

   OR
   - They are on anticoagulant therapy

   IN ADDITION:
   - Patients who meet one of the above criteria must be assessed prior to referral, with respect to their:
     - Mental capacity to make the decision to undergo vasectomy
     - Understanding of the advantages, disadvantages, and relative failure rates of vasectomy and of long-term reversible methods of contraception
     - Understanding that vasectomy should be regarded as irreversible
     - Risk for later regret

4. **Exclusions**
   This policy does not cover children and young people (aged 18 and under).

5. **Additional notes**
   Fear of the procedure, or patient choice, are **not** adequate reasons for requesting vasectomy under general anaesthetic. In cases of severe phobia, application for treatment may be made by individual funding request.

   Additional care should be taken when counselling people who are:
   - Less than 30 years of age
   - Without children
   - Taking decisions during pregnancy
   - Taking decisions in reaction to the loss of a relationship

- Possibly at risk of coercion by their partner, family, or health or social welfare professionals
- Have cultural, religious, psychosocial, psychosexual or psychological issues
- Are at risk for sexually transmitted infection when barrier methods are not being used and if appropriate, advice, testing, promote safer sex, and / or refer for counselling

The man's partner's suitability for sterilisation should also be assessed, as the couple's clinical history, present symptoms, or abnormal examination findings may influence which partner goes forward to have sterilisation.

All referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

6. Compliance with NICE guidance

No relevant NICE guidance.

7. References

7a. References included in original Suffolk/NEE policy / policies.

- Royal College of Obstetricians & Gynaecologists (RCOG). *Male and female sterilisation. Evidence-based Clinical Guideline* No 4. London: RCOG Press; 2004. Available from: http://www.rcog.org.uk/files/rcog-corp/uploaded-files/NEBSterilisationFull060607.pdf (Accessed 22/09/2016)
- NICE Clinical Knowledge Summaries. Contraception -management. *Male sterilization*. Available at: https://cks.nice.org.uk/contraception-sterilization#!scenario (Accessed 22/09/2016)
- RCOG Faculty of Sexual & Reproductive Health Care. *UK Medical Eligibility Criteria for Contraceptive Use.* 2009. Available from: http://www.fsrh.org/pdfs/UKMEC2009.pdf (Accessed 22/09/2016)
- National Guidelines Clearing House, *Male and Female Sterilisation*, Revised Sept 2014, https://www.guideline.gov/summaries/summary/48788/male-and-female-sterilisation, Accessed: 15/09/2016.
- Cook LA, Pun A, van Vliet H, Gallo MF, Lopez LM. *Scalpel versus no-scalpel incision for vasectomy*. Cochrane Database Systematic Reviews. 2007 Apr 18;(2):CD004112
- Faculty of Sexual and Reproductive Healthcare (FSRH), *Clinical Guidelines ,Male and Female Sterilisation,* FSRH, Royal College of Obstetricians & Gynaecologists, 2014, Available from: : https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/ (Accessed: 19.09.2016)

7b. Additional guidance referred to in production of ICS policy.

None

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Policy name	**Vision Therapy and Related Interventions, Coloured Filters and Tinted Lenses**
Policy type	Exceptional clinical circumstances
Included intervention(s)	Vision therapy and related interventions Colourimetry, coloured filters and tinted lenses
Included indication/ condition(s)	Conditions affecting eye position or movement. Conditions associated with visual discomfort and difficulties with perception.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	PE3: Filters & Coloured Lenses for Scotopic Sensitivity Syndrome
NEE CCG policy	Vision therapy/Vision training/Behavioural optometry Including: Scotopic Sensitivity Syndrome / Mears Irlen Syndrome / Coloured Filtered Lenses

1. **Interventions covered by this policy**
   Vision therapy, behavioural optometry or vision training.
   Colorimetry and coloured filters or tinted lenses.

2. **Conditions to be considered for treatment under this policy**
   This policy covers a range of conditions affecting eye position or movement, and conditions associated with visual discomfort and difficulties with perception (see additional notes).

3. **Eligibility criteria for provision of the intervention**
   Vision therapy, behavioural optometry or vision training are considered low priority procedures and will not usually be funded.
   The provision of colourimetry, coloured filters or tinted lenses are considered low priority and will not usually be funded.

4. **Exclusions**
   None

5. **Additional notes**
   Vision therapy may also be referred to as eye exercise therapy, visual therapy, visual training, vision training, orthoptic therapy, orthoptics, orthoptic vision therapy, behavioural optometry or optometric vision therapy. It may include elements of a wide range of optometric treatment modalities, including the use of special lenses, prisms or filters, occlusion and other procedures, and eye exercises and behavioural modalities that are used for eye movement and fixation training.

   Various types of vision therapy have been proposed for a range of conditions including strabismus or squint, amblyopia, nystagmus, convergence excess, dyspraxia, dyslexia and other learning and reading disabilities including specific reading difficulty (SRD), scotopic sensitivity syndrome (SSS), visual stress, Mears Irlen Syndrome and learning disability or language disorder, including developmental delay. SSS was described in 1983 and said to cause visual discomfort in a subgroup of people with developmental dyslexia (specific reading difficulty). The treatment proposed was coloured lenses specific to each individual. The Royal College of Ophthalmologists has raised questions about the existence of SSS. The available evidence on the possible benefits of tinted lenses or

coloured filters appears to be mixed; however there are no proven documented risks to health from their use. Privately available, individually prescribed coloured filters and tinted lenses are available from opticians.

6. Compliance with NICE guidance

There is no relevant NICE guidance.

7. References

7a. References included in original Suffolk / North East Essex policy / policies.

- Markham R. Focus on: Developmental Dyslexia. Occasional Update from the Royal College of Ophthalmologists. 2002;23.
- Committee on Children With Disabilities, American Academy of Paediatrics (AAP), American Academy of Ophthalmology (AAO), American Association for Paediatric Ophthalmology and Strabismus (AAPOS). Learning Disabilities, Dyslexia, and Vision: A subject Review. Paediatrics. 1998; 102:1217-9.
- Wilkins AJ, Evans BJ, Brown JA, Busby AE, Wingfield AE, Jeanes RJ *et al*. Double-masked placebo-controlled trial of precision spectral filters in children who use coloured overlays. Ophthal Physiol Opt. 1994; 14:365-370.
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- Solan HA, Richman J. Irlen Lenses: A critical appraisal. Journ Amer Opt Assoc. 1990; 61:789-796.
- Gole GA, Dibden SN, Pearson CC, Pidgeon KJ, Mann JW, Rice D *et al*. Tinted lenses and dyslexics - a controlled study. SPELD (S.A.) Tinted Lenses Study Group. Aust N Z J Ophthalmol. 1989; 17:137-41

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Squint in children: Clinical Knowledge Summary https://cks.nice.org.uk/squint-in-children#!topicSummary

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Policy name	**Weight Management and Smoking Cessation Prior to Elective Surgery**
Policy type	See individual policies for elective surgical interventions
Included intervention(s)	Weight management support and smoking cessation support while waiting for elective surgery
Included indication/ condition(s)	Adult patients to be referred for elective surgery who have a BMI>35kg/m^2 and/or who smoke
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	T16. Smoking cessation prior to routine elective surgery
NEE CCG policy	General surgery

1. **Interventions covered by this policy**
   Weight management support and smoking cessation support for patients who are waiting for elective surgery.

2. **Indications/conditions to be considered for treatment under this policy**
   Adult patients to be referred for elective surgery who have a BMI>35kg/m^2.
   Adult patients to be referred for elective surgery who are current smokers.

3. **Eligibility criteria for provision of the intervention**
   Patients to be referred for elective surgery who have a BMI >35kg/m^2
   Adult patients requiring elective surgery should have a BMI of 35kg/m^2 or less at the time of surgery. Patients with a BMI >35kg/m^2 should be strongly advised to reduce their BMI before referral via independent weight loss, or with support from their GP practice, or via attendance and support from a weight management programme.

   This policy does not mandate a target for weight loss, which should be within healthy limits for weight loss as advised by their clinician and appropriate to the patient.

   Patients with a BMI>35kg/m^2 should only be referred for elective surgery if one of the following applies:
   - they can demonstrate that they have lost some weight over the previous 3-6 months, even if their current BMI remains >35kg/m^2,

   OR
   - they can demonstrate that they have made a reasonable attempt to lose weight over the previous 3-6 months through their own independent efforts, or with support from their GP practice, or with support from a weight management programme, but there are reasons why this has been unsuccessful,

   OR
   - in the absence of previous weight loss engagement, their GP has referred the patient to an appropriate weight management service,

   OR
   - there are reasons why they cannot be reasonably expected to attempt to lose weight.

   The relevant information should be provided within the referral for the elective surgical procedure being considered. If the patient's BMI remains >35kg/m^2, the specialist who will carry out the procedure should confirm that the potential benefits outweigh the risks for the patient.

Surgery should be supported for patients with a BMI >35kg/m^2 who were accepted onto a NHS waiting list prior to taking up residence in Suffolk or North East Essex, providing the existing clinical evidence has remained the same.

***Patients to be referred for elective surgery who smoke cigarettes*.**
Patients requiring elective surgery who smoke should receive full information on the risks of smoking and should be offered smoking cessation support.

All patients requiring elective surgery should have their smoking status assessed. If the patient is a smoker:

- the referring GP should discuss with them the benefits of stopping smoking with regards to their operation, and should strongly encourage them to quit

AND

- they should be given a 'Stop before your Op' leaflet

AND

- they should be offered smoking cessation support, either through their GP practice or referral to the stop smoking service. This should be as an 'opt-out'; if a patient refuses to embark on a quit attempt this will be recorded in the patient's notes and referral information. Patients who smoke will not be denied surgery or have their surgery delayed.

At the point of referral patients who smoke must be identified as 'Stop before your Op'.

Smoking status and referral status should be checked when patients are seen in the surgical outpatient clinic. Referral for stop smoking support should be made for patients who wish for this but have not yet been referred.

Patients who wish to stop smoking can attempt to do so while they are waiting for their appointment and are on the waiting list for surgery. Patients can, if they wish to, opt to suspend the waiting list while receiving a smoking cessation intervention. Some smokers may feel that they need a longer period of time in order to achieve abstinence. The waiting list, however, must not be suspended for any other reason.

4. Exclusions

This policy does not apply to children and young people (aged 18 and under).

5. Additional notes

NICE recommend that achievable goals for achieving and maintaining weight loss should be discussed with people wishing to lose weight. People should be aware that the more weight they lose, the greater the health benefits, particularly if someone loses more than 5% of their body weight and maintains this for life. On average, people attending a lifestyle weight management programme lose around 3% of their body weight, but this varies a lot. The NHS weight loss plan recommends a safe rate of weight loss is 0.5kg to 1kg (1lb to 2lb) per week.

The Association of Anaesthetists report that while the majority of obese patients presenting for surgery have a similar peri-operative risk to that of patients of normal weight, obese patients present a different set of challenges and require specific peri-operative care compared with non-obese patients. Patients at a higher risk of peri-operative complications are those with central obesity and metabolic syndrome.

There is some limited evidence of worse outcomes for obese patients undergoing some types of surgery (e.g. elective hip and knee surgery; Pozzobon et al, 2018).

Smoking remains the leading cause of preventable morbidity and premature death in England. In the East of England 8,300 deaths per year are attributable to smoking.

There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing. Such complications compromise the intended procedural outcomes and increase the costs of care. Post-operative infections prolong hospital stay, increase ITU admissions and increase re-admission rates. Increased use of hospital beds and associated costs mean less opportunity to treat other patients. The evidence to date has not identified any major concerns about the use of e-cigarettes around surgery, although there are uncertainties about any long-term health effects of e-cigarettes, because the products have not yet had a history of long use. Public Health England state that e-cigarettes are significantly less harmful than tobacco and recognise them as an alternative to smoking which can help people quit.

Smoking cessation interventions before elective surgery have been shown to effectively reduce the number of people who smoke, resulting in a reduction in surgical complications, smoking-related illnesses and smoking-related deaths. Smoking cessation interventions are highly cost-effective for the whole of the NHS, with the estimated cost of a fully integrated smoking cessation service being only £800 per life year gained. This is more effective than almost any other medical interventions apart from immunisation. Helping smokers to quit before elective surgery will therefore improve the health of patients undergoing surgery, reduce the risks of complications and increase the cost-effectiveness of surgical procedures. This policy will also help to increase uptake of smoking cessation services and reduce the number of smokers in Suffolk in-line with the Department of Health white paper “Smoking Kills”.

6. Compliance with NICE guidance

No relevant NICE guidance relating to weight loss before surgery.
NICE NG92 (2018) recommends that people who smoke who are planning surgery should receive support to stop smoking as an opt-out approach.

7. References

7a. References included in original Suffolk/NEE policy/ies.

- Warner MA, Offord KP. Role of preoperative smoking cessation and other factors in postoperative pulmonary complications: a blinded prospective study of CABG patients. Mayo clinic proceedings; 1989;64;609-16.
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- Nakagawa M, Tanaka H, Tsukuma H, Kishi Y. Relationship between duration of the preoperative smoke-free period and the incidence of postoperative pulmonary complications. Chest. 2005; 127:1873-5.
- Myles PS, Iacono G. Risk of respiratory complications and wound infection in patients undergoing ambulatory surgery. Anesthesiology. 2002; 97;842.
- Manassa E, Herti C. Wound healing problems in smokers and non-smokers after 132 abdominoplasties. Plastic and reconstructive surgery. 2003;111:2082.
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- Cropley M, Theadom A, Pravettoni G, Webb G. The effectiveness of smoking cessation interventions prior to surgery: A systematic review. Nicotine Tob Res. 2008; 10:407-12.

- East of England Strategic Health Authority. Public Board Meeting, Sept 2006. Dr Paul Cosford.

7b. Additional guidance referred to in production of ICS policy.

- The Association of Anaesthetists of Great Britain and Ireland & the Society for Obesity and Bariatric Anaesthesia, 2015. Peri-operative management of the obese surgical patient. https://onlinelibrary.wiley.com/doi/full/10.1111/anae.13101
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018;**8:**e017689. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf
- National Institute of Health and Care Excellence, 2014. Weight management: lifestyle services for overweight or obese adults (PH 53). https://www.nice.org.uk/guidance/ph53
- NHS weight loss plan https://www.nhs.uk/live-well/healthy-weight/start-losing-weight/
- National Institute of Health and Care Excellence, 2018. Stop smoking interventions and services (NG92). https://www.nice.org.uk/guidance/ng92
- Action on Smoking and Health (ASH), the Royal College of Anaesthetists (RCoA), the Royal College of Surgeons of Edinburgh (RCSEd) and the Faculty of Public Health. 2016. Joint briefing: smoking and surgery. https://www.rcoa.ac.uk/sites/default/files/Joint-briefing-Smoking-Surgery.pdf
- Public Health England, 2019. Vaping in England: an evidence update https://www.gov.uk/government/publications/vaping-in-england-an-evidence-update-february-2019
- House of Commons, 2018. E-cigarettes. Report of the House of Commons Science and Technology Committee https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/505/505.pdf

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Policy name	Wide Bore and Open/Upright MRI
Policy type	Threshold with prior approval
Included intervention(s)	Wide bore MRI and open/upright MRI
Included condition/ indication(s)	Patients requiring MRI who are morbidly obese.
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Open/ wide bore/ upright MRI

1. **Interventions covered by this policy**
   Wide bore MRI: wide bore MRI systems have a bore of >60cm, whereas standard narrow bore systems have a bore of ≤60cm.
   Open or upright MRI: these may be carried out with the patient standing, sitting or reclining, rather than lying flat within an enclosed space as in standard MRI.

2. **Conditions to be considered for treatment under this policy**
   Patients requiring MRI who are morbidly obese.

3. **Eligibility criteria for provision of the intervention**
   Morbidly obese patients who require an MRI scan and are not able to use local MRI services because of their size and/or their inability to lie flat for the required period of time may be offered a wide bore or open/upright MRI scan.

4. **Exclusions**
   This policy does not cover:
   - Patients who require a wide bore or open/upright MRI scan urgently for clinical reasons

5. **Additional notes**
   Patients who are morbidly obese may be too large to fit into a standard narrow bore (≤60cm) scanner, but may be accommodated by a wide bore scanner.
   A standard MRI may require the patient to be supine for up to 90 minutes, depending on the type of scan being carried out.
   A survey carried out by the Royal College of Radiologists in 2016 of MRI provision in NHS organisations across the UK found that 41% of all MRI systems reported on were wide bore. They did not report on any upright or open MRI systems available within the NHS.
   Patients with claustrophobia who are not morbidly obese are not eligible for open/ upright MRI.
   If the MRI is being carried out prior to a possible referral for elective surgery, please also refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

6. **Compliance with NICE guidance**
   No relevant NICE guidance

7. **References**
   7a. References included in original Suffolk/NEE policy / policies. None
   7b. Additional guidance referred to in production of ICS policy.

   - Royal College of Radiologists, 2017. Magnetic resonance imaging (MRI) equipment, operations and planning within the NHS. https://www.rcr.ac.uk/sites/default/files/cib_mri_equipment_report.pdf

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Policy name	**Wireless Capsule Endoscopy and Double Balloon Enteroscopy**
Policy type	Threshold with prior approval
Included intervention(s)	Wireless capsule endoscopy and double balloon enteroscopy
Included condition/ indication(s)	Obscure gastrointestinal bleeding Investigation of suspected Crohn's disease
Date produced	January 2021
Planned review date	July 2022
Replaces:	
Ipswich & East Suffolk and West Suffolk CCG policy	-
NEE CCG policy	Endoscopy: capsule endoscopy and double balloon endoscopy

1. Interventions covered by this policy

Wireless capsule endoscopy (WCE): the patient swallows a small capsule, usually after an overnight fast. This capsule consists of a camera, a light source and a wireless circuit for the acquisition and transmission of signals. As the capsule moves through the gastrointestinal tract, images are transmitted to a data recorder, worn on a belt outside the body. These data are transferred to a computer for interpretation. The capsule is then passed in the patient's stool and not used again.

Double balloon enteroscopy (DBE): this uses a high-resolution video endoscope and is carried out under sedation. The technique is based on alternating pushing and pulling manoeuvres, and it can be performed via the oral or anal route.

2. Conditions to be considered for treatment under this policy

Obscure gastrointestinal bleeding: bleeding of unknown origin that persists or recurs after a negative initial endoscopy (colonoscopy and/or upper gastrointestinal endoscopy).
Suspected Crohn's disease.

3. Eligibility criteria for provision of the intervention

Patients with obscure gastrointestinal bleeding.

Patients with obscure gastrointestinal bleeding who have undergone a gastroscopy and/or endoscopy with negative results, may be considered for WCE for diagnosis, followed, if indicated, by a DBE for treatment.

Patients with obscure gastrointestinal bleeding who have undergone a WCE as above, which was negative, but have persistent bleeding, may be considered for either a second WCE or a DBE.

Patients with suspected Crohn's disease

Patients with suspected Crohn's disease who have had ileocolonoscopy and/or small bowel radiology which was inconclusive, for whom pain is not a significant feature, or for whom pain is a significant feature but with no evidence of strictures on small bowel radiology, may be considered for WCE for diagnosis.

Patients with suspected Crohn's disease who have had ileocolonoscopy and/or small bowel radiology which was inconclusive, for whom pain is a significant feature and with evidence of strictures on small bowel radiology, may be considered for DBE for diagnosis.

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4. Exclusions

None

5. Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

The evidence available shows that WCE and DBE are safe and effective diagnostic procedures for the detection of obscure gastrointestinal bleeding, with a higher diagnostic yield than conventional methods. WCE and DBE have common indications but different features. WCE can cover the whole GI tract, requires no sedation and is better tolerated by patients. Its major limitations are the inability to obtain a biopsy, precisely localise a lesion, or perform therapeutic endoscopy. DBE has the advantage of being controllable and enabling therapeutic treatment to take place simultaneously. The procedure is invasive and not as well tolerated as WCE, requiring additional staff, typically two physicians or an additional specialist nurse. Cost-effectiveness modelling suggests that that DBE may be associated with better long-term outcomes because of the potential for fewer complications and decreased utilisation of endoscopic resources.

The evidence available also shows that WCE is a safe and effective diagnostic procedure for the detection of Crohn's disease, with a higher diagnostic yield than push enteroscopy and other conventional methods. The results suggest that it is superior to conventional radiological procedures in the detection of lesions in patients with Crohn's disease. However, the high number of patients with strictures limits its use as a first line diagnostic test in patients previously undiagnosed. Capsule retention remains a risk in patients with Crohn's disease with significant strictures. The risk is greater in patients with established Crohn's disease compared to patients suspected to have Crohn's disease.

6. Compliance with NICE guidance

NICE IPG 101 states that 'Current evidence on the safety and diagnostic yield of wireless capsule endoscopy appears adequate to support the use of this procedure, provided that the normal arrangements are in place for consent, audit and clinical governance'.

NICE interventional procedures guidance makes recommendations on the safety and efficacy of a procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS.

7. References

7a. References included in original Suffolk/NEE policy/ies.

- NICE. 2004. IPG 101. Wireless capsule endoscopy for investigation of the small bowel

7b. Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2004. Interventional Procedures Guidance (IPG) 101: Wireless capsule endoscopy for investigation of the small bowel. https://www.nice.org.uk/guidance/ipg101

- Teshima CW, Kuipers EJ, van Zanten SV, Mensink PB, 2011. Double balloon enteroscopy and capsule endoscopy for obscure gastrointestinal bleeding: an updated meta-analysis. Journal of Gastroenterology and Hepatology 26(5): 796-801 https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-1746.2010.06530.x