

**South West London  
Effective Commissioning Initiative  
Policy version 2.0  
2017-18**

**Final  
DRAFT**

**November 2017**

<b>Version</b>	<b>Description of Change(s)</b>	<b>Reason for Change</b>	<b>Author</b>	<b>Date</b>
2.0	<p>Alignment of all SWL CCGs ECI policies following via Task and Finish groups in June – Sept 2017</p> <p>NB: IVF and fertility preservation criteria novated to individual CCGs policy statement document and now excluded from this policy</p>	<p>Policy required improvement both in terms of content and format to ensure that there is a clear policy in place and the same thresholds apply to all SWL patients.</p>	Zoli Zambo	16/11/2017

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## Introduction to the Effective Commissioning Initiative (ECI)

This policy deals with treatments and procedures for which restricted access criteria have been agreed by the South West London Committees in Common on the 16<sup>th</sup> November 2017.

### Background

The South West London Effective Commissioning Initiative Policy (SWL ECI) was established in 2006 for the then Primary Care Trust (PCTs) in South West London, now called SWL Clinical Commissioning Groups (CCG).

The policy is driven by the need to ensure that NHS funded treatments are evidenced-based, clinically effective, safe and access to treatments throughout the SWL area is equitable for patients with similar clinical need, hence reduces variation in care.

Although not the main driving force, the policy also ensures that the NHS provides value for money and uses its resources effectively to achieve financial balance.

### Content of the policy

SWL CCGs have considered evidence of clinical practice, clinical effectiveness, cost-effectiveness, information on current activity, resources, costs and service provision across SWL when formulating these recommendations.

The SWL ECI policy lists 57 procedures, which can be categorised into:

- 'Prior Approval' category
- 'Individual Funding Request (IFR)' category

#### Prior Approval

Clinical criteria have been provided where the available evidence on clinical and cost effectiveness indicates the patient, who will benefit the most from a procedure funded by the NHS.

Prior to the procedure being undertaken authorisation must be obtained for these procedures by the treating clinician. This should be done by using the Prior Approval Tickbox forms on the BlueTeq system (secure online communication platform). This will demonstrate to commissioners that the patient meets the agreed criteria for treatment and assures the commissioners that both the concerned individual and the local population can expect to get maximum health benefits from the procedure in question.

#### Individual Funding Request

The IFR process set out in the South London IFR policy will be used to consider individual requests for funding where a service, intervention or treatment falls outside existing service agreements.

Some treatments are "Not routinely funded" because either their clinical and cost effectiveness is marginal or where NHS provision may be inappropriate (e.g. the benefits are purely cosmetic and not clinical).

Prior to the procedure being undertaken authorisation for these procedures must be obtained by the treating clinician (i.e. the practitioner who is responsible for administering the treatment). This should be done by using the IFR form.

This will be approved only when the SWL IFR panel agrees that the patient is exceptional or the patient has a very rare clinical condition. This is detailed in the South London IFR policy.

Exceptionality is defined as:

- Significantly different from the general population of patient with the condition in question; **AND**
- Likely to gain significantly more benefit from the intervention than might normally be expected for the average patient with the condition.

Any procedures not routinely funded can be requested via the IFR route. The policy cannot exhaustively list all procedures falling into this category but takes into account current clinical practice.

This IFR process will ensure that each request for individual funding is considered in a fair and transparent way, with decisions based on the best available evidence and in accordance with the South London IFR policy.

### **Scope of the policy**

The policy covers the procedures listed in this document when they are undertaken as routine planned treatments. When patients require the procedure due to an emergency this is excluded.

Procedures for the diagnosis and treatment of cancer are also excluded from the policy.

SWL CCGs may modify how authorisation is granted to treating clinicians based on continuous evaluation of the services.

Patients accessing services outside of SWL may be subject to the local clinical criteria set by the host commissioner CCG.

### **Recent developments**

The alignment and update of the SWL ECI policy has been coordinated by the SWL STP Programme Office. This work was based on the ECI policy in place across South West London. Key local stakeholders were invited to participate in the policy refresh between April and October 2017 by attending joint meetings or submitting their feedback electronically. The stakeholders included all SWL CCGs, acute and community providers, primary care and patient representatives.

In addition other England CCGs policies, recently published NICE guidelines and national and international peer-reviewed documentary evidence were also considered by a team of dedicated Public Health specialist with expertise in developing effective clinical commissioning policies.

### **Review**

This policy will be reviewed and updated annually to take into account new evidence and clinical guidance.

# 1. Breast Procedures

## 1.1. Breast enlargement (Breast augmentation / mammoplasty)

### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

### Clinical threshold

SWL CCGs do not routinely fund this procedure, application is only via IFR.

## 1.2. Breast enlargement – Revision (Revision breast augmentation / mammoplasty)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or Group 2.

Group 1: Criteria 1 and 2 must be met

Women, whose implants were inserted for cosmetic reasons funding is provided for removal but not for replacement of breast implants according to the following criteria.

1. Patient is 18 or over at the time of application
---

**AND**

2. Patient has
a) Remnant breast cancer or cancer in the contralateral breast
<b>OR</b>
b) Implants complicated by recurrent infections
<b>OR</b>
c) Implants with Baker Class IV contracture associated with severe pain
<b>OR</b>
d) Implants with severe contracture that interferes with mammography
<b>OR</b>
e) Intra- or extra-capsular rupture of silicone gel-filled implants.

Group 2: Criteria 3 and 4 must be met

Women, whose implants were inserted for medical reasons funding is provided for removal and replacement of breast implants according to the following criteria.



3. Patient is 18 or over at the time of application

**AND**

4. Patient has

a) Remnant breast cancer or cancer in the contralateral breast

**OR**

b) Implants complicated by recurrent infections

**OR**

c) Implants with Baker Class III or IV contracture

**OR**

d) Implants with severe contracture that interferes with mammography

**OR**

e) Intra- or extra-capsular rupture of silicone gel-filled implants

**OR**

f) Extra-capsular rupture of saline implant if the rupture compromises the cosmetic outcome of the implant.

Please note

Removal of ruptured saline-filled breast implants is not carried out for patients who have previously undergone cosmetic breast augmentation surgery.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Demand for breast enlargement is rising in the UK. Most breast implants are undertaken in the private health sector. Breast implants may be associated with significant morbidity and the need for secondary or revision surgery (such as implant replacement) at some point in the future is common. Capsular contracture is an unavoidable complication of breast implant surgery.

After having a breast implant, the body will create a capsule of fibrous scar tissue around the implant as part of the healing process. This is a natural reaction that occurs when any foreign object is surgically implanted into the body. Over time the scar tissue will begin to shrink. The shrinkage is known as capsular contraction. The rate and extent at which the shrinkage occurs varies from person to person. In some people, the capsule can tighten and squeeze the implant, making the breast feel hard and patients may also experience pain and discomfort. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients.

The Department of Health advises patients contemplating private surgery that breast implants are considered a long term commitment, and do not come with a lifetime guarantee. Moreover, not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation. It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time.

## Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply any relevant information to secondary care.

Primary care should assess the grade of capsular contraction where appropriate, according to the Baker Classification as given in the clinical threshold.

Primary care should be aware of information for patients who have received PIP silicone gel implants which is available via NHS Choices: <http://www.nhs.uk/Conditions/Breast-implants/Pages/PIP-introduction.aspx>. National guidance may apply to such patients.

Patients contemplating breast enlargement for cosmetic reasons can access information on breast implants via NHS Choices: <http://www.nhs.uk/Conditions/Breast-implants/Pages/PIP-introduction.aspx>

### \* Baker classification

- Class I Augmented breast feels soft as a normal breast.
- Class II Augmented breast is less soft and implant can be palpated, but is not visible.
- Class III Augmented breast is firm, palpable and the implant (or distortion) is visible.
- Class IV Augmented breast is hard, painful, cold, tender, and distorted.

## 1.3. Breast lift (Mastopexy)

### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

### Clinical threshold

SWL CCGs do not routinely fund this procedure.

## 1.4. Breast reduction surgery – Male (Gynaecomastia)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 6) are met.

1. Patient is 18 or over at the time of application

**AND**

2. Patient's BMI equal to or below 25, and has maintained this for at least 12 months  
*NB. Patient's height and weight with dates will need to be provided on the Tickbox form.*

**AND**

3. Patient's smoking status has been noted and if a smoker then been advised to give up smoking (including referral to appropriate smoking cessation services)

**AND**

4. Patient has Grade III gynaecomastia

**AND**

5. Pseudo-Gynaecomastia has been ruled out

**AND**

6. Patient has been assessed and treated for any one of the following:

- a) Endocrinological causes (e.g. related to the balance of male and female hormones in the body).

**OR**

- b) Therapeutic drug-related causes

**OR**

- c) Recreational drug-related causes (including alcohol, cannabis and body building drugs containing anabolic steroids)

**OR**

- d) Patient has Gynaecomastia as a result of drug therapy following prostate cancer.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Gynecomastia (NB including pseudo-gynaecomastia) is a common medical problem presenting in nearly a third of the male population. Treatment for gynecomastia can be either pharmacological or surgical, depending on the cause. Most cases of gynaecomastia are idiopathic.

Commonly gynaecomastia is seen during puberty and may correct once the post-pubertal fat distribution is complete if the patient has a normal BMI. It may be unilateral or bilateral. It can also occur secondary to medication. Rarely it may be caused by an underlying endocrine abnormality or a drug related cause including the abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

### Primary care advice

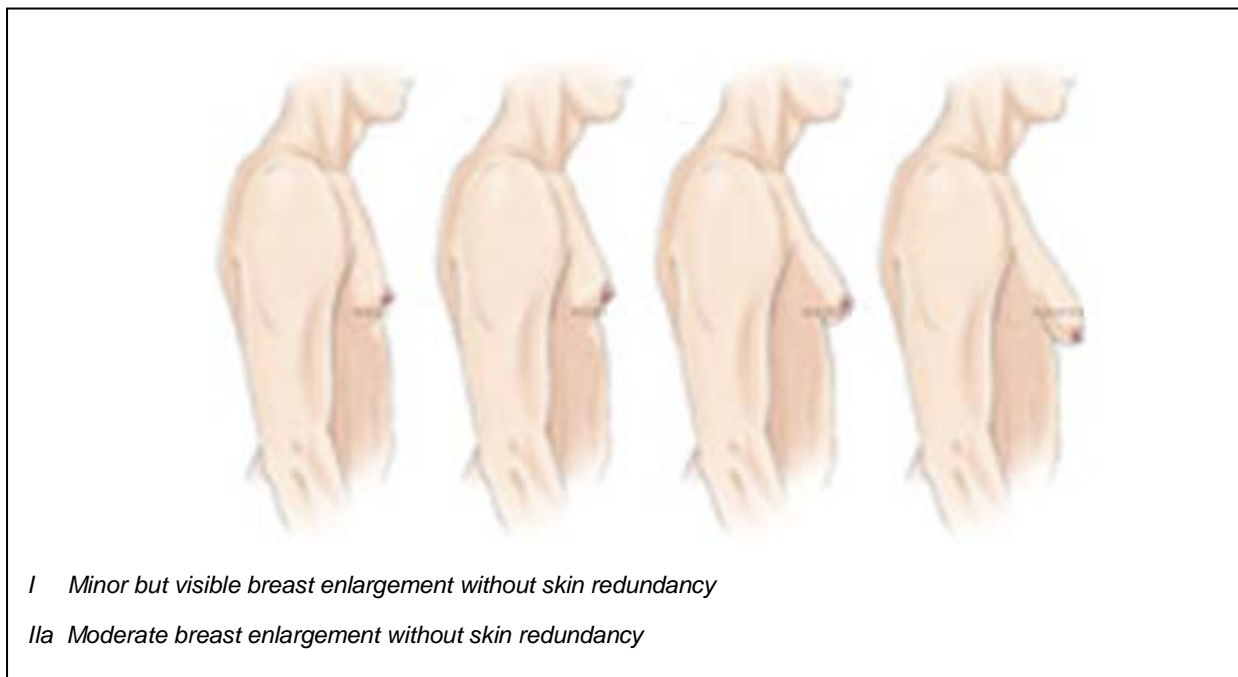
Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply the relevant information to secondary care; in particular this includes smoking cessation services, duration or changes in patient BMI and the grade of gynecomastia.

Primary care should ensure that the patient has 'true' gynecomastia (i.e. excess of breast tissue) as distinct from pseudo-gynecomastia (i.e. excess of chest fat).

Primary care needs to be aware that in some cases (following assessment) treatment may entail cessation of the drug-related cause, as a period of abstinence for one to three years will lead to the regression of Gynecomastia in the vast majority of cases.

### Grading of gynecomastia



### Therapeutic drug-related causes

Some drugs may give rise to Gynecomastia include: calcium channel blockers, cimetidine, phenothiazines, spironolactone, theophylline, diazepam, tricyclic anti-depressants, antibiotics and anti-retroviral therapy for HIV. Treatment in such cases should include consideration of substitution drug therapy.

## 1.5. Breast reduction surgery – Female (Reduction mammoplasty)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

## Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

## Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or Group 2.

Group 1: Criteria (1 – 5) must be met

1. Patient is 18 or over at the time of application and her breast development is considered to be complete

**AND**

2. Patient's BMI equal to or below 26, and has maintained this for at least 12 months  
*NB. Patient's height and weight with dates will need to be provided on the Tickbox form*

**AND**

3. Patient's smoking status has been noted and if a smoker then been advised to give up smoking (including referral to appropriate smoking cessation services)

**AND**

4. Patient has been made aware of side-effects of breast reduction surgery including scarring, loss of sensitivity of nipples, and inability to breast feed post-surgery

**AND**

5. Patient has gross asymmetry of at least 3 cup sizes\* difference between the breasts  
*NB. Patient's cup sizes will need to be provided on the Tickbox form.*

Group 2: Criteria 6-8 must be met

6. Patient has a bra cup size of G or more  
*NB. Patient's cup sizes will need to be provided on the Tickbox form.*

**AND**

7. Patient continues to have pain symptoms despite a 6-month trial of therapeutic measures including **ALL** of the following (unless clinically contra-indicated):

- Use of an appropriate supportive bra with wide bra straps, where the advice of an expert bra-fitter has been sought.
- Analgesic /non-steroidal anti-inflammatory drugs (NSAIDs) interventions.
- A course of physiotherapy has been completed without improvement of symptoms.

**AND**

8. Patient must meet the following clinical criteria:

- a) **At least TWO** of the following symptoms affecting their daily activities for at least 12 months :
  - i. Severe pain in the neck
  - ii. Severe pain in the shoulder or upper back
  - iii. Painful kyphosis documented by X-rays
  - iv. Pain/ ulceration from bra straps cutting into shoulders

**OR**

- b) Chronic intertrigo, in the infra-mammary skin fold which has failed to respond to at least 6 months of documented conservative treatment, (including good skin hygiene, adequate nutrition, and antibiotics or antifungal therapy).

Please note

*Due to risks and long term implications relating to breast implants, surgery to reduce the larger breast only will be approved (i.e. breast implants are not routinely funded).*

Bra cup sizes

AA, A, B, C, D, DD, E, F, FF, G, GG, H, HH, J, JJ, K, L

**Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

All surgery involving incision into healthy tissue, in this case, a healthy breast, whatever its size and shape, is generally considered to be aesthetic, with a few exceptions which have been listed in this policy.

Gross asymmetry may be considered as a deformity, and breast reduction surgery may be carried out for clinical reasons if the size of breasts has led to the patient suffering from intractable back pain, despite trying a range of conservative measures. Reduction mammoplasty is performed to relieve back and shoulder pain on the theory that reducing breast weight will relieve this pain. Because of their inherently subjective nature, pain symptoms are especially prone to placebo effects. In the case of reduction mammoplasty for relief of back, neck and shoulder pain, Aetna considered this procedure medically necessary in women with excessively large breasts because it seems logical, even in the absence of firm clinical trial evidence, that this excessive weight would contribute to back and shoulder pain, and that removal of this excessive breast tissue would provide substantial pain relief, reductions in disability, and improvements in function.

**Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning height with weight, therapeutic measures with dates and bra cup sizes.

Prior to referring the patient to secondary care, primary care should ensure that the patient meets the criterion for age, BMI and smoking cessation as specified in the clinical threshold. Primary care should also ensure that the severity of the patient's pain, together attempts to control this has been recorded in the patient's notes, as well as ensuring that all the criteria for conservative measures attempted over a period of 12 months are met (NB with the exception of referrals for gross asymmetry).

## 1.6. Surgical correction of nipple inversion

### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

### **Malignancy**

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.



## 2. Facial Procedures

### 2.1. Botox injection for cosmetic reasons

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 2.2. Face - Brow lift surgery (Rhytidectomy)

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 2.3. Facial - Skin procedures

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 2.4. Hair-replacement techniques

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

## 2.5. Surgical correction of prominent ears (Pinnaplasty)

### Compliance requirement

Prior Approval must be obtained by treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 4) are met.

1. Patient is aged between 5 and 18 years of age at the time of application

**AND**

2. Patient suffers from psychological distress due to prominent ears in whom corrective surgery should help to resolve these issues

*NB: Evidence of episodes of bullying and/or school refusal will need to be provided on the Tickbox form.*

**AND**

3. The prominence measures >30mm (using the measuring guide below)

*NB: Measurements of the prominence will need to be provided on the Tickbox form.*

**AND**

4. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

It is recommended that the SWL Patient Decision Aid is completed.

*NB: It is the child (and not the parent/carer) who desires surgical correction; referral should not be made for children who appear indifferent or opposed to the idea of surgery. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Please note

SWL CCGs do not routinely fund this procedure for:

- Adults with prominent ears
- Prophylactic reasons in either adults or children

Surgery below the age of 5 should only be offered if correction of prominence will help in retaining hearing aids securely, in children for whom they are required.

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Prominent ears are an inherited problem affecting 1-2% of the population (although its diagnosis is somewhat subjective and this figure depends on what is considered to be a prominent ear). It may be unilateral or bilateral and arises as a result of a lack (or malformation) of cartilage during primitive ear development in intrauterine life. The ear subsequently has

abnormal helical folds or grows laterally. Occasionally, folds seen at birth resolve spontaneously (source: [www.patient.co.uk](http://www.patient.co.uk)).

Prominence of the ears is often associated with bullying and consequent significant psychological distress. In individuals in whom distress is high, psychological therapy, whether or not subsequent surgery is offered, should be provided.

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly about psychological distress and measurements of prominence.

This procedure is for patients aged between 5 and 18 who suffer from psychological distress due to prominent ears. Evidence of this could be documented episodes of bullying and or school refusal.

Patients should desire surgical correction, not the parent or carer. Referral should not be made for children who appear indifferent or opposed to the idea of surgery.

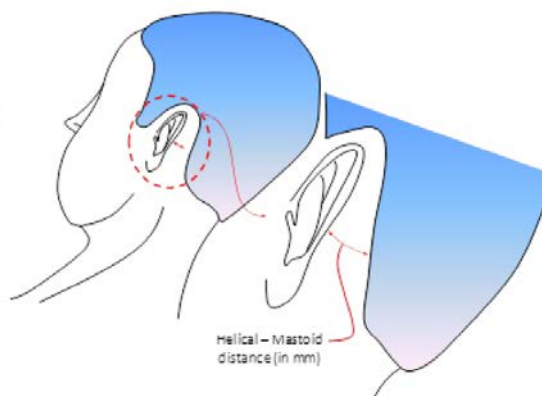
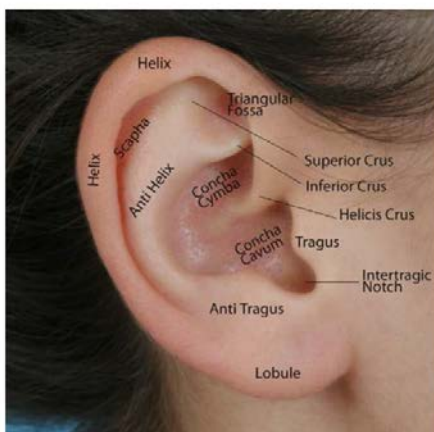
Cartilage moulding devices are advised in infants up to 6 months of age (this is not funded on the NHS).

This procedure is not routinely funded for cosmetic reason or for any reason for adults.

### Measuring Guide

- One of the most consistent methods for measuring the degree of prominence is the helical-mastoid (H-M) distance. Typically, the HM distance is 18-20 mm. As the H-M distance increases, the ear is perceived to be increasingly prominent.
- Measure from the posterior aspect of the Helix. Prominence = H-M distance > 20mm, but Surgical correction of prominent ears will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids.

See diagram below for guidance on how to measure.



### Psychological Distress

Parents requesting surgery for their child in order to prevent psychological distress when their child starts school or at some time in the future should be advised that referral should wait until their child specifically requests treatment.

Prominence of the ears is often associated with bullying and consequent significant psychological distress. In individuals in whom distress is high, psychological therapy, whether or not subsequent surgery is offered, should be provided.

## 2.6. **Surgical repair of external ear lobe (Lobules)**

### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 3. Miscellaneous Procedures

#### 3.1. Body contouring surgery

(Abdominoplasty, apronectomy, panniculectomy, 'tummy tuck' procedures, excision of excess skin, buttock lift, thigh lift, arm lift, brachioplasty)

##### Compliance requirement

Prior Approval must be obtained by treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

##### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

##### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or Group 2.

Group 1: Criteria 1-5 must be met

1. Patient is 18 or over at the time of application

**AND**

2. Patient has not already had the body contouring procedure(s) requested performed

**AND**

3. Patient's smoking status has been noted and if a smoker then been advised to give up smoking (including referral to appropriate smoking cessation services)

**AND**

4. Patient maintains low and stable BMI:

- a) Post bariatric surgery – patient has lost at least 50% of their excess weight\* and has maintained this for at least six months, and is at least 18 months post-surgery

**OR**

- b) Following significant weight loss (NB without bariatric surgery) – patient has BMI equal to or below 27 and has maintained this for at least 18 months

*NB. Patient's height and weight with dates will need to be provided on the Tickbox form.*

**AND**

5. Patient has

- a) Severe difficulties with activities of daily living\*\* (e.g. ambulatory restrictions) in relation to each of the affected body parts for which body contouring procedures are requested

**OR**

- b) Evidence of recurrent intertrigo beneath the skin folds that fails to respond despite appropriate medical therapy (oral or topical prescription medication) for at least 6 months

Group 2: criteria 6-8 must be met (Abdominoplasty for problems with Stoma Bags)

6. Patient has a poorly fitting stoma bag where the problems are caused by an apron of loose abdominal skin

**AND**

7. Problems with the stoma bag are due to the apron of loose abdominal skin impacting on their ability to maintain hygiene standards

**AND**

8. Written clinical opinion from the specialist that abdominoplasty is necessary to enable them to maintain their use of stoma bags

*NB. Name of the specialist and the date of request for the procedure to maintain the use of the stoma bag will need to be provided on the Tickbox form.*

\* Percentage of excess weight lost = 
$$\frac{\text{initial weight} - \text{current weight}}{\text{initial weight} - (25 \times \text{height}^2)} \times 100$$

(NB where weight is in kilos and height is in metres)

\*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work), and meeting nutritional needs (shopping, preparing and eating food). Difficulties of activities of daily living, including where appropriate ambulatory restrictions, must be described and documented

Please note

Body contouring comprises the removal of excess skin only. Liposuction does not form part of body contouring following significant weight loss.

Abdominoplasty or apronectomy (including panniculectomy) ('tummy tuck' procedures), together with other body contouring procedures (i.e. excision of excess skin, including buttock lift, thigh lift, arm lift (brachioplasty)) are considered cosmetic and will not be funded unless the above criteria are met.

It is important that patients who are considering bariatric surgery are given full information prior to undergoing surgery about the possible cosmetic consequences of significant weight loss following the bariatric procedure in terms of excess skin, and advised that they will not be eligible for abdominoplasty or any other body contouring procedure on the NHS unless these criteria are met in full for each procedure.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Removal of excess skin following bariatric surgery or massive weight loss is considered cosmetic and is not routinely funded in the absence of serious clinical symptoms, or serious loss of function affecting activities of daily living, and after conservative measures have been tried or failed (with the exception of patients having problems with poorly fitting stoma bags).

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply the relevant information to secondary care. In particular, primary care should ensure that the patient meets the clinical criteria for BMI or loss of excess weight, and the clinical criteria for maintaining a stable weight over the stipulated period of time (see clinical threshold). Primary care should also document the impact of the patient's excess skin on their activities of daily living.

Where recurrent intertrigo beneath the skin folds is a relevant clinical criterion (see 'clinical threshold' below), primary care should ensure that appropriate medical therapy (oral or topical prescription medication) has been tried for at least 6 months without success.

Primary care should ensure that patients are made aware of the possible cosmetic consequences of significant weight loss following a bariatric procedure in terms of excess skin, and should advise them that they will not be eligible for NHS-funded abdominoplasty or any other body contouring procedure unless they have serious clinical symptoms and meet the criteria in the clinical threshold.

## 3.2. Circumcision – Male

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when any of the following criteria (1 -7) are met.

1. Patient suffering from clinically significant **Recurrent Paraphimosis** (more than 3 annually)

**OR**

2. Patients with **Pathological Phimosis** where **ALL** the following criteria is met:

- a) Pathological white scarring of the foreskin secondary to lichen sclerosus (Balanitis Xerotica Obliterans [BXO]) in a child 4 years or older

**AND**

- b) The patient is suffering from pain or difficulty in passing urine

**AND**

- c) Conservative management has failed or is inappropriate

**OR**

3. Patient suffering from clinically significant **Balanitis or Balanoposthitis** (more than 3 annually), which has not responded to appropriate conservative management such as self-care, topical treatment or medication\*

**OR**

4. Patient with **Congenital abnormalities of the urinary tract** where circumcision is proposed as part of the management of this underlying condition

**OR**

5. Patients with **Physiological Phimosis** where **ALL** the following criteria is met:

- a) Suffering from recurrent urinary tract infection

**AND**

- b) The patient is 10 years or older at the time of application

**AND**

- c) Non-surgical methods have proved ineffective (min. of 4 weeks is recommended)

**OR**

6. Patient with **Severe Traumatic Injury** who has medical needs following a traumatic injury, such as zipper injury

**OR**

7. Patient with **Severe Pain on Arousal** where **ALL** the following conservative measures failed:

- a) Advice on preputial hygiene but advise parents/patients not to force an adherent foreskin back

**AND**

- b) Topical steroid plus an imidazole cream should be considered

**AND**

- c) If the appearance is typical of Balanitis Xerotica Obliterans (BXO) then a topical ointment based potent steroid e.g. hydrocortisone butyrate used nightly for four weeks followed by alternate night then maintenance is recommended

**AND**

- d) Antibiotics if bacterial infection confirmed

**AND**

- e) Advice on using a condom during sexual intercourse

\*Circumcision will not be funded where a patient has non-retractile ballooning of the foreskin and/or spraying of urine or non-significant balanitis (up to 3 episodes in one year).



## Please note

Female Circumcision, often known as Female Genital Mutilation (FGM), is prohibited by law (Serious Crime Act 2015) and will therefore not be funded by the CCG. Incidences where parents seek advice on FGM must be reported to the local Safeguarding Children Team.

SWL CCGs will not routinely fund this procedure for:

- Purely personal, social, cultural or religious reasons
- The prevention of sexually transmitted diseases.

## Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The foreskin is still in the process of developing at birth and is often non-retractable up to the age of three years. The process of separation is spontaneous and does not require any manipulation or intervention. By 3-11 years of age 90% of boys will have a partially or fully retractable foreskin. By the age of 14+, only 1% of boys will have an unretractable foreskin.

Pathological phimosis (scarring of the foreskin making it non-retractable) is unusual under 5 years of age.

Paraphimosis can usually be reduced under anaesthetic and the chance of recurrence reduced by avoiding forcibly retracting the foreskin. Paraphimosis is not a routine indication for circumcision.

The World Health Organisation does not recommend circumcision in developed nations\* and the BMA position\*\* is that the evidence for the health benefits of non-therapeutic circumcision is insufficient for the health benefits alone to be a justification for carrying out the procedure. WHO guidance\*\*\* is that routine infant male circumcision should only be undertaken "if the infant is healthy, full-term, weighs more than 2500g, has a normal physical examination, and has a penis and scrotum of completely normal appearance."....."Contraindications for early infant male circumcision include any known haematological disorders and jaundice."

\* WHO (2010) Manual for early infant male circumcision under local anaesthesia

\*\* BMA (2006) The law and ethics of male circumcision – guidance for doctors

\*\*\* Patient.co.uk (2013) Circumcision, <http://patient.info/health/circumcision-leaflet>

## Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service. Without this commissioner face significant costs in out-patient appointments for patients that may not qualify for surgery and inappropriately raises the patient's expectation of treatment. Providers are encouraged to reject referrals not meeting the clinical criteria.

Primary care must also make sure that they supply the relevant information to secondary care.

Primary care should also utilise conferral systems, such as Kinesis where primary care can liaise with providers, to seek specialist advice if needed.

## Please note

Female Circumcision, often known as Female Genital Mutilation (FGM), is prohibited by law (Serious Crime Act 2015) and will therefore not be funded by the CCG. Incidences where parents seek advice on FGM must be reported to the local Safeguarding Children Team.

SWL CCGs do not routinely fund this procedure for:

- Purely personal, social, cultural or religious reasons
- The prevention of sexually transmitted diseases.

### 3.3. **Cosmetic genital surgery**

(Labiaplasty, Clitoral reduction, Vaginoplasty, Hymenoplasty, Re-virginisation, G-spot amplification, Pubic liposuction or lift, Labia majora surgery, Vaginal tightening)

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

Please note

Female Circumcision, often known as Female Genital Mutilation (FGM), is prohibited by law (Serious Crime Act 2015) and will therefore not be funded by the CCG. Incidences where parents seek advice on FGM must be reported to the local Safeguarding Children Team.

### 3.4. **Fat removal (Liposuction)**

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 3.5. **Hair removal (Hair depilation by Laser and Electrolysis)**

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

### 3.6. Scar revision surgery (Keloidectomy)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

#### Malignancy and biopsies

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See: NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. Patient has scarring as a consequence of burns or trauma, or previous surgery (either directly funded by the NHS, or surgery taking place overseas which would have merited funding by the NHS)

*NB. The cause of the scarring with dates will need to be provided on the Tickbox form.*

**AND**

2. Patient has scarring causing

- a) Adverse physical consequences leading to significant functional impairment which impacts upon activities of daily living\* (e.g. pain due to contraction, tethering or recurrent breakdown, or obstruction of orifice or vision),

**OR**

- b) Recurrent bleeding over a period of at least 3 months

**AND**

3. Conservative therapies aimed at arresting the development of adverse, keloid or hypertrophic scarring have been tried (where clinically appropriate) over a period of at least 18 months, but have not been effective (e.g. steroid injections, pressure garments, medication or massage)

\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

Please note

SWL CCGs do not routinely fund this procedure (including skin resurfacing and dermabrasion) in secondary care for any of the categories listed below:

- Hypertrophic or keloid scars that are not causing adverse consequences or functional impairments (e.g. keloid scarring after ear piercing and other body piercings)
- Scarring / ulceration from chronic tattoo breakdowns
- Post-acne scarring
- Scars resulting from self-harm
- Scar treatment for skin rejuvenation or other cosmetic purposes.

## **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Scar revision is usually carried out for aesthetic reasons and is therefore considered a procedure of low clinical value. This type of surgery is only commissioned where function, e.g. movement of a joint, is restricted by the scar.

## **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning symptoms and their duration and the conservative treatments tried including dates where relevant.

## **Malignancy and biopsy**

**If there is any suspicion of malignancy\*, patients should be referred immediately to an appropriate service as described in the NICE improving outcomes guidance\*\*.**

**Biopsies are not covered by this policy and may be undertaken as required at the discretion of the managing clinician.**

\*See NICE Clinical Guideline 27: *Referral Guidelines for Suspected Cancer* (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

\*\* NICE. *Improving outcomes for people with skin tumours including melanoma (update): the management of low-risk basal cell carcinomas in the community (partial update)*. NICE; May 2010. Available at: <http://guidance.nice.org.uk/CSGSTIM>

### 3.7. Surgical removal of minor skin lesions

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

#### Malignancy and biopsies

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. Biopsies are not covered by this policy and may be undertaken as required at the discretion of the managing clinician.

NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

NICE. Improving outcomes for people with skin tumours including melanoma (update): the management of low-risk basal cell carcinomas in the community (partial update). NICE; May 2010. Available at: <http://guidance.nice.org.uk/CSGSTIM>

#### Clinical threshold

SWL CCGs fund this procedure when any of the following criteria (1-3) are met.

**NB: Scars (keloids) are covered in the Scar Revision Surgery clinical threshold**

1. Patient has a large proven lipomata (>5cms)

*NB. The size and location of the lipomata will need to be provided on the Tickbox form.*

**OR**

2. Patient has a skin lesion that causes serious functional limitation on movement resulting in impairment of activities of daily living\*

*NB. Impairment of activities of daily living and its severity will need to be provided on the Tickbox form.*

**OR**

3. Patient has a skin lesion that is causing recurrent symptoms such as bleeding, infection or discharge over at least three months, and has not responded to appropriate conservative treatment over this period

*NB. Recurrent symptoms and their severity will need to be provided on the Tickbox form.*

\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

Please note

Asymptomatic conditions which could be submitted for consideration via IFR may include severe disfiguring non-malignant lesions of the face, or severe port wine stains (haemangiomas) that extend onto the face and/or neck.

#### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

There is limited evidence that surgery on these lesions for aesthetic reasons offers benefit to patients.

Where there is no suspicion of malignancy or complications, benign skin lesions may be self-limiting, respond to conservative measures and have no long-term health consequences for patients.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning symptoms and their severity including dates where relevant.

### **Malignancy and biopsy**

**If there is any suspicion of malignancy\*, patients should be referred immediately to an appropriate service as described in the NICE improving outcomes guidance\*\*.**

**Biopsies are not covered by this policy and may be undertaken as required at the discretion of the managing clinician.**

\*See NICE Clinical Guideline 27: *Referral Guidelines for Suspected Cancer* (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

\*\* NICE. *Improving outcomes for people with skin tumours including melanoma (update): the management of low-risk basal cell carcinomas in the community (partial update)*. NICE; May 2010. Available at: <http://guidance.nice.org.uk/CSGSTIM>

Soft tissue subcutaneous lesions, particularly over 5cms, that are not clearly longstanding and asymptomatic may of course be a soft tissue sarcoma. NICE guidance suggests that a rapid access ultrasound scan is usually the most appropriate diagnostic test to check the nature of any suspicious lesions which then, if abnormal, should be referred on to the appropriate [Specialist London Sarcoma Service](#) as a Two Week Wait.

### **Minor Surgery Direct Enhanced Service**

Where removal is supported, this should generally be undertaken in Primary Care through the Minor Surgery Direct Enhanced Service. Treatment in secondary care will only be approved where the removal is beyond GP surgical care. Applications for referral to secondary care for surgery must therefore be clear about why the patient is not suitable for surgery within Primary Care through the Minor Surgery Direct Enhanced Service.

### **Types of minor skin lesions**

For the purposes of this policy the following list was compiled to provide guidance on what falls with the remit of minor skin lesions. This is not expected to be fully exhaustive:

- Seborrheic keratoses (also known as basal cell papillomas, senile warts or brown warts);
- Sebaceous cysts ( pilar and epidermoid cysts)
- Benign pigmented nevi (moles)
- Dermatofibromas (skin tags, including anal tags)
- Pilomatrixomata (slow-growing, hard mass underneath the skin that arises from hair follicle matrix cells)
- Other benign skin lesions including:

- Comedones
- Corn/callus
- Milia
- Molluscum contagiosum
- Spider naevi (telangiectasia)
- Xanthelasma (cholesterol deposits underneath the skin)
- Haemangioma
- Neurofibromata

Scars (keloids) are covered in the Scar Revision Surgery clinical threshold.

#### Clinical threshold for surgical removal

Only the following indications will be routinely funded:

- Patient has a large proven lipomata (>5cms)
- Patient has a skin lesion that causes serious functional limitation on movement resulting in documented impairment of activities of daily living\*
- Patient has a skin lesion that is causing recurrent symptoms such as bleeding, infection or discharge over at least 3 months, and has not responded to appropriate conservative treatment over this period

\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

#### Please note

Asymptomatic conditions which could be submitted for consideration via IFR may include severe disfiguring non-malignant lesions of the face, or severe port wine stains (haemangiomas) that extend onto the face and/or neck. In such circumstances requests should be supported by photographic evidence, or confirmation of the extent to which the face is covered, taking into account the patient's normal hairstyle.

### 3.8. Tattoo removal

#### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### Clinical threshold

SWL CCGs do not routinely fund this procedure.

### 3.9. Treatment of hyperpigmentation

#### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.



**Clinical threshold**

SWL CCGs do not routinely fund this procedure.

## 4. Diagnostics

### 4.1. Open Magnetic Resonance Imaging (Open MRI)

#### Compliance requirement

Prior Approval must be obtained by either primary or radiology teams. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box form.

Primary care can request an Open MRI via the prior approval route for two reasons:

- a) Patient who either cannot comfortably fit in closed MRI machines due to obesity
- OR**
- b) Patient cannot lie properly in a closed MRI machine due to severe pain or other significant medical conditions.

Consultant radiologist or radiology departments can request Open MRIs for the above two reasons and also for patients suffering from claustrophobia.

#### Clinical threshold

SWL CCGs fund this procedure (0.5 Tesla or more) when all of the following criteria (1 -2) are met.

1. There is a clear diagnostic need consistent with supported agreed local clinical pathways

**AND**

2. Patient

- a) Cannot fit comfortably in a closed MRI machine due to obesity (measurements required with the application)

**OR**

- b) Cannot lie properly in a closed MRI machine due to severe pain or other significant medical conditions (details of evidence must be provided with the application)

**OR**

- c) Suffers from claustrophobia, where an oral prescription sedative\* has not been effective in enabling the patient to undergo closed MRI.

*NB: Must be requested by a consultant radiologist or radiology department.*

*\* When requesting an MRI the requesting clinician (primary or secondary care) should identify patients susceptible to claustrophobia or who may not be able to tolerate a closed MRI. Once identified, these patients should be offered oral sedatives. Other coping mechanisms could also be suggested such as listening to music or going to the procedure with a friend.*

#### Please note

SWL CCG do not routinely fund this procedure:

- In standing, weight-bearing, positional, or upright MRI scanners
- For whole spine or body imaging (i.e. imaging for the specific anatomy requested will only be funded)

Low field MRI for interventional and intraoperative procedures fall outside the scope of this policy and do not require prior approval.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Open MRI should not be considered as an equally effective alternative for patients who express apprehension prior to closed MRI due to suspected claustrophobia. Such patients should be encouraged to attempt a closed MRI with the aid of an oral sedative. Only patient physically unable to undergo conventional MRI should be considered for open MRI. This is because the quality of MRI images is partly dependent on the field strength of the magnet which is measured in Tesla (above 1 Tesla (T) is considered high). Closed MRIs have magnet field strengths of >1.5 tesla whereas open MRIs have medium strengths magnets of 0.5T - 1.0T. The lower field strength of open MRIs results in poorer quality images in comparison to closed MRIs, with lower signal-to-noise ratios and more motion artefacts. The length of time required to obtain an image is also longer, which may lead to a less distinct image due to movement of the patient.

### **Primary care advice**

Primary care can request an Open MRI via the prior approval route for two reasons when there is a clear diagnostic need consistent with supported agreed local clinical pathways:

- a) Patient who either cannot comfortably fit in closed MRI machines due to obesity
- OR**
- b) Patient cannot lie properly in a closed MRI machine due to severe pain or other significant medical conditions.

### **Claustrophobia**

Patients who suffers from claustrophobia, where an oral prescription sedative\* has not been effective in enabling the patient to undergo closed MRI, an Open MRI must be requested by a consultant radiologist or radiology department.

When requesting an MRI the requesting clinician (primary or secondary care) should identify patients susceptible to claustrophobia or who may not be able to tolerate a closed MRI. Once identified, these patients should be offered oral sedatives or other coping mechanisms such as listening to music or going to the procedure with a friend.

### **Closed vs. Open MRI**

Patients should be encouraged to have closed MRIs in all cases due to their effectiveness over Open MRIs. The lower field strength of open MRIs results in poorer quality images in comparison to closed MRIs, with lower signal-to-noise ratios and more motion artefacts. The length of time required to obtain an image is also longer, which may lead to a less distinct image due to movement of the patient.

## MRI capacity

Location	Max weight	Bore size	Notes
<b>Croydon Hospital 1</b>	<b>300kg</b>	<b>180 cm</b>	<b>Open MRI</b>
Croydon Hospital 2	200kg	180cm	For patients on trolley
Epsom Hospital	227kg	70cm	Any patients
St Helier Hospital	152kg	50cm	Any patients
Queen Mary's Hospital – In Health	140kg	60 cm	Mobile unit
Kingston Hospital – In Health	140kg	60 cm	Mobile unit
St George's Hospital – In Health	140kg	60 cm	Mobile unit
St George's Hospital AMH	200 kg	70 cm	Neurology only Secondary care only
Waterloo 1 – In Health	160kg	65 cm	Any patients
Waterloo 1 – In Health	200kg	72 cm	Mainly for private patients

The girth of the patient and reason for the scan may impact on the need for open MRI and should take precedence over consideration of the patient's weight. For example, any scans to investigate back issues will require complete insertion of the patient into the conventional MRI machine, and a patient's girth may preclude this.

## 4.2. Wireless Capsule Endoscopy and Double Balloon Enteroscopy

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

### Clinical threshold obscure gastrointestinal bleeding

SWL CCGs fund this procedure when at least one of the following criteria (1 -3) is met

1. Patient had a gastroscopy and/or endoscopy and results are negative then patients are eligible for a **wireless capsule endoscopy**

**OR**

2. Patient had a wireless capsule endoscopy that identified the source of bleeding in small bowel then the patients are eligible for **double balloon enteroscopy for treatment**

*NB. The date of the wireless capsule endoscopy will need to be provided on the Tickbox form.*

**OR**

3. Patient had a wireless capsule endoscopy with normal results but there is persistent bleeding then the patient is eligible for a **repeat wireless capsule endoscopy or double balloon enteroscopy for treatment**

*NB. The date of the wireless capsule endoscopy will need to be provided on the Tickbox form.*

### **Rationale for obscure gastrointestinal bleeding clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The evidence available shows that Wireless Capsule Endoscopy (WCE) and Double Balloon Enteroscopy (DBE) are safe and effective diagnostic procedures for the detection of obscure gastrointestinal bleeding OGIB. Both have 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 CE, requiring additional staff, typically two physicians or an additional specialist nurse.

Cost-effectiveness modelling suggests that that WCE-guided DBE may be associated with better long-term outcomes because of the potential for fewer complications and decreased utilisation of endoscopic resources.

### **Clinical threshold for Chron's disease**

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or Group 2.

Group 1: Wireless capsule endoscopy - criteria 1 and 2 must be met

1. Patient had an inconclusive ileocolonoscopy and/or small bowel radiology clinical suspicion of Crohn's disease remains

*NB. The date of the inconclusive ileocolonoscopy and/or small bowel radiology will need to be provided on the Tickbox form.*

**AND**

2. Pain is not a significant feature **or** where pain is a significant feature and there is no evidence of strictures on small bowel radiography

Group 2: Double balloon enteroscopy - criteria 3 and 4 must be met

3. Patient had an inconclusive ileocolonoscopy and/or small bowel radiology clinical suspicion of Crohn's disease remains

*NB. The date of the inconclusive ileocolonoscopy and/or small bowel radiology will need to be provided on the Tickbox form.*

**AND**

4.

a) Pain is a significant feature **and** there is evidence of strictures on small bowel radiography

**OR**

b) There is evidence of strictures on small bowel radiography

**OR**

c) Wireless capsule endoscopy results are inconclusive

### **Rationale for Crohn's disease clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The evidence available shows that Wireless Capsule Endoscopy (WCE) is a safe and effective diagnostic procedure for the detection of Crohn's disease. WCE has 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 diagnosed.

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.

## 5. ENT

### 5.1. Surgery for glue ear - Adults (Grommets)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician care. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or 2.

Group 1: Criteria 1 – 5 must be met

1. Patient has persistent bilateral Otitis Media with Effusion (OME) over a period of 6 months

*NB. The dates of the first and the second confirmatory audiological tests will need to be provided on the Tickbox form (minimum 6 months in between the two).*

**AND**

2. Patient's hearing level in the better ear of at least 25 dBHL (decibels hearing level) or worse, based on averages at 0.5, 1, 2 and 4 kHz

*NB. The results of the last audiological test will need to be provided on the Tickbox form.*

**AND**

3. Patient suffers from conductive hearing loss due to OME confirmed by audiology assessment

**AND**

4. Investigation and treatment of underlying causes has been completed without improvement in hearing

**AND**

5. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided*

## Group 2: Criteria 6 and 7 must be met

6. Patient has a severe retraction of the tympanic membrane that is considered to be reversible to avoid erosion of the ossicular chain or the development of cholesteatoma

### AND

7. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

National guidance advises that management of adults with Otitis Media with Effusion (OME) should focus on determining the underlying cause.

The outcome of OME is less clear in adults, than children. Insertion of grommets in adults is a much less common procedure than in children, primarily because adults benefit from certain changes in the anatomy of the middle ear that occur after childhood.

Grommet insertion in adults with OME is a procedure with limited or no evidence of effectiveness and/or only effective within a limited threshold range.

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care in particular dates and results of audiological tests.

The lack of published research trials means that there is a high level of uncertainty about the benefits, harms and costs of myringotomy with or without grommet insertion as a means of relieving symptoms of OME in adults.

Primary care should be aware that:

- Management of adults with OME should focus on determining the underlying cause.
- Grommet insertion is rarely indicated for adults with OME, and that the main role is to ensure that adequate investigations are done if OME fails to resolve spontaneously.
- At least 6 months (24 weeks) should have elapsed between the first and the second confirmatory audiological tests before referring for consideration of surgery.

Primary care should refer adults to ENT for assessment of persistent OME in order to exclude underlying malignancy.



## 5.2. Surgery for glue ear - Children (Grommets)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

Group 1: Children under 12 criteria 1 – 4 must be met

1. Patient has persistent bilateral Otitis Media with Effusion (OME) over a period of 3 months

*NB. The dates of the first and the second confirmatory audiological tests will need to be provided on the Tickbox form (minimum 3 months in between the two).*

**AND**

2. Patient's hearing level in the better ear of at least 25 dBHL (decibels hearing level) or worse based on average at 0.5, 1, 2 and 4 kHz

*NB. The results of the last audiological test will need to be provided on the Tickbox form.*

**AND**

3. Patient suffers from conductive hearing loss due to OME confirmed by audiology assessment at 3 months

**AND**

4. Patient or their carer has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Group 2 - Children 12 to under 18: criteria 5 - 8 must be met

5. Patient has persistent bilateral Otitis Media with Effusion (OME) over a period of 6 months

*NB. The dates of the first and the second confirmatory audiological tests will need to be provided on the Tickbox form (minimum 6 months in between the two).*

**AND**

6. Patient's hearing level in the better ear of at least 25 dBHL (decibels hearing level) or worse based on average at 0.5, 1, 2 and 4 kHz

*NB. The results of the last audiological test will need to be provided on the Tickbox form.*

**AND**

7. Patient suffers from conductive hearing loss due to OME confirmed by audiology assessment at 6 months

**AND**

8. Patient or their carer has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided*

Group 3: Children under 18 with complex conditions: criteria 9 and 10 must be met

9. Patient is/has

c) Preparing for insertion of cochlear implants

**OR**

d) Severe learning difficulties and is suspected to have impaired hearing

**AND**

10. Patient or their carer has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

**Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The clinical threshold is based on NICE guidance surgical management of Otitis Media with Effusion (OME) in children (NICE CG60).

OME is a common condition of early childhood in which an accumulation of fluid within the middle ear space causes hearing impairment. The clinical criteria require the monitoring of persistent OME associated with significant hearing loss over a period of time (which is shorter for the younger age range), in view of the following:

- The hearing loss is usually transient and self-limiting over several weeks, but may be more persistent and lead to educational, language and behavioural problems.

- It is most common in young children, with a bimodal peak at 2 and 5 years of age; 80% of children will have had at least one episode of OME by the age of 10 years.
- In most instances of uncomplicated OME, no intervention is required because the fluid clears spontaneously.
- In cases of significant hearing loss sustained over a period of several months, surgical insertion of grommets may be beneficial in terms of the child's development in the domestic and educational environment.
- However, these benefits should be balanced against the risks of serious complications of anaesthesia and surgery.

Children with certain specified complex conditions may also be funded for insertion of grommets.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care in particular dates and results of audiological tests.

### **Advice for parents during the period of assessment**

Primary care should be aware of the types of advice to give to parents and patients during the active observation period. This should include advice on the following strategies to minimise the effects of the hearing loss in the home and school environments:

- When speaking to the child, face them, slow the rate of speech, raise the level, and speak clearly.
- Turn off competing auditory stimuli, such as music or television.
- Daily reading helps language development. Books with explanatory pictures are useful.
- Discuss seating arrangements with the school, ideally placing the child near the teacher.

Parents of children should be advised that parental smoking increases the risk of OME. Parents with concern of speech, language and developmental delay of their child should be advised that the evidence shows that the child quickly recovers following resolution of the OME.

### **Referral of children for an ENT opinion from primary care is advised**

#### **Urgent**

- The child has hearing loss suggestive of sensori-neural deafness
- The otoscopic features are atypical and accompanied by a foul smelling discharge lasting for more than 6 weeks, suggestive of cholesteatoma

#### **Soon**

- There is a reasonable suspicion of hearing loss plus a delay in speech or language development, poor educational progress, social or behavioural problems or another disability such as Down's syndrome or cleft palate

#### Routine

- The child has persistent hearing loss detected on two occasions separated by 3 months or more; NICE guidelines suggest a threshold of 25 dBHL or worse in the better ear;
- The child has suffered more than 6 episodes of acute otitis media effusion in 12 months;

**Primary care should refer to audiology services (school, community or secondary care) prior to making routine referrals to ENT services and include the audiology report with the referral.**

### 5.3. Nasal surgery (Rhinoplasty, Septoplasty, Septo-rhinoplasty and Nasal Polyps)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in one of Group 1 to 5.

Group 1: Intra-nasal septoplasty: at least one of criteria are met

1. Patient is/has
a) Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (e.g. ethmoidectomy)
<b>OR</b>
b) Patient has recurrent rhino-sinusitis due to a deviated septum not relieved by appropriate medical and antibiotic therapy after at least 6 months of medical therapy
<b>OR</b>
c) Patient suffers from recurrent epistaxis (nosebleeds) related to a septal deformity
<b>OR</b>
d) Patient suffers from continuous nasal airway obstruction resulting in nasal breathing difficulty due to obvious and severe septal deviation with no other cause for the patient's apparent breathlessness (e.g. rhinitis, COPD)
<b>OR</b>
e) Patient require this procedure with the association of cleft palate repair

Group 2: Extracorporeal (Open) Septoplasty: criteria 2 and 3 must be met

2. Patient is/has
a) Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (e.g. ethmoidectomy)
<b>OR</b>
b) Patient has recurrent rhino-sinusitis due to a deviated septum not relieved by appropriate medical and antibiotic therapy after at least 6 months of medical therapy
<b>OR</b>

- c) Patient suffers from recurrent epistaxis (nosebleeds) related to a septal deformity
- OR**
- d) Patient suffers from continuous nasal airway obstruction resulting in nasal breathing difficulty due to obvious and severe septal deviation with no other cause for the patient's apparent breathlessness (e.g. rhinitis, COPD)
- OR**
- e) Patient require this procedure with the association of cleft palate repair

**AND**

3. Patient has an extremely deviated nasal septum that cannot be corrected adequately with an intranasal septoplasty.

**Group 3: Rhinoplasty: criteria 4 must be met**

4. Patient is/has
- a) Nasal deformity is secondary to congenital cleft lip and/or palate  
*NB: this should be managed by a specialist cleft team*
- OR**
- b) Chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves), which may be due to trauma, disease, or congenital defect, when  
**ALL** of the following criteria are met:
    - i. Prolonged, persistent obstructed nasal breathing
    - ii. Physical examination confirming moderate to severe vestibular obstruction
    - iii. Airway obstruction will not respond to septoplasty alone
    - iv. Nasal obstruction is causing significant symptoms (e.g. chronic rhinosinusitis, difficulty breathing)
    - v. Conservative management for 6 months or more failed to relieve symptoms
    - vi. Patient suffers from severe or extreme obstruction of one or both nares.  
*NB: Recommend use of Nasal Obstruction Symptom Evaluation (NOSE) Scale instrument (score 55 or more) see Appendix*
- OR**
- c) Significant distortion of external anatomy subsequent to recent trauma  
*NB: A humped or bent nose is not by itself sufficient evidence of injury*

**Group 4: Septorhinoplasty: criteria 5 and 6 must be met**

5. Patient requires the procedure as an integral part of a medically necessary septoplasty

**AND**

6. Patient has gross nasal obstruction on the same side as the septal deviation, so that to correct the nasal obstruction the external skeleton will also need correction.

#### Group 5 Surgery for Nasal Polyps criteria 7 or 8 must be met

7. Patient has a nasal polyp that

- a) Fails to improve after a trial of maximal medical treatment for a period of at least 6 months

**AND**

- b) Causing severe or extreme functional impairment of breathing

*NB: Recommend use of Nasal Obstruction Symptom Evaluation (NOSE) Scale instrument (score 55 or more) see Appendix.*

**OR**

8. Patient has a large nasal polyp causing complete obstruction of the nasal cavity

Please note

SWL CCGs do not routinely fund the following procedures:

- Inferior Turbinate reduction surgery such as Turbinoplasty, Radiofrequency Ablation and Turbinectomy
- Surgery to repair septal perforation
- Extracorporeal septoplasty for revision of deviated septum is considered experimental and investigational because its effectiveness for this indication has not been established

#### **Rationale for the clinical thresholds**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need.

Rhinoplasty is considered an aesthetic procedure and no evidence was found for its use in treating any underlying medical conditions.

Septoplasty is an effective intervention in patients who have known septal deviation causing nasal obstruction. Outcomes are best where non-invasive interventions have failed and the nasal obstruction is having an impact on the individual's quality of life.

Where the obstruction is the result of trauma, septo-rhinoplasty may be indicated to get the best outcome for the patient.

There is evidence from randomised controlled trials that conventional medical management with saline irrigation, antibiotics, corticosteroids and short-term decongestants is effective for the treatment of chronic rhinosinusitis, and that corticosteroids are effective for the treatment of nasal polyps. Surgical management of chronic rhinosinusitis has not been shown to be more effective compared with medical management in randomised controlled trials of patients with or without nasal polyps.

## **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments attempted.

## **Documentation**

For consideration for rhinoplasty or septorhinoplasty is maintained and includes all of the following:

- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.
- Documentation of results of conservative management of symptoms.
- If there is an external nasal deformity, pre-operative photographs may be helpful if the patient agrees, but are not an essential requirement.
- It is essential that any relevant history of accidental or surgical trauma, congenital defect, or disease (e.g. Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity) be provided.
- There is severe or extreme obstruction of one or both nares. The use of Nasal Obstruction Symptom Evaluation (NOSE) Scale instrument (score 55 or more) is recommended (see Appendix).

## **Conservative management**

Primary care should be aware that conventional medical management with saline irrigation, antibiotics, corticosteroids and short-term decongestants is effective for the treatment of chronic rhinosinusitis.



## Appendix: Nasal Obstruction Symptom Evaluation (NOSE) Scale instrument



### Nasal Obstruction and Septoplasty Effectiveness Scale



Physician AAO-HNS#: \_\_\_\_\_ Patient ID: \_\_\_\_\_ Today's date: \_\_/\_\_/\_\_\_\_

→ **To the Patient:** Please help us to better understand the impact of nasal obstruction on your quality of life by **completing following survey**. Thank You!

Over the past **ONE month**, how much of a **problem** were the following conditions for you?

Please **circle** the most correct response

	<i>Not a Problem</i>	<i>Very Mild Problem</i>	<i>Moderate problem</i>	<i>Fairly Bad Problem</i>	<i>Severe problem</i>
1. Nasal congestion or stuffiness	0	1	2	3	4
2. Nasal blockage or obstruction	0	1	2	3	4
3. Trouble breathing through my nose	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

### NOSE SCALE ADMINISTRATION

1. Have patient complete the questionnaire as indicated by circling the response closest to describing their current symptoms.
2. Sum the answers the patient circles and multiply by 20 to base the scale out of a possible score of
3. 100 for analysis.

Category	Score range
Mild	5 - 25
Moderate	30 - 50
Severe	55 - 75
Extreme	80 - 100

[jamanetwork.com/journals/jamafacialplasticsurgery/fullarticle/1709837](http://jamanetwork.com/journals/jamafacialplasticsurgery/fullarticle/1709837)

## 5.4. Obstructive Sleep Apnoea in Adults

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 -5) are met.

#### **NB: OSA for children is covered in the Tonsillectomy clinical threshold**

1. Patient has moderate to severe symptoms (Epworth score 15 or above) or sleepy in dangerous situations such as driving

*NB. The date of the negative gastroscopy and/or endoscopy will need to be provided on the Tickbox form*

**AND**

2. Patient has significant sleep disordered breathing

**AND**

3. Patient has already tried the entire range of conservative therapies available

**AND**

4. Patient has already tried Continuous Positive Airways Pressure (CPAP) unsuccessfully for 6 months prior to being considered for surgery or had major side effects to CPAP such as significant nosebleeds

**AND**

5. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Please note

SWL CCGs do not routinely fund this procedure to reduce the impact of normal snoring.

Surgical treatments specifically for OSA such as uvulopalatopharyngoplasty (UPPP), laser-assisted uvuloplasty (LAUP), soft palate implants, and radiofrequency ablation are not routinely funded. These should be considered as a last resort as a one-off exceptional treatments where all other treatments have failed.

The choice of procedure should be decided based on a multi-disciplinary team planning approach between all specialists treating the patient.

## Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Surgery to treat OSA is not routinely recommended because evidence shows that it is not as effective as CPAP at controlling the symptoms of the condition. It also carries the risk of more serious complications. Surgery is usually only considered as a last resort when all other treatment options have failed, and only if the condition is severely affecting quality of life.

## Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care should ensure that patients attempt the following range of lifestyle changes and conservative therapies **before referring them for consideration for surgery for OSA**. In addition, patients complaining of the impact of snoring (i.e. not OSA) should be counselled without referral to secondary care, and advice should be given on implementing the following lifestyle changes and conservative therapies where appropriate:

- Lose weight if above recommended BMI
- Advised to stop smoking if a smoker
- Reduce or stop evening alcohol intake
- Keeping the nose clear (including therapies such as nasal sprays or strips)
- Partners using ear plugs whilst asleep to minimise sleep disruption
- Self-training to alter their sleep position to avoid lying on back (e.g. sewing lump into back of pyjamas/nightdress as temporary training method).
- Obtaining a mandibular advancement device to be worn at night. (NB patients may obtain this device from their orthodontist, and should be advised that this device is not funded by the NHS.)

In addition, patients suffering from OSA should attempt Continuous Positive Airways Pressure (CPAP).

Please note

OSA for children is covered in the tonsillectomy clinical threshold.

## 5.5. Tonsillectomy

### Compliance requirement

Prior Approval must be obtained by secondary care. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 -5) are met.

**NB: OSA for adults is covered in the OSA in Adults clinical threshold**

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1, 2 or 3

Group 1: Quinsy: criteria 1 must be met

1. Patient had two or more episodes of Peri-tonsillar abscess (Quinsy) requiring hospital admission

*NB. The dates of admissions will need to be required be provided on the Tickbox form*

Group 2: Tonsillar enlargement causing upper airways obstruction: criteria 2 and 3 must be met

2. Patient suffers from recurrent sore throat due to acute tonsillitis

a) 7 or more episodes of tonsillitis in the last year

**OR**

b) 5 episodes per year in the preceding two years

**OR**

c) 3 episodes per year in the preceding three years

*NB. The dates of treatments will need to be required be provided on the Tickbox form*

**AND**

3. Patient experiences significant impact on quality of life due to acute tonsillitis

Group 3: Obstructive Sleep Apnoea children: criteria 4 and 3 must be met

4. Patient experiences significant impact on quality of life

**AND**

5. Patient's

a) Medical notes show strong clinical history suggestive of sleep apnoea

**OR**

- b) A habitual snorer with labored breathing and falls into complex high-risk category for sleep apnoea:
- i. Down's syndrome
  - ii. Cerebral palsy
  - iii. Craniofacial disorders
  - iv. Chronic lung disease
  - v. Sickle cell disease
  - vi. Neuromuscular disorders
  - vii. Genetic/metabolic/storage disease
  - viii. Central hyperventilation syndromes

**AND**

7. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Please note

SWL CCGs do not routinely fund this procedure for:

- Tonsillar Crypts
- Tonsilloliths
- Tonsillar Stones

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The natural history of tonsillitis is for the episodes to get less frequent with time.

The frequency of sore throat episodes and upper respiratory infections reduces with time whether or not tonsillectomy has been performed. Tonsillectomy offers relatively small clinical benefits compared with non-surgical treatment.

Watchful waiting is more appropriate than tonsillectomy in children with mild sore throats.

Tonsillectomy probably gives an additional, but small, reduction of sore throat episodes, days of sore throat associated school absence, and upper respiratory infections compared to watchful waiting.

The benefit in the year after the operation is roughly 2.8 less days off school.

This benefit needs to be weighted against the risk of mortality (estimated to be between 1/8,000 - 1/35,000) and other surgical complications.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply the relevant information to secondary care or referrals may be rejected if for example the dates of tonsillitis are not provided.

Primary care should inform patients about the risks and benefits of the possible procedure by leaflets and shared decision aids.

As there are multiple indications for tonsillectomy, careful assessment of the patients is essential. For assessment for referral, Primary care should follow the SIGN guidance for sore throat and management of tonsillectomy: <http://www.sign.ac.uk/sign-117-management-of-sore-throat-and-indications-for-tonsillectomy.html>

### Sleep apnoea

Primary care should not refer children with simple snoring without symptoms or signs of apnoea as they are unlikely to benefit from adeno-tonsillectomy. Consider allergy testing and appropriate treatment first.

In older children >6 years with mild/moderate symptoms of obstructive sleep disordered breathing consider a trial of nasal saline irrigation and/or intranasal steroids for 6-8 weeks.

However, patients who are high risk for sleep apnoea may benefit from referral to specialist services if they suffer from laboured breathing. These risk factors are:

- Down's syndrome
- Cerebral palsy
- Craniofacial disorders
- Chronic lung disease
- Sickle cell disease
- Neuromuscular disorders
- Genetic/metabolic/storage disease
- Central hyperventilation syndromes.

## 6. Eyes

### 6.1. Cataracts surgery

#### Compliance requirement

Prior Approval must be obtained by secondary care. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or 2.

Group 1: Criteria 1, 2 and 3 must be met

1. The best corrected visual acuity is 6/9 or worse in either the first or second eye  
*NB. The best corrected visual acuity for both eyes will need to be provided on the Tickbox form*

**AND**

2. The patient suffers impairment of vision which has a substantial negative impact on **one or more** of the following:

- a) Quality of life (e.g. reading, watching TV, doing hobbies, etc.)
- b) Social functioning (e.g. recognising people, coins, etc.)
- c) Mobility (e.g. driving, recognising road signs, seeing steps or curbs, crossing roads)

*NB. Examples of the most significant impairment will need to be provided on the Tickbox form.*

**AND**

3. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Group 2: Criteria 4 and 5 must be met

4. Surgery (at any visual acuity) is indicated for management of ocular co-morbidities for patients with at least one of the following:

- a) Glaucoma

- b) Diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management
- c) Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- d) Inadequate view of fundus during diabetic retinopathy screening
- e) Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- f) Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)
- g) Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)
- h) Severe anisometropia in patients who wear glasses
- i) Posterior subcapsular cataracts.

**AND**

5. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Visually impairing cataract is common in persons aged 65 years and over.

The effectiveness of cataract surgery is established for first and second eyes.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care or community services (community optometrists) must also ensure that they supply all the relevant information to secondary care, particularly visual acuity and the impact of the visual impairment of the patient's life.

Primary care should avoid referring patients who do not meet the clinical criteria as providers can reject referrals not meeting the clinical criteria. Primary care should also utilise conferral systems, such as Kinesis where primary care can liaise with providers, to seek specialist advice if needed.



## 6.2. Eyelid surgery (Blepharoplasty)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1, 2, 3 or 4. Any requests must relate to a Prior Approval for a single eye.

Group 1: Patients suffering from ptosis or dermatochalasis: criteria 1, 2 and 3 must be met

1. Patient has ptosis or dermatochalasis that impacts on their quality of life.

**Two or more** items from the list below are reported by the patient:

- a) Eyelids block vision i.e. a noticeable deficit in vision
- b) Must raise eyelid/eyebrow to see out
- c) Problems with fine manual work
- d) Superior visual field blocked
- e) Problems with reading
- f) Problems with watching television
- g) Problems with hanging or reaching for objects above eye level
- h) Problems with reading road signs at side of the road
- i) Problems with reading road signs or see stoplights above driver

**AND**

2. Patient has adequate Visual Acuity in affected eye (i.e. visual acuity of 3/60 or better)

*NB. The best corrected visual acuity for both eyes will need to be provided on the Tickbox form*

**AND**

3. Patient has

- a) Reduced Marginal Reflex Distance (Bilateral MRD1 of 1.0 mm or smaller)

**OR**

- b) Significant Visual Field loss, such as one of the following:
  - i. The horizontal visual field should be at least 160 degrees (full distance left to right around horizontal meridian)
  - ii. The extension should be at least 70 degrees left and right
  - iii. The extension should be at least 30 degrees up and down

*NB: Binocular or Integrated Visual Field Testing is the preferred mode of testing.*

*These tests must be with central fixation. It is acceptable to have a total of up to 3 missed points wholly or partly within the 30°, which may or may not be contiguous.*

Group 2: Patients with ectropion criteria 4, 5 or 6 must be met

4. Patient has ectropion and conservative managements failed

- a) Taping lids closed at night to reduce risk of exposure keratopathy

**AND**

- b) Therapeutic contact lens

**AND**

- c) Ocular lubricants

*NB: It is recognised that for some patients some or all of the above treatments are impractical, if this is the case please state this on the Tickbox form.*

**OR**

5. Patient's cornea is exposed (e.g. in paralytic ectropion) and hence there is an increased risk of keratopathy

**OR**

6. Patient suffers from persistent and troublesome overflowing of tears onto the face (epiphora) resulting in watery eyes where **at least one** of the following applies:

- a) Impaired vision on a daily basis, causing smearing on glasses
- b) Watering occur both in outdoor and indoor settings
- c) Symptoms of persistent clear watering plus 3 episodes of infection or sticky discharge within 12 months

Group 3: Patients with entropion: criteria 7 and 8 must be met

7. Patient has entropion and conservative managements failed

- a) Epilation of eye lashes

**AND**

- b) Therapeutic contact lenses (protect cornea)

**AND**

- c) Ocular lubricants

*NB: It is recognised that for some patients some or all of the above treatments are impractical, if this is the case please state this on the Tickbox form.*

**AND**

8. Patient has eyelashes that cause persistent and on-going irritation to the eye risking trauma to the cornea

Group 4: Patients needing blepharoplasty as part of other surgery/treatment for other conditions: criterion 9 must be met

9. Patient require blepharoplasty to:

- a) Harvest skin for periocular reconstructions  
(e.g.: congenital defects, after tumour excision, following trauma, repair malpositions, etc.)

**OR**

- b) De-bulking the upper/lower lids in patients with in thyroid problems as part of their rehabilitation once the disease is no longer active

Please note

SWL CCGs do not routinely fund this procedure for purely cosmetic reasons.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Eyelid problems are common and rarely serious and there are multiple conservative treatment options available in primary care. If these failed and the patient continues to have symptoms or there is a risk of complications blepharoplasty will be funded by SWL CCGs.

In order to promote the cost-effective use of healthcare resources conservative management options must be exhausted before blepharoplasty is considered and it will not be funded for purely cosmetic reasons.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care.

### **Dermatochalasis**

Dermatochalasis is defined as an excess of skin in the upper or lower eyelid. Eyelid Surgery should only be performed if the dermatochalasis is severe enough to obstruct the peripheral or superior visual fields. The improvement of vision is an indication for Eyelid Surgery on the superior eyelid. In general, Eyelid Surgery of the inferior eyelid is considered cosmetic, as dermatochalasis in the lower eyelid does not interfere with vision.

### **Ptosis**

Ptosis is the dropping of the eyelid. It can be unilateral, bilateral, complete, incomplete, acquired or congenital.

### **Ectropion**

Ectropion is the outward drooping of the lower eye lid, away from the ocular surface. It is most commonly seen in older patients as a part of ageing – referred to as involuntional or senile entropion. Clinical features include irritation (like that of the presence of a foreign body), watering of the eye, conjunctival hyperaemia and exposure keratopathy.

Mild cases often do not require any treatment. Management options that can be considered are listed below:

- Taping lids closed at night to reduce risk of exposure keratopathy
- Therapeutic contact lens
- Ocular lubricants

If the patient's cornea is exposed (e.g. in paralytic ectropion) then there is an increased risk of keratopathy so urgent referral is needed.

### Entropion

Entropion is defined as inward rotation of the tarsus and lid margin, causing the eye-lashes to come into contact with the ocular surface. This is most commonly seen in older patients as a part of ageing – referred to as involutional or senile entropion. Clinical features include irritation (like that of the presence of a foreign body), watering of the eye, blurred vision, corneal abrasions, conjunctival hyperaemia.

Management options that can be considered are listed:

- Epilation of eye lashes
- Therapeutic contact lenses (protect cornea)
- Ocular lubricants

### Please note

SWL CCGs will not routinely fund this procedure for purely cosmetic reasons.

## 7. General Surgery

### 7.1. Asymptomatic gallstones

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

#### **Rationale for the clinical threshold**

The natural history of asymptomatic gallstones is that serious symptoms and complications only develop in 1-2% of patients annually.

The cumulative risk of requiring treatment in the first 5 years after the detection of asymptomatic gallstones is 7.6%

The World Gastroenterology Organisation (WGO) Practice Guidelines do not recommend cholecystectomy in patients with asymptomatic gallstones.

#### **Primary care advice**

SWL CCGs will not support the funding of cholecystectomy in asymptomatic patients.

If there is any suspicion of malignancy, patients should be referred immediately to an appropriate service as described in the NICE Clinical Guidance 27: *Referral Guidelines for Suspected Cancer*.

Primary care GPs can refer to secondary care for an expert opinion in cases where diagnostic uncertainty exists.

Patients experiencing one episode of pain only and who can be safely managed in primary care/a community setting do not require referral for surgery. In keeping with the Royal College of Surgeons guidelines on gallstones, these patients can be managed with oral analgesia and advised to follow a low fat diet. If they develop further episodes or they have symptoms in addition to the pain, or their pain cannot be safely managed in primary care or a community setting then they can follow the referral pathway for patients with symptomatic gallstones.

## 7.2. Haemorrhoidectomy

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 4) are met.

- |   |
|---|
| 1. Patient has <ul style="list-style-type: none"><li>a) Haemorrhoids that are prolapsed and non-reducible</li></ul> <b>OR</b> <ul style="list-style-type: none"><li>b) Haemorrhoids are associated with recurrent bleeding.</li></ul> |
|---|

#### AND

- |  |
|--|
| 2. Patient tried the entire range of conservative therapies available over a period of at least 6 months prior to referral: <ul style="list-style-type: none"><li>a) Increasing fluids and fibre intake (using bulking agents if necessary)</li><li>b) Use of appropriate laxatives</li><li>c) Avoidance of straining</li><li>d) Weight management: reduce weight if BMI &gt; 25</li><li>e) Maintain alcohol intake within normal range</li><li>f) Regular physical exercise</li><li>g) Abstinence from smoking.</li></ul> |
|--|

#### AND

- |  |
|--|
| 3. Patient tried all appropriate non-surgical interventions have been attempted and failed, unless contra-indicated: <ul style="list-style-type: none"><li>a) Rubber band ligation</li></ul> <b>OR</b> <ul style="list-style-type: none"><li>b) Injection sclerotherapy.</li></ul> |
|--|

#### AND

- |   |
|---|
| 4. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.<br><br><i>NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials</i> |
|---|

*provided.*

#### Please note

SWL CCGs will not routinely fund this procedure for the removal of anal skin tags (see also Minor Skin Lesions policy).

Pregnancy predisposes women to symptomatic haemorrhoids that usually resolve after delivery. Surgical intervention is contraindicated because of the risk of inducing labour.

#### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Haemorrhoids (piles) occur when vascular tissue in the anal canal becomes enlarged. These are termed 'internal haemorrhoids' as they originate inside the anal canal. They may prolapse out of the rectum and are often associated with bleeding, itching or discomfort. External haemorrhoids arise in the area around the anus and are usually left untreated. It has been estimated that up to 25% of the UK population is affected by haemorrhoids. In 2014–15, approximately 23,000 haemorrhoidal procedures were carried out in England, of which around 8,000 were excisional procedures.

In people with symptomatic internal haemorrhoids, randomised controlled trials have shown that conventional management with added dietary fibre improves rates of symptom relief and reduces rates of bleeding compared with usual diet. Bulk laxatives have been shown to be as effective as minor interventions (rubber band ligation/injection sclerotherapy) in randomised trials at six months and patients should, therefore, be encouraged to engage with lifestyle changes before more intensive intervention. Where conservative management fails, minor interventions, such as rubber band ligation or injection sclerotherapy may be effective. These have been shown to have reasonable effectiveness compared with surgical treatments. Although rates of recurrence are slightly higher, minor interventions are associated with less post-procedural pain, lower risk of complications and lower cost.

Therefore, surgical treatments such as haemorrhoidectomy, haemorrhoidopexy, and haemorrhoid artery ligation should only be considered as a last resort, when all other conservative and less invasive treatment options have failed.

#### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments.

#### Conservative management

Primary care should manage patients with haemorrhoids by giving advice on lifestyle including increasing fluids and fibre intake and the avoidance of straining. Bulking agents or medications may be recommended.

Lifestyle changes should be over a period of at least 6 months prior to referral including all of the following:

- Increasing fluids and fibre intake (using bulking agents if necessary)
- Use of appropriate laxatives

- Avoidance of straining
- Weight management: be within the range of normal BMI, or reduce weight if BMI > 25
- Maintain alcohol intake within normal range
- Regular physical exercise
- Abstinence from smoking

### Haemorrhoids in pregnancy

Pregnancy predisposes women to symptomatic haemorrhoids that usually resolve after delivery. Surgical intervention is contraindicated because of the risk of inducing labour.

### Referral to secondary care

This should only be made for patients who have tried lifestyle alterations for longer than 6 months and experience daily discomfort (itching or pain) or frequent (weekly) blood loss.

Only patients with grade 3 or 4 should be referred to secondary care. Grade 1 and 2 patients may need referral for non-surgical treatments.

### Grading of haemorrhoids

- |         |  |
|---------|--|
| Grade 1 | Normal appearance. Bleeding but not prolapsing         |
| Grade 2 | Bleeding and prolapsing, but will reduce spontaneously |
| Grade 3 | Bleeding and prolapsing, but requires manual reduction |
| Grade 4 | Bleeding and permanently prolapsed.                    |



### 7.3. Hernia repair surgery (Herniorrhaphy)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Clinical threshold

SWL CCG fund this procedure when all of the following criteria are met in Group 1, 2, 3 or 4. The clinical criteria below includes primary, recurrent and bilateral hernias.

Group 1: Criteria 1 and 2 must be met

1. Patient has a hernia causing symptoms of incarceration, strangulation or obstruction

**AND**

2. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Group 2: Criteria 3 must be met

3. Patient has a femoral hernia

Group 3: Criteria 4 and 5 must be met

4. Patient with inguinal hernia has

a) Difficulty in reducing the hernia

**OR**

b) Inguino-scrotal hernia

**OR**

c) Pain with strenuous activity, prostatism, or discomfort significantly interfering with activities of daily living

**AND**

5. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

#### Group 4: Criteria 6 and 7 must be met

6. Patient with abdominal (including incisional and umbilical) hernia has pain/discomfort significantly impairment of activities of daily living\*

*NB: Patients with BMI $\geq$ 30kg/m<sup>2</sup>, should attempt weight reduction to resolve the pain/discomfort*

#### AND

8. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

#### Please note

SWL CCGs do not routinely fund this procedure for:

- Small, asymptomatic inguinal hernias
- Minimally symptomatic inguinal hernias
- Large, wide necked hernias unless there is demonstrable clinical evidence that it is causing significant symptoms
- Groin pain, including 'athletic pubalgia', sometimes known as 'sports hernia'
- Impalpable hernias/abdominal wall weakness including divarication of recti<sup>ll</sup>

#### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

The incidence of patients presenting in primary care rises from 11 per 10,000 person years in those aged 16-24 years to 200 per 10,000 person years in those aged 75 years or above. Most cases are groin hernias (inguinal or femoral hernia). Inguinal hernias account for 96% of all groin hernias which predominantly present in men (95%). Femoral hernias account for 4% of groin hernias and they are more common in women than men (3:1 incidence).

Patients with symptoms of incarceration, strangulation or obstruction

These patients need to be referred urgently.

#### Femoral hernia

Has a high risk of morbidity and mortality and surgery is recommended, even in the absence of symptoms.

## Inguinal hernia

Surgical hernia repair is associated with low rates of mortality (0.05%), but a proportion of patients are likely to experience chronic pain and discomfort, with a significant impact on Health Related Quality of Life (HRQL). Randomised controlled trials of asymptomatic and minimally symptomatic patients show no difference in pain scores or general health status at 1-2 years for watchful waiting compared to surgery. In these trials, a low number of emergency hernia repairs (1.5%) occurred in the watchful waiting group over long-term follow-up (~7 years) and guidelines recommend watchful waiting for male adults with asymptomatic or mildly symptomatic hernia. Given the risks of surgical morbidity, evidence of equivalent health status following surgery and watchful waiting and low risk of emergency herniations, observation and review for asymptomatic patients is justified. However, it is recommended that, where symptoms are affecting activities of daily life, patients should be treated surgically.

## Abdominal hernia

Incidence is associated with obesity. It increases with increasing BMI and is higher even in the overweight (BMI 25-30 kg/m<sup>2</sup>) and non-morbidly obese (BMI 30-40 kg/m<sup>2</sup>) (odds ratio 1.63 and 2.62 respectively) compared to lean. When surgery is conducted on incisional or umbilical hernias, rates of recurrence are around 5-25%<sup>12-16</sup> and increased BMI is associated with even higher rates of recurrence and with post-surgical morbidity.

Considering the costs and risks of recurrence, surgery for these hernias should be avoided where possible by attempted weight loss.

## Divarication of recti

Does not carry the risks that are associated with actual hernias and repairs are primarily cosmetic. There are high rates of recurrence following surgery (40%) and other commonly reported complications include haematomas, minor skin necrosis, wound infections, dehiscence, post-operative pain and nerve damage. Surgery should, therefore, be avoided unless extreme symptoms present.

## Groin pain with clinical suspicion of hernia (obscure pain or swelling)

A quarter to a third of patients presenting with groin pain were found to have an occult hernia. Diagnostic procedures may identify the majority of occult hernias, but the specificity of some tests may be low (ultrasound -77%, CT - 65%) and incorrectly identify patients as having a hernia. Where symptoms do not indicate incarceration, strangulation or obstruction of a potential hernia, the costs of diagnostic procedures and any surgical interventions, and the risks associated with misdiagnosis and surgical morbidity, do not justify investigation with imaging tests and patients should be offered watchful waiting.

## Day surgery

European guidelines for the management of inguinal hernia recommend that: 'An operation in day surgery should be considered for every patient. This may be possible for many cases of non-emergency hernia surgery.'

## Recurrent and bilateral hernias

NICE guidance recommends that "Laparoscopic surgery for inguinal hernia repair should only be performed by appropriately trained surgeons who regularly carry out the procedure."

## **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Patients with symptoms of incarceration, strangulation or obstruction

Refer urgently.

Femoral hernia

High risk of morbidity and mortality hence surgery is recommended, even if asymptomatic.

Inguinal hernia

Randomised controlled trials of asymptomatic and minimally symptomatic patients show no difference in pain scores or general health status at 1-2 years for watchful waiting compared to surgery.

Given the risks of surgical morbidity, evidence of equivalent health status following surgery and watchful waiting and low risk of emergency herniations, observation and review for asymptomatic patients is justified. However, it is recommended that, where symptoms are affecting activities of daily life, patients should be treated surgically.

Abdominal hernia

Incidence is associated with obesity. It increases with increasing BMI and is higher even in the overweight (BMI 25-30 kg/m<sup>2</sup>) and non-morbidly obese (BMI 30-40 kg/m<sup>2</sup>) (odds ratio 1.63 and 2.62 respectively) compared to lean. When surgery is conducted on incisional or umbilical hernias, rates of recurrence are around 5-25% 12-16 and increased BMI is associated with even higher rates of recurrence and with post-surgical morbidity.

Considering the costs and risks of recurrence, surgery for these hernias should be avoided where possible by attempted weight loss.

Divarication of recti

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Where symptoms do not indicate incarceration, strangulation or obstruction of a potential hernia, the costs of diagnostic procedures and any surgical interventions, and the risks associated with misdiagnosis and surgical morbidity, do not justify investigation with imaging tests and patients should be offered watchful waiting.

## 7.4. Obesity surgery (Bariatric surgery)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 6) are met.

1. Patient is 18 or over at the time of application

**AND**

2. Patient's BMI is

a) Over 40kg/m<sup>2</sup>

**OR**

b) Over 35kg/m<sup>2</sup> in the presence of other significant diseases/co-morbidities

*NB. Patient's height and weight will need to be provided on the Tickbox form.*

**AND**

3. Patient has been morbidly or severely obese for at least five years.

**AND**

4. Patient has followed dietary and exercise advice for at least 12 months.

*NB: Patients with BMI greater than 50 attending a specialist bariatric service, this period of 12 months may include the stabilisation and assessment period prior to bariatric surgery. The minimum period is six months.*

**AND**

5. Patient has undergone a formalised MDT-led process for the screening of co-morbidities and the detection of other significant diseases

**AND**

6. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Please note

The removal of excess skin resulting from weight loss following bariatric surgery is not routinely funded. Please ensure that the patient is aware of this before proceeding with bariatric surgery.

Criteria for revision of bariatric surgery to be agreed and added later as an integral part of the bariatric surgery pathway for SWL.

## Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Bariatric surgery for the morbidly obese is an increasingly available intervention. However, surgical intervention is not the whole solution and appropriate clinical selection of fully informed patients is important. It is also important to ensure that surgery is not offered prematurely in a patient's weight loss pathway. Bariatric surgery is only one component of the multimodal lifetime treatment pathway: multidisciplinary medical assessment, pre-operative management of comorbidities, conservative treatments and life-long follow-up care. Patients need to be informed of the benefits and risks as well as the life-long implications of bariatric surgery.

With informed choice patients are better able to cope with the eating restrictions of a post surgically altered gastrointestinal anatomy and mandatory follow up for nutritional supplementation and monitoring to prevent nutritional deficiencies; the management of comorbidities; and adjustment of medications and dosage post operatively. Preparation will improve patient awareness of their role in following a healthy lifestyle to consolidate surgically achieved weight loss and resolution of c-comorbidities.

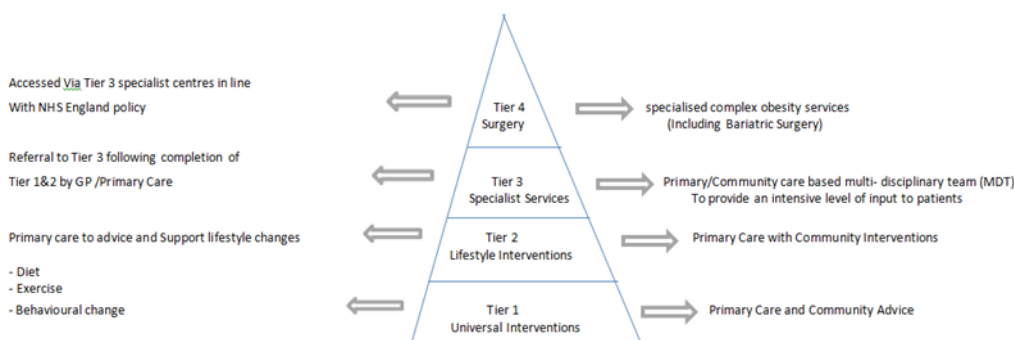
## Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments.

Weight management has multiple tiers and the following pyramid provides an overview.

### Weight management services



Bariatric surgery for the morbidly obese is an increasingly available intervention. However, surgical intervention is not the whole solution and appropriate clinical selection of fully informed patients is important. It is also important to ensure that surgery is not offered prematurely in a patient's weight loss pathway. Bariatric surgery is only one component of the multimodal lifetime treatment pathway: multidisciplinary medical assessment, pre-operative management of co-morbidities, conservative treatments and life-long follow-up care. Patients need to be informed of the benefits and risks as well as the life-long implications of bariatric surgery.

With informed choice patients are better able to cope with the eating restrictions of a post surgically altered gastrointestinal anatomy and mandatory follow up for nutritional supplementation and monitoring to prevent nutritional deficiencies; the management of co-morbidities; and adjustment of medications and dosage post operatively. Preparation will improve patient awareness of their role in following a healthy lifestyle to consolidate surgically achieved weight loss and resolution of co-morbidities.

**The removal of excess skin resulting from weight loss following bariatric surgery is not routinely funded. Please ensure that the patient is aware of this before proceeding with bariatric surgery.**

## 8. Gynecology

### 8.1. Bartholin cyst

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. Patient has a cyst causing significant functional impairment of activities of daily living\* or cause Dyspareunia (painful sexual intercourse)

**AND**

2. Conservative management has been tried and failed to resolve the condition for at least 6 months

**AND**

3. Patient had

a) At least one clinically significant, episode of infection in the last 6 months

**OR**

b) An infected lesion incised and drained in secondary care as an urgent/emergency case in the last 6 months

*NB. Date of infection or emergency treatment will need to be provided on the Tickbox form.*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

*NB: Being unable or unwilling to sunbathe, swim or take part in other recreational activities due to the cosmetic impact of a Bartholin's cyst does not indicate that the patient is suffering from significant functional impairment.*

Please note

SWL CCGs do not routinely fund the insertion of a balloon catheter for the treatment of Bartholin's Cyst.

#### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.



The Bartholin's glands are at the entrance of the vagina. A cyst or abscess can form in the Bartholin's duct (which drains the glands) if it becomes blocked or infected. Cysts are usually treated either by 'incision and drainage' or 'marsupialisation', which involves cutting into the cyst and placing stitches to make a permanent opening so that the gland can drain freely. Insertion of a balloon catheter is a non-surgical alternative to incision and drainage or marsupialisation. However, NICE IPG 323: 'Inserting an inflatable balloon to treat a Bartholin's cyst or abscess' does not provide any information regarding cost effectiveness.

A systematic review of 4 studies (5 controlled trials, 2 cohort studies, and 17 case series) identified there are multiple treatments for Bartholin duct cysts and abscesses. A review of the literature failed to identify a best treatment approach<sup>4</sup>.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments.

### **Management of Bartholin's cyst in primary care**

- Exclude gonococcal infection
- Small and asymptomatic cyst - watchful waiting
- Symptomatic or enlarging cyst – at least six months of conservative management
  - Warm compresses/baths
  - Analgesics and/or antibiotics where appropriate.

### **Referral to specialist**

Urgent referral is needed for patients with acutely infected Bartholin's cyst.

Refer to secondary care when the cyst is enlarging or symptomatic despite at least six months of conservative management.

## 8.2. Dilatation and Curettage (D&C)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. Patient had a hysteroscopy with targeted biopsy that failed or was not possible due to cervical stenosis  
*NB. Date of hysteroscopy will need to be provided on the Tickbox form.*

**OR**

2. Patient has had a hysteroscopy and endometrial biopsy with an inconclusive histological result  
*NB. Date of the inconclusive endometrial biopsy will need to be provided on the Tickbox form.*

Please note

SWL CCG do not routinely fund this procedure for:

- Investigation and/or treatment of menorrhagia
- Investigation of dysfunctional uterine bleeding or post-menopausal bleeding
- Treatment of irregular periods
- Treatment of endometrial hyperplasia
- Removing unwanted tissue, endometrial polyps or benign tumours of the womb
- Removing an IUD that has become embedded in the wall of the womb

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

D&C is no longer recommended as a diagnostic tool in Heavy Menstrual Bleeding (HMB). To detect histological abnormalities in HMB endometrial sampling or hysteroscopy with directed biopsy have superseded D&C for obtaining endometrial tissue.

Evacuation of retained products of conception after incomplete miscarriage or delivery has been recommended in order to reduce potential complications such as haemorrhage or infection. Surgical evacuation has been considered the most effective method by D&C or vacuum aspiration/suction curettage. Evidence suggests that vacuum aspiration/suction curettage was safe, quick and easy to perform, and less painful than D&C and is therefore recommended as the first treatment option, with D&C only recommended where this is contraindicated.

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

D&C is no longer recommended as a diagnostic tool in heavy menstrual bleeding (HMB). To detect histological abnormalities in HMB endometrial sampling or hysteroscopy with directed biopsy have superseded D&C for obtaining endometrial tissue.

## 8.3. Female Genital Prolapse

### Compliance requirement

Prior Approval must be obtained by the treating clinician care. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 and 2) are met

1. Patient completed all the conservative treatments prior to referral
--

**AND**

2. Patient
------------

a) Requires an assessment and fitting of pessary that cannot be undertaken in primary care
--

**OR**

b) Declines to have a pessary inserted and requests surgery for the prolapse
--

**OR**

c) Prolapse combined with urinary or faecal incontinence
--

**Red flag symptoms hence urgent referral is needed**

**OR**

d) Has moderate to severe (grade 3-4) symptoms of prolapse
--

**OR**

e) Had failure of pessary
---------------------------

Please note

SWL CCG do not routinely fund this procedure for asymptomatic prolapse.

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Symptoms of prolapse can be classified as mechanical, sexual, lower urinary tract or bowel. Mechanical symptoms include tissue protruding from the vagina, having to manually reduce the bulge to urinate or defecate, spotting from ulceration of the protrusion and vaginal

pain/discomfort. Sexual symptoms include dyspareunia, decreased sexual satisfaction and incontinence/prolapse during intercourse. Lower urinary tract symptoms include stress incontinence and urge incontinence. Bowel symptoms include faecal and flatus incontinence.

Four main POP grading systems are currently in use – quantitative POP (POPQ), vaginal profile, grading system and severity. Pelvic organ prolapse (POP) is common and many women with POP are asymptomatic.

POP is not always chronic and progressive. Although prolapse can be associated with varied symptoms few are specific to prolapse. The extent of prolapse does not correlate well with symptoms.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments (see checklist and GP referral letter below).

### **Pelvic organ prolapse – quantification system**

- |     |  |
|-----|--|
| 0   | No prolapse  |
| I   | > 1 cm above the hymen   |
| II  | ≤ 1 cm proximal or distal to the plane of the hymen  |
| III | > 1 cm below the plane of the hymen, but protrudes no farther than 2 cm less than the total vaginal length |
| IV  | Eversion of the lower genital tract is complete  |

### **Checklist for Conservative Management**

- Has the patient kept a bladder diary and has the patient undergone bladder drill exercises?
- Has the patient had access to gynae physiotherapy for a course of pelvic floor exercises?
- If underlying atrophy is present, has the patient had a course of vagifem 10mg/gynest cream daily for 2 weeks, then twice weekly for 3 months?
- If Cystocele / Uterine Prolapse present – has a ring pessary been fitted\*?

### **Referral letter content**

- Reason for referral
- Examination findings: Grade 1 to Grade 4 uterine prolapse with/without cystocele or rectocele or enterocele
- Treatment to date
  - Gynae physiotherapy completed
  - Atrophy treated
  - Bladder drill/urinary symptoms addressed
- Bladder diary completed and attached
- Past medical/surgical history

- Drug history
- BMI (should be below 35)
- Smoking cessation

Excessive BMI predisposes patients to genital prolapse hence as part of any conservative management weight management should be signposted.

#### 'Red Flags' for early referral

- Exclude cancerous cause for 'lump'
- New presentation of procidentia (Grade 4 Prolapse) with poor urinary output – consider acute gynaecology admission
- Genital prolapse with urinary or faecal incontinence.

## 8.4. Hysterectomy for Heavy Menstrual Bleeding (Menorrhagia)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 4) are met.

<p>1. Patient had an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) for at least 6 months that</p> <ul style="list-style-type: none"> <li>a) Failed to relieve symptoms</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>b) Was medically inappropriate or contraindicated</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>c) Declined by the patient</li> </ul>
--

#### AND

<p>2. Patient had <b>at least two</b> of the following treatments that have failed after trial for at least 3 months for each treatment</p> <ul style="list-style-type: none"> <li>a) Non-steroidal anti-inflammatory agents</li> <li>b) Tranexamic acid</li> <li>c) Other hormone methods (injected progestones, combined oral contraceptives, Gn-RH analogue)</li> </ul>
--

*NB: It is recognised that for some patients some or all of the above treatments are inappropriate or contraindicated in line with NICE CG44, if this is the case please state this on the Tickbox form.*

**AND**

3. Patient had surgical treatments such as endometrial ablation, or myomectomy that

a) Failed to relieve symptoms

**OR**

b) Was medically inappropriate or contraindicated

**OR**

c) Declined by the patient.

**AND**

4. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

**Please note**

SWL CCGs do not routinely fund the following procedures:

- Uterine artery ligation
- Magnetic Resonance guided Focused Ultrasound (MRgFUS)
- Myolysis.

**Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

NICE released clinical guidelines on heavy menstrual bleeding in January 2007 (CG44), and these form the basis of these proposals.

Hysterectomy should not be used as a first-line treatment solely for Heavy Menstrual Bleeding (HMB).

The levonorgestrel intrauterine system is effective in the treatment of heavy menstrual bleeding and is considerably cheaper than performing a hysterectomy, even if required for many years, and fertility of the woman may be maintained.

A number of effective conservative treatments are available as second line treatments after failure of Mirena or where it is contraindicated.

Endometrial ablation is suitable for women who do not want to conceive in the future and should only be offered after full discussion of risks and benefits and other treatment options.

**Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

In women whose physical examination is normal, HMB should be managed in primary care with medical treatment (unless contraindicated), until all reasonable options have been exhausted, and are demonstrated to have failed.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments, including dates of these.

### Conservative treatments

Primary care must attempt conservative treatments in line with NICE recommendations (CG44) for the management of HMB.

The levonorgestrel intrauterine system is effective in the treatment of heavy menstrual bleeding and is considerably cheaper than performing a hysterectomy, even if required for many years, and fertility of the woman may be maintained. This (e.g. Mirena®) should be tried for at least 6 months.

A number of effective conservative treatments are available as second line treatments after failure of Mirena or where it is contraindicated. A minimum of 3 months trial of this is recommended:

- Non-steroidal anti-inflammatory agents
- Tranexamic acid
- Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue).

## 8.5. Surgery for uterine fibroids

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 4) are met.

1. Patient has a fibroid that is greater than 3 cm in diameter

#### AND

2. Patient has a fibroid which is causing symptoms that have a severe impact on her quality of life including **at least one** of the following:

- a) Heavy or painful menstrual bleeding
- b) Problems with fertility
- c) Pressure symptoms

#### AND

3. Patient wants to avoid surgery and/or retain her uterus

#### AND

4. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

#### Please note

SWL CCGs do not routinely fund the following procedures for the removal of uterine fibroids:

- MRI-guided percutaneous laser ablation
- MRI-guided focused ultrasound ablation
- Laparoscopic laser myomectomy

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Uterine fibroids or leiomyomata are benign tumours that occur in the uterus. They are the most common type of female tumour and their aetiology is not fully understood. They are found anchored to the uterine wall and can vary in size from the size of a grape to large masses that can be palpated through the uterine wall.

Current evidence on Uterine Artery Embolization (UAE) suggests that it is safe enough for routine use and there are symptomatic benefits in the majority of patients in the short term.



However, more evidence is required on the degree and duration of the benefits and of its effects on fertility.

Evidence review commissioned by NICE showed that Laparoscopic Laser Myomectomy may be suitable for small fibroids, most of which are asymptomatic, and therefore the Specialist Advisors to NICE questioned the clinical value of the procedure.

NICE clinical guideline on heavy menstrual bleeding (CG44) states that when surgery for fibroid-related HMB is felt necessary, UAE, myomectomy and hysterectomy must all be considered discussed and documented. UAE should be considered in women with HMB associated with fibroids who want to retain their uterus and /or avoid surgery.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care.

If the patient has heavy menstrual bleeding which is due to fibroids less than 3 cm in diameter, primary care should try conservative medical management as specified in NICE (CG 44).

## 9. Trauma and Orthopedics – Back

### 9.1. Acupuncture for Low Back Pain

#### **Compliance requirement**

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### **Clinical threshold**

SWL CCGs do not routinely fund this procedure.

#### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need.

NICE released clinical guidelines on low back pain and sciatica in over 16s in November 2016 (CG59), and these form the basis of this proposal.

#### **Primary care advice**

Primary care should be aware that this procedure is not routinely funded, and should not make referrals to secondary care for this procedure.

NICE specifically state that acupuncture should not be offered for the management of low back pain with or without sciatica (NG59).

[Managing low back pain and sciatica - NICE Pathways](#)

## 9.2. Back pain injections (Facet joints, Medial branch block, Radiofrequency denervation)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1, 2, 3 or 4

Group 1: Diagnostic facet joint injections: criteria (1 - 4) must be met

1. Patient is 18 or over at the time of application

**AND**

2. Patient has been assessed for surgical management of chronic spinal pain which has lasted more than 24 months without a diagnosis of the cause

*NB. Date of patients first presented with chronic spinal pain date will need to be provided on the Tickbox form.*

**AND**

3. All conservative management options have been tried and failed  
(e.g.: exercise, pharmacotherapy including analgesia and muscle relaxants)

**AND**

4. Patient shows an awareness that managing their condition requires making lifestyle changes

Group 2: Medial Branch Block: criteria 5 must be met

5. Patient requires therapeutic testing prior to undergoing radiofrequency denervation

Group 3: First Radiofrequency Denervation: criteria (6-8) must be met

6. Patient's main source of pain is thought to come from structures supplied by the medial branch nerve and this is confirmed by a positive response to a diagnostic median nerve block in a suspected facet joint pain lasting more than 24 months

*NB: Positive response is expected to be 75 to 100% pain relief*

**AND**

7. Patient has pain that is greater than 5 on VAS scale or equivalent at the time of the application

*NB. Patient's VAS score will need to be provided on the Tickbox form.*

**AND**

8. All conservative management options have been tried and failed (exercise, pharmacotherapy including analgesia and muscle relaxants)

Group 4: Second or Third Radiofrequency Denervation: criteria (9 - 13) must be met

9. Patient had the last radiofrequency denervation at least 12 months before this planned procedure

**AND**

10. Patient had a positive response to the previous radiofrequency denervation as evidenced by VAS scale

*NB. Patient's VAS scores pre and post procedure will need to be provided on the Tickbox form.*

**AND**

11. Patient had a positive response to the previous radiofrequency denervation as evidenced by an improvement in the EQ-5D scores

**AND**

12. Patient had a reduction in medication taken at three months following the previous radiofrequency denervation

**AND**

13. Patient had no more than two previous radiofrequency denervation

Please note

SWL CCGs do not routinely fund

- Facet joint injections and medial branch block for any therapeutic indications
- More than three radiofrequency denervation injections for patients.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Facet Joint injection: the effectiveness of therapeutic facet joint injection is unproven and not medically necessary for the treatment of chronic spinal pain. The available evidence is based on small studies with low power and the results of available studies are conflicting and do not provide a unidirectional view. Despite this, there is strong support amongst clinicians for this intervention as evident from the wider practice of facet joint injections and there is some qualitative evidence that not providing facet joint injections might lead to an increase in the

number of spinal fusion operations. There are no studies or local or national data to quantify this impact.

Radiofrequency denervation: NICE recommends that it is not unreasonable to expect the duration of pain relief following radio frequency denervation around 2 years. It also noted that some trials showed adverse event (allodynia) rates higher than expected with radio frequency denervation.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments.

Primary care should ensure that conservative management has been tried, such as exercise and pharmacotherapy, including analgesia and muscle relaxants.

Prior to referral patients must show awareness that managing their condition requires making lifestyle changes. This includes:

- Weight loss and diet control
- Increased fitness through exercise
- Physiotherapy
- Avoidance of illicit drugs and alcohol
- Improved engagement in activities of daily living and purposeful occupation where appropriate.

### 9.3. Epidural injections for Low Back Pain

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1 or 2.

Group 1: First Injections criteria (1 – 4) must be met

1. Patient is 18 or over at the time of application

*NB. Children for complex pain management should receive their care at a specialist centre, which is commissioned by NHS England*

**AND**

2. Patient has

- a) Radicular pain consistent with the level of spinal involvement (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation)

**OR**

- b) Nerve-root irritation with a positive nerve-root tension sign (straight leg raise—positive between 30° and 70° or positive femoral tension sign)

**AND**

3. All conservative management options have been tried and failed within the last 12 months (physiotherapy treatments and guided exercise programmes where a patient is able to participate, pharmacotherapy including analgesia and muscle relaxants)

*NB. This should be provided via comprehensive pain management services where it is available*

**AND**

4. Patient suffers from moderate to severe low back pain for more than 12 months as measured by a recognised pain scale\* (where comprehensive pain management service is not accessible, then the period of conservative treatment should be 6 months)

*NB. Date of patients first presented with low back pain date will need to be provided on the Tickbox form.*

## Group 2: Repeat Injections Criteria (5 – 6) must be met

Patients may receive a maximum of 2 injections within a 12 month period.

5. Patient had a positive response to the last epidural injection as measured by a recognised pain scale\* (Positive response is expected to be 75 to 100% pain relief)

*NB. Patient's VAS scores pre and post procedure will need to be provided on the Tickbox form.*

### AND

6. Patient had a positive response to the last epidural injection resulting in improved functioning

\* The following tools are recognised by NICE to be used as pain scales

- Brief Pain Inventory (BPI)
- Roland Morris Disability Questionnaire (RMDQ)
- Visual Analogue Pain Scale (VAS)

Please note

- Injections MUST be carried out under radiological guidance.
- Patients may receive a maximum of 2 injections within a 12 month period.

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Around 20% of people with low back pain will consult their GP about it. In patients experiencing lower back pain, symptoms usually improve within weeks, however, about 10% remain off work and about 20% have persistent symptoms at 1 year.

Epidural injections are provided in order to provide temporary pain relief. They can break the cycle of pain and inflammation and allow for conservative treatment, including physiotherapy and guided exercise as part of a comprehensive pain management plan. In this way, the injections can provide benefits that outlast the effects of the steroid itself. For patients with non-specific back pain, NICE does not recommend the use of therapeutic injections. Although there appears to be short-term pain relief, trials do not show evidence of longer-term benefit on pain and function in patients with non-specific Chronic Low Back Pain (CLBP), spinal stenosis or radicular CLBP. However, epidural steroid injections may bring short-term relief and are recommended as an option in patients with persistent radiculopathy due to herniated lumbar disc.

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning symptoms and their duration and the conservative treatments tried including dates where relevant.

Epidural injections are provided in order to provide temporary pain relief. They can break the cycle of pain and inflammation and allow for conservative treatment, including physiotherapy and guided exercise as part of a comprehensive pain management plan. In this way, the injections can provide benefits that outlast the effects of the steroid itself.

For patients with non-specific back pain, NICE does not recommend the use of therapeutic injections.

### Conservative treatments

Primary care should be aware of the conservative treatment options for managing of chronic low back pain which may include self-management, physiotherapy treatments and guided exercise programmes where a patient is able to participate, and pharmacotherapy including analgesia, as well as and psychological therapies (which may be combined with physical programmes) according to NICE recommendations. Where appropriate these options should be tried over a period of 12 months prior to referral.

Primary care should consider the use of risk stratification using the [STarT back risk assessment tool](#).

The Comprehensive Pain Management Programme could be part of an MSK care pathway within the community (NB the role of the community MSK service is to accept referrals from GPs for assessment and treatment and for triaging of patients suitable for treatment in secondary care).



## 9.4. Discectomy for Low Back Pain

### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

### Clinical threshold

SWL CCGs do not routinely fund this procedure.

**This clinical threshold only covers Low Back Pain and not the Compression of the spine.**

### Rationale for the clinical threshold

NICE guidance came out in November 2016 (NG59), which explicitly stated that epiduroscopic lumbar discectomy through the sacral hiatus for sciatica **should only be used in the context of research.**

[Managing low back pain and sciatica - NICE Pathways.](#)

NICE IPG 570 superseded NICE IPG 300.

## 10. Trauma and Orthopedics – Feet

### 10.1. Excision of Bunion (Hallux Valgus)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. The patient suffers from:

- a) Severe deformity (with or without second toe deformity\*) that causes significant functional impairment that impacts on activities of daily living\*\*

**OR**

- b) Severe pain to the hallux valgus, and/or to the second toe, that causes significant functional impairment\*\*

**AND**

2. Conservative management has been tried and failed to resolve the condition for at least 6 months

**AND**

3. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

\*Second toe deformity includes: Claw toe, hammer toe and mallet toe

\*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

#### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

NICE have published two interventional procedure guidance (IPG 140) concerning hallux valgus. This supports the metatarsophalangeal joint replacement of the hallux, whereas IPG 332 stresses caution for the implementation of surgical correction of hallux valgus using minimal access techniques.

There are two commissioning guides, both published in November 2013, which are considered in the development of this commissioning policy.

NHS England's Interim Clinical Commissioning Policy: Bunion Surgery which was published in November 2013.

This policy sets down clear criteria for the removal of symptomatic or painful bunions, this includes:

- Conservative methods have failed
- Severe deformity causing significant impairment
- Severe pain causing significant functional impairment

It stresses that referral for surgery should not be offered for cosmetic reasons.

The British Orthopaedic Foot and Ankle Society, British Orthopaedic Association, Royal College of Surgeons of England, (2013), Commissioning guide: Painful deformed great toe in adults. The most relevant and up-to-date studies are referenced and the guidance presents a high value care pathway for painful deformed great toe with criteria for Primary Care, Intermediate Care and Secondary Care. The guide states that referral to Secondary Care should not occur for prophylactic or cosmetic reasons.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply the relevant information to secondary care.

### **Conservative measures**

Ensure that the following conservative measures have been implemented by the clinician and/or patient over a period of 6 months:

- Avoiding high heels shoes, and tight pointed footwear
- Wearing roomier footwear with soft leather uppers
- Having podiatry care to remove corns and calluses
- The use of bunion pads to reduce irritation and protect prominent areas
- The use of oral analgesia to help reduce pain and inflammation
- Treatments for recurrent ulceration (where necessary)

### **Prior to referral**

Ensure that the patient is made aware of and understands the following:

- There is no guarantee that the foot will be perfectly straight or pain-free after surgery
- That post-surgery, the patient may still not be able to wear normal shoes (or high heels)
- They will be out of sedentary work for 2-6 weeks, and physical work for 2-3 months
- They will be unable to drive for 6-8 weeks
- Full recovery can take an average of 4-6 months.

## Patients with diabetes

- Patients with poorly controlled diabetes should be referred for further management at the Diabetic Service and only referred for bunion surgery when their diabetes is under control
- Complication rates for patients with poorly controlled diabetes are very high for this procedure.

# 11. Trauma and Orthopedics – Hand

## 11.1. Surgery for Carpal Tunnel

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 2) are met.

1. Patient has
  - a) Mild or moderate symptoms after 6 months of conservative management which includes:
    - i. Steroid injections over 6 months (maximum 2 injections)

**AND**

  - ii. Nocturnal splinting used for at least 8 weeks
- OR**
- b) Severe signs/symptoms significantly interfering with activities of daily living\* (e.g.: severe sensory blunting, muscle wasting, weakness on thenar abduction)
- OR**
- c) Neurological deficit or median nerve denervation

### AND

2. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration
- NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

### **Rationale for the policy**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

There are a relatively large numbers of patients with mild to moderate CTS, however the majority of these cases will resolve with the aid of conservative treatment within six months. Annual incidence of 139 cases per 100,000 females and 67 per 100,000 males. CTS is more common in middle age (older than 40 years) and in women (during pregnancy and menopause).

Untreated Carpal Tunnel Syndrome has been shown to resolve or significantly improve in up to 49% of cases. Non-surgical treatment, including oral steroids, splinting, ultrasound, yoga and carpal bone mobilisation show short-term benefit compared with placebo or other non-surgical interventions.

Conservative treatment is preferred in mild to moderate cases and surgical treatment is mainly applied in severe cases including nerve denervation. Surgical treatment is indicated in cases where initial conservative management has failed. Corticosteroid injection has been shown to be effective at one month, but the effect decreases by 30% at one year.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also make sure that they supply all the relevant information regarding the grading of the severity of carpal tunnel syndrome, as well as the conservative treatment attempted (i.e. steroid injections and/or wrist splinting).

### **Grading of Carpal Tunnel Syndrome**

Mild: Intermittent paraesthesia with or without pain that may be nocturnal, or occurs with a certain hand position.

Moderate: Paraesthesia that interferes with activities of daily living or causes constant night waking; and/or reversible numbness and/or pain (perhaps by clenching and unclenching of fist or hand shaking).

Severe: Constant numbness or disabling pain with wasting of thenar muscles, and/or weakness of thumb muscles (Abductor Pollicis Brevis and Opponens Pollicis).

Patients with severe symptoms should be referred urgently without attempting conservative therapies.

## 11.2. Surgery for Dupuytren's Contracture (Fasciotomy/fasciectomy)

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria are met in Group 1, 2 or 3.

Group 1: Criteria (1 – 2) must be met

1. Patient is unable to put hand flat on the table

**AND**

2. Patient has

a) Proximal interphalangeal joint contracture of at least 30°

**OR**

b) Metacarpophalangeal joint contracture of at least 30°

*NB. The name and the angle of the joint contracture will need to be provided on the Tickbox form.*

Group 2: Criterion 3 must be met

3. Patient has at least 10° loss of extension in 2 or more joints

*NB. The names and the angle of the joint contractures will need to be provided on the Tickbox form.*

Group 3: Criteria (4 – 6) must be met

4. Patient has

a) Proximal interphalangeal joint contracture of at least 30°

**OR**

b) Metacarpophalangeal joint contracture of at least 30°

*NB. The name and the angle of the joint contracture will need to be provided on the Tickbox form.*

**AND**

5. Patient has **ALL** the following risk factors for aggressive progression

- a) Bilateral disease
- b) Family history of the condition
- c) Ectopic lesion
- d) Sex : male
- e) Age : Under 50 years of age.

**AND**

6. Patient has severe symptoms significantly interfering with activities of daily living\*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

Please note

SWL CGs do not routinely fund radiation therapy for Dupuytren's Contracture.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Symptoms of Dupuytren's contracture are often mild and painless and do not require treatment. Disease progression is unpredictable; where the contractures themselves are not functionally limiting management should comprise of reassurance and observation.

Treatment seeks to restore hand function and prevent progression, however the underlying disease will remain. Recurrence following surgical intervention is common, ranging from 30-40% following open partial fasciectomy to 60% following needle aponeurotomy/fasciectomy.

Dupuytren's contracture has a greater tendency for aggressive progression and recurrence after surgical treatment in the presence of 5 factors - bilateral disease, family history of condition, ectopic lesions, age under 50 and male gender.

Surgery should not be considered a cure and patients should be advised of the risks of recurrence when deciding whether to consider surgical intervention

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments.

Treatment for Dupuytren's contracture is usually only required if the condition affects the function of the hand. Many cases are mild and painless and do not require treatment. In such cases management should comprise of reassurance and observation.

Primary care needs to be aware that simple nodules in the palm are not an indication for referral.

Please note

SWL CGs do not routinely fund radiation therapy for Dupuytren's Contracture.



## 11.3. Excision of Ganglia

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria 1 is met

1. Patient has a ganglion causing
- a) Severe pain due to size and location
- OR**
- b) Significantly interfering with activities of daily living\*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Management of ganglia is considered to be a procedure of low clinical value. Ganglia are benign lesions that often spontaneously resolve and which only rarely cause functional problems. The evidence suggests that aspiration is useful for reassurance and where there is diagnostic uncertainty. Injection into the ganglion does not have any advantage over aspiration alone.

Surgery is the treatment of choice for those that are symptomatic.

### Primary care advice

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning symptoms and their duration and the conservative treatments tried including dates where relevant.

Primary care should consider utilising conferral systems such as Kinesis, where primary care can liaise with providers to seek specialist advice if needed.

If there is a suspicion of malignancy patients should be referred via the established cancer referral pathways and are excluded from this policy.

If there are concerns about the diagnosis an ultrasound scan may be required.

Clinicians should consider aspiration as an alternative to excision due to its lower complication rates. If aspiration has not been attempted and there are local minor surgery services referral to these services should be considered.

### Grading and treatment options for ganglion cysts

Mild: An asymptomatic lump.

Treatment is reassurance and observation.

Moderate: Symptomatic lump with a long duration of symptoms **OR** Occult ganglion.

Treatment is reassurance and observation, with aspiration in primary care for reassurance.

Severe: Severe pain due to size or location **OR** Restriction of activities of daily living\*.

Treatment is referral for surgical removal or surgical opinion.

\* 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), *functional mobility* (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).

## 11.4. Surgery for Trigger finger

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

### Clinical threshold

SWL CCGs fund this procedure when at least one of the following criteria (1 – 2) are met.

1. Patient suffers from triggering despite **ALL** conservative management have been attempted

- a) Rest from aggravating activities
- b) Non-steroidal anti-inflammatory drugs for pain control
- c) Splinting
- d) Corticoid steroid injections (maximum of 2 with 10 weeks between the injections)

**OR**

2. Patient has a fixed flexion deformity that cannot be corrected

## **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Spontaneous recovery has been reported in up to 29% of cases. Initial treatment should be conservative involving activity modification, non-steroidal anti-inflammatory drugs for pain control, joint immobilisation (splinting) and corticosteroid injection. Splinting has been shown to have a 55 - 73% success rate.

## **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, concerning conservative treatments and steroid injections in particular.

## **Conservative treatments**

Primary care should ensure that all conservative measures have been attempted prior to referral to specialists.

- Activity modification (i.e. rest from aggravating activities)
- Non-steroidal anti-inflammatory drugs for pain control
- Joint immobilisation (splinting)

Only once the above conservative measures have been attempted and failed over a period of 6 months should primary care provide

- Corticosteroid injections (unless contra-indicated): up to two injections ten weeks apart.

## **Please note**

- Patients with diabetes are less likely to respond to corticosteroid injections.
- Patients who smoke should be encouraged to stop smoking prior to surgery.
- Overweight or obese patients should be encouraged to lose weight prior to surgery.

## 12. Trauma and Orthopedics – Hip

### 12.1. Autologous Chondrocyte Implantation (ACI)

#### Compliance requirement

Providers should be aware that this procedure is not routinely funded in South West London, application only via the IFR process by the treating clinician.

#### Clinical threshold

SWL CCGs do not routinely fund this procedure.

### 12.2. Surgery for hip impingement (Hip arthroscopy)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 6) are met.

1. Patients is skeletally mature at the time of application

*NB: Aged 19 or over and have completed puberty*

**AND**

2. Patient has a positive impingement sign with sudden pain on 90 degree hip flexion with adduction and internal rotation or extension and external rotation

**AND**

3. Patient has severe symptoms significantly interfering with activities of daily living\*

**AND**

4. Patient engaged with conservative therapy for at least 6 months and these **ALL** failed including:

- a) Activity modification (e.g.: restriction of athletic pursuits and avoidance of symptomatic motion)
- b) Pharmacological intervention (e.g.: non-steroidal anti-inflammatory drugs [NSAIDS]), injections of local anaesthetics into the joint)
- c) Physiotherapy

**AND**

5. Patient's diagnosis has been confirmed by appropriate radiological investigation

a) Cam impingement (alpha angle greater than 50 degrees)

**OR**

b) Pincer impingement (center edge angle greater than or equal to 40 degrees)

**OR**

d) Pistol grip deformity (non-spherical femoral head shape)

*NB: Date and modality of the radiological investigation will need to be provided on the Tickbox form.*

**AND**

6. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

Please note

SWL CCGs do not routinely fund the following indications:

- Patients who are a candidate for hip replacement
- Patient with severe hip dysplasia or with a Crowe grading classification of 4
- Patients with osteogenesis imperfecta
- Patients with a joint space that is less than 2.0mm wide anywhere along the sourcil (shadow of dense osseous tissue) on plain radiograph of the pelvis
- Patients who have severe hip dysplasia
- Presence of generalised joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome
- Absence of advanced osteoarthritis change on pre-operative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade III or IV)

SWL CCGs will not routinely fund the following procedures:

- Capsular plication
- Autologous osteochondral mosaicplasty in combination with femoral neck osteochondroplasty
- Labral reconstruction
- If provided as an adjunct to hip impingement surgery:
  - Debridement of trochanteric bursitis
  - Hip microfracture
  - Gluteus medius repair

- Lesser trochanteric resection

SWL CCGs will seek annual confirmation with supporting evidence on the following:

- Any surgeon undertaking this procedure must have completed specialist training and has experience of providing arthroscopic hip surgery and for each case had discussion with a specialist musculoskeletal radiologist.
- Data will be entered for each patient undergoing this procedure to the British Hip Society register (British Hip Society, 2016) to support assessment of long term outcomes as well as undertake local review of cases to monitor safety and short term outcomes.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Hip impingement syndrome is caused by unwanted contact between abnormally shaped parts of the head of the thigh bone and the hip socket. This results in limited hip movement and pain.

Femoroacetabular impingement is characterised by abnormal contact between the femoral head/neck and acetabulum (ball & socket). There are two described types:

- “Cam” impingement is defined as an abnormality of the anterolateral femoral head/neck junction
- “Pincer” impingement is described as over coverage of the acetabulum over the femoral head causing abnormal compressive forces between the rim of the acetabulum and the femoral head/neck during hip movement.

In the majority of cases (86%), cam and pincer forms exist together i.e. “mixed impingement”. The aim of femoro-acetabular surgery is to reduce pain and improve range of movement. It is believed that it may also help prevent hip arthritis in later life, although longer term studies are needed to prove this.

There is limited evidence of clinical and cost effectiveness available for surgical interventions for FAI syndrome. With regard to safety, there are well recognised complications. Open femoro-acetabular surgery for hip impingement syndrome involves major surgery with the potential for serious complications and should only be undertaken by surgeons who are well-trained and highly experienced in this type of procedure. Arthroscopic femoro-acetabular surgery for hip impingement syndrome should only be carried out by surgeons with specialist expertise in arthroscopic hip surgery.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate MSK services.

Primary care must also ensure that they supply the all the relevant information to MSK or T&O services, particularly concerning conservative treatments. Conservative treatments should be documented in the patient’s primary care record, or via Musculoskeletal Services’ letters, or other clinic letters and provided with any referrals to secondary care.

Prior to referral for consideration of surgery, primary care should ensure that the patient has fully engaged with conservative therapy for at least 6 months including all of the following:

- Activity modification (e.g., restriction of athletic pursuits and avoidance of symptomatic motion)
- Pharmacological intervention (e.g. nonsteroidal anti-inflammatory drugs [NSAIDS]), injections of local anaesthetics into the joint)

- Physiotherapy.

### 12.3. Hip replacement surgery

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. Patient is
- a) Suffering from intense or severe persistent pain with moderate or severe functional impairment as measured by the classification system below\*
- OR**
- b) In immediate danger of losing their independence due to severe persistent pain and the joint replacement would prevent this
- OR**
- c) At risk of destruction of their joint of such severity that delaying surgical correction would increase the technical difficulties of the procedure
- OR**
- d) Diagnosed as suffering from end-stage osteoarthritis confirmed by appropriate radiological investigation\*.

**AND**

2. Patient engaged with conservative therapy for at least 6 months and these failed
- NB: Patients with end-stage osteoarthritis should proceed to surgery without attempting conservative treatments.*

**AND**

3. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration
- NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

\* See Appendix

Please note

SWL CCGs do not routinely fund specialist custom hip prosthesis.

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Patients with lower than severe pain or lower than severe functional impairment should be treated conservatively as evidence assessed by NICE found that hip replacement was not the most effective treatment for this group of patients. Shared decision making taking account of severity of pain and functional impairment is of key importance in deciding the most appropriate time for surgery.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to MSK or T&O services, particularly concerning conservative treatments. Conservative treatments should be documented in the patient's primary care record, or via Musculoskeletal Services' letters, or other clinic letters and provided with any referrals to secondary care.

### **Conservative treatments**

Primary care should ensure that ALL of the following conservative measures are attempted over a period of 6 months prior to referral for hip replacement surgery:

- Weight reduction where appropriate, particularly when the patient has a BMI greater than 35.
- Education and self-management such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes.
- Non-pharmacological management such as biomechanical interventions, physiotherapy and exercising to improve local muscle strength and general aerobic fitness (note: physiotherapy is ineffective in bone on bone osteoarthritis).

Management with medication including where appropriate oral/topical nonsteroidal anti-inflammatory drugs [NSAIDS] and paracetamol based analgesics (COX-2 Inhibitor of NSAIDS). Opioid analgesics can be used effectively if paracetamol or NSAIDS are ineffective or poorly tolerated.

### **Oxford score**

The Oxford Hip Score may be used in primary care to guide clinicians whether to make a referral to specialist or not. Patients with a score of 20 or more could be considered for referral. However, it is not a validated tool and should not be used to make the final decision on hip replacement.

See: [http://www.orthopaedicscore.com/scorepages/oxford\\_hip\\_score.html](http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html). Similarly, the tables given in the Appendix below may help patients and clinicians to classify pain and functional impairment in order to judge whether it is the appropriate time to refer a patient to secondary care.



## Appendix: Classification systems for hip

Pain Levels - at least one of following is met in any category

### *Slight*

- *Sporadic pain.*
- *Pain when climbing/descending stairs.*
- *Allows daily activities to be carried out (those requiring great physical activity may be limited).*
- *Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.*

### *Moderate*

- *Occasional pain.*
- *Pain when walking on level surfaces (half an hour, or standing).*
- *Some limitation of daily activities.*
- *Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.*

### *Intense*

- *Pain of almost continuous nature.*
- *Pain when walking short distances on level surfaces or standing for less than half an hour.*
- *Daily activities significantly limited.*
- *Continuous use of NSAIDs for treatment to take effect.*
- *Requires the sporadic use of support systems walking stick, crutches).*

### *Severe*

- *Continuous pain.*
- *Pain when resting.*
- *Daily activities significantly limited constantly.*
- *Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.*
- *Requires more constant use of support systems (walking stick, crutches).*

Source: <https://www.aetnabetterhealth.com>

Functional Impairment - at least one of following is met in any category

### *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 or none of the normal activities and self-care*
- *Walking capacity of between thirty minutes to an hour*
- *Aids such as a cane are needed*

*Severe*

- *Largely or wholly incapacitated*
- *Walking capacity of less than half hour or unable to walk or bedridden*
- *Aids such as a cane, a walker or a wheelchair are required*

Source: <https://www.aetnabetterhealth.com>

Radiographic evidence of severe osteoarthritis of hip

a) 2 or more of the following:

- *Ubchondral cysts*
- *Subchondral sclerosis*
- *Periarticular osteophytes*
- *Joint subluxation*
- *Bone on bone articulation or joint space narrowing) of hip joint*

**OR**

b) *Avascular necrosis (osteonecrosis) with stage III collapse of the femoral head*

**OR**

c) *Rheumatoid arthritis (joint space narrowing)*

Source: <https://www.aetnabetterhealth.com>

## 13. Trauma and Orthopedics - Knee

### 13.1. Knee arthroscopy (including knee washout)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 2) are met.

1. Patient has/needs
- a) Loose body that has not responded to at least 6 months of conservative treatment
- OR**
- b) Loose body with locking
- OR**
- c) Meniscal repair or partial meniscectomy for traumatic meniscal tears
- OR**
- d) Degenerative meniscal tears causing mechanical locking that has not responded to at least 3 months of conservative treatment
- OR**
- e) Ligament reconstruction/ repair (including lateral release) that has not responded to at least 3 months of conservative treatment
- OR**
- f) Detailed understanding of the degree of compartment damage because imaging was inadequate (e.g.: considering patients for certain surgical interventions such as high tibial osteotomy)

**AND**

2. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration
- NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

Please note

SWL CCGs do not routinely fund the following procedures:

- Routine lavage (knee washout), except in cases of mechanical locking of the knee due to loose bodies
- Procedures restricted by NICE, e.g. knee meniscus replacement with biodegradable scaffold mosaicplasty, autologous chondrocyte implantation and trochleoplasty for patellar instability
- Debridement, except in cases where there is mechanical locking

- Use as a diagnostic tool, except in cases where there is on-going diagnostic uncertainty following both clinical examination and non-invasive imaging procedures (e.g.: MRI) conducted by specialists

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to MSK or T&O services, particularly concerning conservative treatments. Conservative treatments should be documented in the patient's primary care record, or via Musculoskeletal Services' letters, or other clinic letters and provided with any referrals to secondary care.

### **Referral for specialist consultation**

Prior to referral to specialist consultation conservative treatment options must be tried for 12 months.

Conservative treatments include the following:

- Lifestyle advice
- Optimum pharmacological treatments
- Self-, or physiotherapy-guided mobilisation and strengthening exercises

Patients with mechanical locking or symptoms that worsen with conservative treatment, should be referred after shorter periods of conservative treatment.

### **MRIs**

Referral for MRI scans should only be made by secondary care consultants or specialists working in CCG-commissioned MSK services.

Primary care should also utilise conferral systems, such as Kinesis where primary care can liaise with providers, to seek specialist advice if needed.

## 13.2. Knee replacement surgery

### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 3) are met.

1. Patient has
- a) Intense or severe persistent pain with moderate or severe functional impairment when compared to the classification system\*
- OR**
- b) Significant instability of the knee joint with severe functional impairment\*
- OR**
- c) Radiological features of severe disease with moderate functional impairments\*
- OR**
- d) Radiological features of moderate disease with severe functional impairment or instability of the knee joint\*

**AND**

2. Patient engaged with conservative therapy for at least 6 months and these failed

**AND**

3. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

\* See Appendix

Please note

SWL CCGs do not routinely fund Patellar Resurfacing as a stand-alone procedure.

### Rationale for the clinical threshold

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure.

Evidence from the Musculoskeletal National Service Framework (NSF), NICE, the GP Training Network and the National Institute of Health (NIH) Consensus Panel suggests that management of common musculoskeletal problems, including knee pain, should ideally be undertaken in primary care. Patients should be referred for a specialist opinion on total joint replacement when prolonged use of all conservative means has failed to alleviate the patient's pain and disability. This initial non-surgical management of knee pain due to osteoarthritis (OA) may include (as appropriate for the individual patient) weight reduction, activity modification, patient specific exercise programmes, adequate doses of NSAIDs and analgesics, joint

injection, walking aids, home adaptations, curtailment of inappropriate activities and other forms of physical therapies. Total knee replacement (TKR) is most commonly performed for knee joint failure caused by osteoarthritis (OA); other indications include rheumatoid arthritis (RA), juvenile rheumatoid arthritis, osteonecrosis and other types of inflammatory arthritis. The aims of TKR are relief of pain and improvement in function. TKR can be very successful for carefully selected patients with over 90% of TKRs still in place and functioning well at 10 to 15 years after surgery. However, optimum selection of patients is uncertain, a wide range of conservative measures may be effective in alleviating symptoms in the majority of patients affected by osteoarthritis. Hence, shared decision making taking account of the patient's severity of pain and functional impairment is of key importance in deciding the most appropriate treatment option including surgery.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate service.

Primary care must also ensure that they supply the all the relevant information to MSK or T&O services, particularly concerning conservative treatments. Conservative treatments should be documented in the patient's primary care record, or via Musculoskeletal Services' letters, or other clinic letters and provided with any referrals to secondary care.

### **Conservative treatments**

Primary care should ensure that ALL of the following conservative measures are attempted over a period of six months prior to referral for knee replacement surgery:

#### **Medication**

- Optimum tolerated doses of analgesic should be used and patients should have gained an understanding of how to use oral or topical analgesics (Paracetamol, NSAIDs or Opioid analgesics).
- Intra-articular corticosteroid injections should be considered as an adjunct to analgesia.

#### **Physiotherapy**

- NICE "core" treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy must have been given.
- Patient Education and Orthosis
- Patient education such as elimination of damaging influence on knees (by reducing weight loading), activity modification (avoid impact and excessive exercise) and lifestyle adjustment.
- Patients must have been advised about, and/or assessed for, clinically appropriate walking aids and home adaptations.

#### **Lifestyle improvement**

- It is strongly advised to reduce BMI to less than 35 kg/m<sup>2</sup> as this may reduce complications and improve outcomes. Patients with a BMI greater than 35 kg/m<sup>2</sup> should be routinely offered referral to a weight management service to reduce these risks.
- Smoking: Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services.

- Non-pharmacological management such as biomechanical interventions, physiotherapy and exercising to improve local muscle strength and general aerobic fitness (note: physiotherapy is ineffective in bone on bone osteoarthritis).

#### Oxford score

The Oxford Hip Score may be used in primary care to guide clinicians whether to make a referral to specialist or not. Patients with a score of 20 or more could be considered for referral. However, it is not a validated tool and should not be used to make the final decision on hip replacement.

See: [http://www.orthopaedicscore.com/scorepages/oxford\\_hip\\_score.html](http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html) . Similarly, the tables given in the Appendix below may help patients and clinicians to classify pain and functional impairment in order to judge whether it is the appropriate time to refer a patient to secondary care.

## Appendix: Classification systems for knee

Pain Levels - at least one of following is met in any category

### *Slight*

- *Sporadic pain.*
- *Pain when climbing/descending stairs.*
- *Allows daily activities to be carried out (those requiring great physical activity may be limited).*
- *Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects.*

### *Moderate*

- *Occasional pain.*
- *Pain when walking on level surfaces (half an hour, or standing).*
- *Some limitation of daily activities.*
- *Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.*

### *Intense*

- *Pain of almost continuous nature.*
- *Pain when walking short distances on level surfaces or standing for less than half an hour.*
- *Daily activities significantly limited.*
- *Continuous use of NSAIDs for treatment to take effect.*
- *Requires the sporadic use of support systems walking stick, crutches).*

### *Severe*

- *Continuous pain.*
- *Pain when resting.*
- *Daily activities significantly limited constantly.*
- *Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.*
- *Requires more constant use of support systems (walking stick, crutches).*

Source: <https://www.aetnabetterhealth.com>

Functional Impairment - at least one of following is met in any category

### *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 or none of the normal activities and self-care*
- *Walking capacity of between thirty minutes to an hour*
- *Aids such as a cane are needed*

*Severe*

- *Largely or wholly incapacitated*
- *Walking capacity of less than half hour or unable to walk or bedridden*
- *Aids such as a cane, a walker or a wheelchair are required*

Source: <https://www.aetnabetterhealth.com>

Grade of radiological findings

Slight	Ahlbach Grade I
Moderate	Ahlbach Grade II and III
Severe	Ahlbach Grade IV and V

## 14. Vascular

### 14.1. Manual Lymphatic Drain (MLD)

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Clinical threshold

SWL CCGs do not routinely fund this procedure.

### 14.2. Surgery for Varicose Veins

#### Compliance requirement

Prior Approval must be obtained by the treating clinician. This must include details of how the patient meets the criteria as specified on the Prior Approval Tick Box Form.

#### Malignancy

If there is any suspicion of malignancy, patients should be referred immediately to the appropriate service. See NICE Clinical Guideline 27: Referral Guidelines for Suspected Cancer (NICE 2005). Available at: <http://www.nice.org.uk/guidance/CG27>

#### Clinical threshold

SWL CCGs fund this procedure when all of the following criteria (1 - 4) are met.

1. Patient has confirmed varicose veins
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**AND**

2. Patient had a duplex ultrasound that shows truncal reflux <i>NB. Date of duplex ultrasound that shows truncal reflux will need to be provided on the Tickbox form.</i>
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**AND**

3. Patient has at least one of the following: a) Primary or recurrent varicose veins causing significant functional impairment that impacts on activities of daily living* (Venous Clinical Severity Scoring of 9 or more is also accepted) <b>OR</b> b) Skin changes including: varicose eczema, lipodermatosclerosis or a venous ulcer, which took over 2 weeks to heal <b>OR</b> c) At least two episodes of superficial thrombophlebitis <b>OR</b> d) A major episode of bleeding from the varicosity
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## AND

4. Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

*NB: It is recommended that the SWL Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided.*

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

Please note

SWL CCG do not routinely fund the following:

- Patients with no symptoms or skin changes associated with venous disease
- Patients whose concerns are cosmetic including telangiectasia and reticular veins
- Patients with mild symptoms including itch, ache, mild swelling, minor changes of skin eczema and haemosiderosis
- Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out

### **Rationale for the clinical threshold**

This policy has been developed to ensure that resources are targeted at those with the greatest clinical need. In addition, this policy aims to reduce the variation in access to this procedure in line with [NICE guidelines CG168](#)

The prevalence of significant venous incompetence is around 40% in men and 32% in women with up to 80% people having minor venous abnormalities<sup>2</sup>. Risk factors for developing varicose veins include two or more pregnancies, obesity (women only) and work that involves prolonged standing<sup>3</sup>.

Venous symptoms include pain limiting normal activity, eczema with progressive skin changes, phlebitis, bleeding and, if untreated, venous ulceration. 1% of the adult population have active leg ulceration, most of which is due to underlying venous disease.

Symptomatic varicose veins are defined as those that are significantly affecting the individual's activities of daily living\* including their ability to work or provide care.

### **Primary care advice**

Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service.

Primary care must also ensure that they supply the all the relevant information to secondary care, particularly concerning conservative treatments including dates and modalities of treatments.

## Conservative treatment

Patients should have received 6 months of conservative treatment (listed below) before referral and will not normally be accepted for interventional treatment without evidence that conservative treatment has failed.

- Patients should lose weight loss if their BMI is raised
- Taking up light to moderate exercise
- Avoidance of prolonged immobility
- Patients should also be advised to stop smoking – in particular, patients with thrombophlebitis

## Grading of varicose veins

There are seven grades of increasing clinical severity listed below. For the initial assessment of a patient, the clinical severity assessment can be simple observation and does not need special tests.

- C0 No evidence of venous disease
- C1 Superficial spider veins reticular veins only
- C2 Simple varicose veins only
- C3 Ankle oedema of venous origin (not foot oedema)
- C4 Skin pigmentation in the gaiter area (lipodermatosclerosis, varicose eczema)
- C5 A healed venous ulcer
- C6 An open venous ulcer

## Pregnancy

Particular attention should be paid to the conservative management of varicose veins in primary care during pregnancy. So in addition to the conservative management listed above these should be considered.

- Give pregnant women presenting with varicose veins advice on varicose veins
- Do not carry out interventional treatment for varicose veins during pregnancy
- Consider compression hosiery for symptom relief

## Referral to vascular services

Patients should be referred to vascular services when patients have at least one of these:

- At least two episodes of superficial thrombophlebitis
- A major episode of bleeding from the varicosity
- Primary or recurrent varicose veins significantly impacting on the patient's Quality of Life. Evidence of this must be documented through VCSS score (9 or more) or substantial negative impact on activities of daily living\*
- An active ulcer
- Skin changes including: eczema, lipodermatosclerosis or a healed venous ulcer

*\* For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

Please note

SWL CCG do not routinely fund the following:

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- Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out.