## Service Restriction Policy

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<th>Version:</th>
<th>June 2014</th>
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| Ratified by: | South Essex CCGs  
Basildon & Brentwood (BB), Castle Point & Rochford (CP&R), Southend and Thurrock |
| Date ratified: | |
| Name/Department/Sponsor/Author | Tom Abell – Chief Officer BB CCG  
Paul Husselbee – Accountable Officer, Southend CCG  
Sunil Gupta – Accountable Officer, CP&R CCG |
| Name/Title of responsible committee/individual: | BB CCG: Joint Clinical Executive Group.  
CP&R CCG : Quality & Governance Committee  
Southend CCG: Clinical Executive Group  
Thurrock CCG: QIPP Board, |
| Date issued: | 22<sup>nd</sup> April 2014 |
| Review date: | March 2015  
Specific policy statements may be reviewed within year as part of an agreed process |
| Target audience | GPs, Optometrists, Dentists, Secondary Care consultants, Central Referral Services, community services, patients |
Document Summary

The policy of Basildon and Brentwood CCG, Castle Point and Rochford CCG, Southend CCG and Thurrock CCG (referred to hereafter as ‘The south Essex CCGs’) is that treatments/interventions/procedures not currently included in commissioned established care pathways (as identified for example in the schedules to the service agreements with acute care providers) or identified for funding through the commissioning process, are not routinely funded. For a number of commissioned interventions the South Essex CCGs have specific policy statements setting out restrictions on access, based on evidence of effectiveness or relative priority for funding. Those related to treatments/interventions/procedures are included within this document; those relating to prescribing can be found on the Medicines Management page of each CCGs website:

- Brentwood and Basildon CCG: http://www.basildonandbrentwoodccg.nhs.uk/
- Castle Point and Rochford CCG: https://www.castlepointandrochfordccg.nhs.uk/
- Southend CCG: http://www.southendccg.nhs.uk/
- Thurrock CCG: http://www.thurrockccg.nhs.uk/

Policy development is an on-going process and future policy on further treatments as developed or in response to NICE Guidance/Guidelines, health technology assessments etc. will be produced and published periodically, and the south Essex CCG’s will review and update the policy as required at a minimum of annually.

This policy sets out the access/approval guidance for treatments/ interventions/ procedures where there is specific policy guidance in place.

The access/approval route may vary between localities across south Essex, however, this is variation in the process of applying this policy only and does not represent any variation in the policy itself.

The ICD10 & OPCS codes for each of the procedures named in this policy can be found in Appendix 5. Providers should contact commissioners should they be under any doubt as to which procedures are included within the scope of this policy.

**Threshold Approvals**

Those that are commissioned by the south Essex CCGs on a routine basis where patients meet the defined criteria set out within this policy, and for which individual prior approval is **not** required. CCG notification of compliance or audit will be required according to contractual arrangements. Providers should be aware that payment will be withheld where they cannot demonstrate that patients treated meet the criteria specified in this policy.
**Individual Prior Approvals**

Those that are commissioned by south Essex CCGs but only for patients who meet the defined criteria set out within this policy and which require individual prior approval on a patient by patient basis, e.g. Spinal Cord Stimulators.

For these procedures, the criteria listed form guidance to both the referring and treating clinicians. If a patient is deemed to meet these criteria, prior approval must also be sought (Prior Approval Forms see Appendix 1).

**Not Funded**

Those which have been assessed as Low Clinical Priority by the south Essex CCGs and which will not be funded unless there are **exceptional clinical circumstances**. Applications for funding for these procedures can be made to the Individual Funding Request team, where the patient demonstrates true clinical exceptionality.

**Individual Funding Requests (IFR)** - The south Essex CCGs allow patients the opportunity to make specific funding requests via the Individual Funding Request team. Requests may include conditions for which the south Essex CCGs do not have an agreed policy, including patients with rare conditions and whose proposed treatment is outside agreed service agreements. In instances in which eligibility is unclear the final decision is made through an application to the Individual Funding Requests team by contacting them at:

**fundingrequests.south@nhs.net**

The Individual Funding Request policy and application forms can be found in the following appendices:

- Appendix 3.1 – for referring Consultants
- Appendix 3.2 – for referring Community Providers
- Appendix 3.3 – for referring GPs.

**The responsibility for adherence to the Service Restriction Policy lies with the referring and treating clinicians. Failure to adhere to these criteria will result in non-payment of the activity.**

All patients being referred for non-urgent elective surgery and who are smokers should be referred to smoking cessation services at the initial referral/assessment/appointment.

There is strong clinical evidence that obese patients undergoing surgery are at significantly higher risk of getting infections and suffering heart, kidney and lung problems than people who are a healthy weight. Obese patients may have to spend more time in hospital recovering and risk of dying as a result of surgery is higher compared to patients with a healthy weight. Overweight and obese patients should be strongly encouraged to lose weight before their operation.
Equality Impact Assessment (EIA) - (Appendix 4)

The Service Restriction Policy has been assessed.

What has been done to promote equality in the SRP and how will this be evaluated and how effective this has been?
Clinical engagement and Public Health have with Medicines Management been instrumental in developing the Policy document.

The evaluation of how successful this has been will be monitored by the level of clinical challenge that is received. Whilst it is recognised that individuals may challenge some of the criteria it is hoped that from the extensive engagement in developing the policy it does reflect clinical practice and current evidence. Those areas that through this process still have equality impact i.e. fertility have been prioritised as an area for further review.

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### Policy statement: Abdominoplasty or Apronectomy

**Status:** Threshold Approval

South Essex CCGs do not routinely commission abdominoplasty or apronectomy. Funding may be considered on a restricted basis for patients who meet the following criteria:

**A** Where it is required as part of abdominal hernia correction or other abdominal wall surgery

**OR**

**B** Those patients from the following groups who have significant abdominal aprons as a result of weight loss and have severe functional problems*:
- Patients with excessive abdominal folds who had an initial BMI > 40 and have achieved a reduction in BMI < 25 and have maintained the BMI < 25 for at least 2 years.
  **OR**
  - Patient with excessive abdominal folds who have an initial BMI > 50 and have achieved a minimum drop of 20 BMI points and have maintained this BMI (reduction of a minimum of 20 points) for at least 2 years.

*Severe functional problems include, but are not limited to:*
- Recurrent intertrigo beneath the skin fold that re-occurs or fails to respond despite appropriate medical therapy for at least 6 months.
- Abdominal wall prolapse with proven urinary symptoms.
- Problems associated with poorly fitting stoma bag.
- Patient is experiencing severe difficulties with daily living i.e. ambulatory restrictions.

**Patient Information:**

**References:**

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### Policy statement: Acne (Mild to Moderate) Vulgaris

**Status:** Not Funded

The treatment of mild to moderate acne vulgaris should be provided in primary care. Severe acne, that is acne unresponsive to prolonged courses of oral antibacterials, or with scarring, or acne associated with psychological problems should be referred to a consultant dermatologist.

Resurfacing procedures can be undertaken under the NHS for severe facial post-acne by the plastic surgery service once the active disease is controlled. All resurfacing techniques,
including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring, including post-surgical and severe acne scarring once the active disease is controlled.

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Acupuncture is commissioned in accordance with NICE Guidance

**Patient Information:**
http://www.nhs.uk/conditions/Acne/Pages/Introduction.aspx

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For policy see Grommets.

**Patient Information:**
http://www.nhs.uk/conditions/adenoids-and-adenoidectomy/Pages/Introduction.aspx

NHS funding will only be available in the following circumstances:

- Pathological abnormalities.
- Anatomical abnormalities in children <19 years, likely to cause impairment of normal emotional development.
- Correction of post traumatic bony and soft tissue deformity of the face.

**Rhinoplasty**

Rhinoplasty is funded on a restricted basis only. Before proceeding except in instances of trauma or where patients are being treated as an emergency, referring and treating clinicians must:
For south east Essex – obtain individual prior approval.
For south west Essex – ensure thresholds are met.

Requests for Rhinoplasty may be considered for the following indications:

- Significant post-traumatic nasal injury causing functional impairment. **OR**
- Correction of complex congenital conditions e.g. cleft lip and palate. **OR**
- Part of reconstructive head and neck surgery.

Policy statement: Allergy disorders – Unconventional Treatment

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Only standard treatments with evidence of clinical effectiveness will be funded under the NHS. These include allergen avoidance, drugs and immunotherapy. Unconventional approaches to the management of allergy disorders should not be funded. These include clinical ecology, acupuncture, homeopathy, hypnosis, ionisation and herbal medicine.

Policy statement: Alopecia

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For policy see Hair Transplantation.

Patient Information: http://www.nhs.uk/conditions/hair-loss/Pages/Introduction.aspx

Policy statement: Apnoea

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For policy see Sleep Studies.

Policy statement: Arthroscopy – knee, hip, shoulder

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Arthroscopy is commissioned by south Essex CCGs on a restricted basis

Knee
Cases for knee arthroscopy will only be funded if they meet the criteria below:
- Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic reason) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee arthroscopy can therefore be carried out for:
- Removal of loose body
- Meniscal repair or resection / repair of chondral defects
- Ligament reconstruction/repair (including lateral release)
- Synovectomy/symptomatic plica
- To assist selection of appropriate patients for unicompartmental knee replacement

Knee arthroscopy should **NOT** be carried out (and will not be funded) for any of the following indications:
- Investigation of knee pain (MRI is a less invasive alternative for the investigation of knee pain)
- Treatment of osteoarthritis including arthroscopic washout and debridement.
- In line with NICE guidance CG59; this should not be offered as part of treatment for osteoarthritis unless the individual has knee osteoarthritis with a clear history of mechanical locking (not gelling, ‘giving way’)

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Hip
In diagnosis, Hip Arthroscopy (HA) was found to be more sensitive and specific than MRI and MRI arthropraphy. It is useful in patients with chronic (>6m) hip pain who have negative radiological investigations.

Therapeutic HA is indicated for the following:
- Loose bodies Labrum lesions tears, flaps) Septic arthritis – for debridement and lavage

NICE Intervenational Procedure Guidance 213 suggests that arthroscopic femoro-acetabular surgery for hip impingement syndrome should only be used with “special arrangements for consent and for audit or research”. Individual Funding Request should be sought.

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Shoulder
Shoulder arthroscopy will only be funded for patients with adhesive capsulitis (‘frozen shoulder’) if the following treatments have all been tried and failed:

(a) Activity modification
(b) Physiotherapy and exercise programme
(c) Oral analgesics including NSAIDs (unless contraindicated)
(d) Intra-articular steroid injections
(e) Manipulation under anaesthetic

Frozen shoulders or adhesive capsulitis following a fracture WILL be funded as undertaking manipulation under anaesthetic increases the risk of a re-fracture

In the majority of circumstances a clinical examination (history and physical examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination or if there are “red flag” symptoms/signs/conditions then an MRI scan might be indicated.

Red flag symptoms or signs include recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.

Policy statement: Assisted Conception Using IVF/ICS/IUI for infertility

| Status: | Individual Prior Approval - For Individual Prior Approval form, click here |

South Essex CCGS commissions Assisted Conception Using IVF/ICS/IUI for infertility on a restricted basis in line with the East of England Specialised Commissioning Group fertility services commissioning policy http://www.eoescg.nhs.uk/Policies.aspx which has been adopted as policy by south Essex CCGS.

Intrauterine insemination (IUI) is considered a low priority treatment for couples who are mutually eligible for both in-vitro fertilisation (IVF) and IUI.

Pre-implantation Genetic Diagnosis (PGD)
This policy does not include pre-implantation genetic screening as it is not considered to be within the scope of fertility treatment. This service is the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link: http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/
References:
1. Human Fertilisation and Embryology Authority (HFEA)
   http://www.hfea.gov.uk/3478.html

Patient Information:
Infertility Network- http://www.infertilitynetworkuk.com/

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See PRP

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The south Essex CCGs will not fund Autologous Cartilage Transplantation unless there are exceptional circumstances (via IFR)

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Patients will only be considered for surgery if the patient fulfils the criteria for treatment as per NHS England’s Clinical Commissioning Policy: Complex & Specialised Obesity Surgery, www.england.nhs.uk/wp-)content/uploads/2013/04/a05-p-a.pdf released April 2013, AND

- Previously been referred to the specialist multidisciplinary obesity service provider (Tier 3 weight management),
- Completed at least 80% of the sessional contact time with the Tier 3 specialist multidisciplinary obesity service provider during the 12 month intervention.

Please note: The NHS England complex obesity surgery policy states that bariatric surgery should not be commissioned for children under 18 years. Such cases will be reviewed on an exceptional treatment case basis by the NHS England Individual Funding Request panel.
South Essex CCGs do not commission removal or treatment of clinically benign skin lesions/conditions for purely cosmetic reasons.

N.B. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to appropriate setting for assessment – this may be a 2 week wait clinic (for suspected melanoma/Squamous Cell Carcinoma).

Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing.

Lesions included in this policy include:

- Benign pigmented naevi (moles)
- Comedones
- Corn/callous
- Dermatofibromas (skin growths)
- Lipomas
- Milia
- Molluscum contagiosum
- Sebaceous cysts (epidermoid and pilar cysts)
- Xanthelasma (cholesterol deposits underneath the skin),
- Neurofibromata
- Seborrhoeic keratoses (benign skin growths, basal cell papillomas)
- Skin tags including anal tags
- Spider naevus (telangiectasia)
- Thread veins
- Warts and plantar warts
- Xanthelasma (cholesterol deposits underneath the skin),

South Essex CCGs commission the removal of benign skin lesions on a restricted basis only. This applies to GPs providing Directed Enhanced Services for Minor Surgery under GMS/APMS/PMS contracts as well as secondary care consultants. Practices should not submit, and the CCG reserves the right not to fund, claims for procedures that would be classified as exclusions under this service restriction policy.

Individual prior approval must be obtained before referral to secondary care in all circumstances other than where a patient meets criteria A below.

A. Threshold Approval
If a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an appropriate service for removal.

B. Individual Prior Approval
Requests for the removal of benign skin lesions will be considered for:

- Sebaceous cysts where there has been more than one episode of infection.
Lesions which cause functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities.

Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with lesions.

Evidence that previous treatment has been pursued before referral has been made will be required. For those requiring prior approval this evidence must be provided with the request for funding.

### Policy statement: Beta Interferon and Glatiramer for Multiple Sclerosis

| Status: | Funding Responsibility of NHS England |

South Essex CCGs do not commission Beta Interferon and Glatiramer; this is the responsibility of NHS England.

NHS England routinely commissions this.

http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies

### Policy statement: Biological Mesh

| Status: | Not Funded |

See Synthetic Mesh

### Policy statement: Blephoraplasty

| Status: | Threshold Approval |

South Essex CCGs commission blepharoplasty on a restricted basis in patients who meet the following criteria:

**Upper Lid**

This procedure will be funded to correct functional impairment and **not purely for cosmetic reasons**.

**Indications:**

- Impairment of visual fields in the relaxed, non-compensated state. Evidence will be required that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically (to be confirmed by visual fields test).

  OR
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

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**Lower Lid**
This will be funded for correction of ectropion or entropian or for the removal of lesions of the eyelid skin or lid margin.

**Also see related policy for Dysthyroid eye disease**

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The south Essex CCGs do not directly commission Bobath Therapy. Funding will only be granted in exceptional circumstances and applications should be made via the IFR process.

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For policy see Liposuction/Liposculpture.

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South Essex CCGs do not commission BAHAs; this is the responsibility of NHS England.

NHS England routinely commissions unilateral BAHAs for patient’s meeting the commissioning policy but will not normally commission bilateral Bone Anchored Hearing Aid (BAHA) implantation. Such requests for funding will only be considered through an exceptions route.


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South Essex CCGs do not routinely commission Bone Morphogenic Protein. Funding will only be granted in exceptional circumstances and applications should be made via the IFR process.

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Botulinum Toxin A (Botox) will not normally be funded by south east Essex CCGs except for the treatment of spasticity, spasmodic torticollis, hemifacial spasm, cervical dystonias or blepharospasm and chronic migraines.

South east Essex CCGs commission botulinum Toxin A on a restricted basis in patients who meet the following criteria for Chronic Migraine as outlined in Nice Guidelines TA260 http://guidance.nice.org.uk/TA260/Guidance/pdf/English as below:

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

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

For the use of Botulinum Toxin A in hyperhidrosis please refer to the section on Hyperhidrosis / Sweating.

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Breast Asymmetry

Funding will only be considered if there is gross disparity of breast cup sizes i.e. asymmetry where there is at least 2 cup size difference in breast size on initial consultation with the patient’s GP.

The goal of surgery is to correct a significant deformity. Contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any post-surgical cosmetic irregularities will not be funded by the CCGs in revision surgery.

Patients are eligible for surgery to correct breast asymmetry if all the following criteria are met and confirmed by a consultant plastic surgeon:

- There is a natural absence of breast tissue unilaterally where there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra).
- There is a difference of at least 2 cup sizes (e.g. C and DD cup size differential).
- Patient Aged ≥ 18 years old and has reached end of puberty (referral should be delayed if end of puberty has not been reached).
- Where relevant, treatment of the underlying cause of the problem has been undertaken.
- The patient has a BMI<25 and evidence that the patient’s weight has been stable for 2 years.

The choice of surgical intervention (i.e. unilateral breast reduction or unilateral breast augmentation) should be made jointly by the person and the clinician and taking into account:

- The experience of the surgeon who will perform the operation, and
- the best available evidence on effectiveness and long term effects, and
- the facilities and equipment available, and
- Significant musculo-skeletal pain/functional problems.

Patient must be aged at least 18 years. Surgery for patients aged 16 or 17 years will only be funded if breast size has been stable for at least one year, and the referring clinician can satisfy the Individual Funding Request panel that it is unreasonable to wait until the patient is 18 years old.

Breast Augmentation / Breast Reconstruction

Breast augmentation is routinely funded for the following indications:

- Reconstructive following or as part of surgery for breast malignancy or its prevention – Funding Approval not required.
• Congenital amastia (complete absence of breast tissue).

**Breast implants for cosmetic purposes are not funded.** In particular funding is not available for breast augmentation in the case of:
- Small but normal breasts,
- Breast changes following pregnancy or with age.

Patients who have undergone gender reassignment and who request breast augmentation will be considered under the East of England Policy for the Commissioning & Treatment of People with Gender Dysphoria.

**Breast lift / Mastoplexy**

This is included as part of the treatment of breast asymmetry and reduction but not for purely cosmetic/aesthetic purposes such as post-lactational ptosis.

**Breast Reduction**

Breast reduction surgery is regarded as a procedure of a low clinical priority. Cosmetic breast surgery (surgery undertaken exclusively to improve appearance) is not provided to correct natural changes such as those associated with pregnancy or ageing. This procedure is therefore not routinely funded by the CCGs. Breast reduction surgery is an effective intervention that should be funded if one of the following sets of criteria is met:

**CRITERIA SET 1:**
- The patient is suffering from neck ache or backache. Clinical evidence will need to be produced to rule out any other medical/physical problems to cause these symptoms; and the wearing of a professionally fitted brassiere has not relieved the symptoms, 
  and
- Full evidence is provided of all conservative management options that have been attempted, 
  and
- The patient has a BMI < 25 and evidence that the weight has been stable for 2 years, 
  and
- The patient has persistent intertrigo for at least one year and confirmed by GP OR another serious functional impairment for at least one year

**CRITERIA SET 2:**
The patient is male with hormonal or drug related breast growth (Please see Gynaecomastia)

**CRITERIA SET 3:**
Pubertal hyperplasia
- A reduction can be performed if it is expected that at least 500g will be removed from each breast.

Patients who have predictable breast changes due to pregnancy are excluded.
Patients should have an initial assessment by the referrer prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. Assessment of the thorax should be performed, including relevant diagnostics.

**Removal and replacement of breast implants**

South Essex CCGs only commission the removal and replacement of breast implants in the following circumstances:

- Breast implants were provided by the NHS (e.g. as part of treatment for breast cancer).
- OR
- The implant needs to be removed for clinical reasons such as implant rupture (whether the implantation was funded privately or under the NHS).

If privately funded breast implants are required to be removed for clinical reasons, patients will be offered the choice of removing both prostheses in the event that only one has ruptured with the intention of preserving symmetry.

The replacement of privately funded breast implants where removal is clinically required is **not** routinely commissioned.

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**Policy statement:** Brow Lift

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See Aesthetic Facial Surgery

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**Policy statement:** Bunions

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The surgical treatment of asymptomatic bunions is regarded as a procedure of low clinical priority. These procedures are, therefore, are not routinely funded by south Essex CCGs.

Removal of bunions will only be considered where:

- Conservative methods of management* have failed,

and
- The patient suffers significant functional impairment** as a result of the bunions, and
- There is radiographic evidence of joint damage (at point of referral).

*Conservative measures include:
Avoiding high heel shoes and wearing wide fitting leather shoes
Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate

**Significant functional impairment is defined as:
The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.

Concerns about cosmetic appearance should be managed by the patient or Primary Care and not referred into secondary care or a Community Podiatric service.
Detailed documentation against the above criteria that are fulfilled is mandatory in the referral letter to secondary care. Clinically inappropriate referrals will be returned to GPs.
Follow up will be capped at one follow up unless there are exceptional circumstances.

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Policy statement: Caesarean Section (Elective)
Status: Threshold Approval

Elective Caesarean Section procedures will only be considered when one of the following criteria is met:

- Breech presentation.
- Multiple pregnancy.
- Preterm birth.
- Small for gestational age.
- Placenta praevia.
- Morbidly adherent placenta.
- For cephalopelvic disproportion in labour.
- Mother-to-child transmission of maternal infections.
- Maternal request— see NICE.

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Policy statement: Carpal Tunnel

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South Essex CCGs commissions surgery for carpal tunnel syndrome on a restricted basis.
Nerve conduction studies (EMG) are **NOT** generally needed to confirm the diagnosis and are not routinely funded by the south Essex CCGs. In elderly patients the condition may develop insidiously and nerve conduction studies may be useful to assess severity.

Community based conservative treatment should be initiated for **ALL** patients with suspected Carpal Tunnel Syndrome for a period of 6 months, excluding those noted below. Conservative treatment will include the following:

- Analgesia
- Splinting with Futuro-type cock up splint (night time only or constant)
- Steroid injection – should be administered twice prior to referral for consideration of surgery

**All GPs should seek access to carpal tunnel injections in the community**

**Patients with Carpal Tunnel Syndrome should be referred if any of the following criteria apply:**

- Severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, significantly interfering with daily activities.
- Neurological deficit i.e. constant sensory blunting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).
- Unclear diagnosis or dual pathology
- Rheumatoid
- Recent trauma
- Previous surgery

Where applicable, referral letter must detail conservative methods tried and the length of time that each of these was carried out.

Uncomplicated cases who have **NOT** responded to conservative management for 6 months should be referred.

**Rationale:**

Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients’ symptoms may resolve for at least a year after conservative treatment. After corticosteroid injection, up to 50% of patients may report minor or no symptoms at one year. The benefits of conservative therapy are seen early after treatment and then decrease while the benefits of surgery take longer to be fully realised.

Corticosteroid injections and nocturnal splinting are effective conservative therapies. Therefore patients would not normally be referred for carpal tunnel syndrome unless they have had a local steroid injection into the carpal tunnel together with the provision of night splints.

Electro-diagnostic tests are not indicated in the diagnosis of classical carpal tunnel syndrome. These may be done where there is doubt about the diagnosis, which is uncommon.

In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.
A trial of conservative therapy offers the opportunity to avoid surgery for some patients.

**Policy statement: Cataracts**

**Status:** Threshold Approval

Referrals should not be based simply on the presence of a cataract. **Referral of patients with cataracts to ophthalmologists should be based upon the two following indications:**

A: Impairment of lifestyle (not exhaustive list) such as;
- the patient is at significant risk of falls, or
- the patient’s vision is affecting their ability to drive, or
- the patient’s vision is substantially affecting their ability to work, or
- the patient’s vision is substantially affecting their ability to undertake leisure activities such as reading, watching television or recognising faces or
- management of other co-existing eye conditions

and

B: Willingness to have cataract surgery.

The referring optometrist or GP should discuss the risks and benefits using an approved information leaflet (national or locally agreed) and ensured that the patient understands and is willing to undergo surgery before referring.

**Second eye**

As the benefits of second eye surgery have been demonstrated patients will be offered second eye surgery provided they fulfil the referral criteria. Second eye surgery should be deemed urgent when there is resultant anisometropia (a large refractive difference between the two eyes of 2 ½ dioptas) which would result in poor binocular vision or diplopia (this should be clearly recorded in the patient’s notes). The reasons why the patient’s vision and lifestyle are adversely affected by cataract and the likely benefit from surgery must be documented in the clinical records. Providers will be audited on the indications for cataract surgery.

**Policy statement: Chalazia (cyst on or in eye lid) / Chalazion**

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Chalazia are benign, granulomatous lesions caused by blockage of the Meibomian gland duct, which will normally resolve within 6 months with conservative management in primary care.
Community excision of Chalazia (where a community service is available / commissioned) will be funded for those patients with Two or more of the following:

- Present for more than six months.
- Present on the upper eyelid.
- Source of regular infection (2 times within six month time frame) requiring medical treatment.
- Interferes with vision.
- Conservative management has been tried & failed and there is no appropriate alternative to surgical intervention.
- The site of the lesion or lashes renders the condition as requiring specialist intervention.

Only the patients meeting the following criteria should be referred to secondary care:

- All children should be referred on.
- Any recurrent chalazion should be referred.
- Any atypical features i.e. lash loss, bleeding should be referred.
- Any patient with previous history of Basal cell carcinoma (BCC) or Squamous cell carcinoma (SCC) or where malignancy is suspected should be referred on.

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See Gall Stones

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Patients should be diagnosed and managed in a community setting. Referral for a specialist opinion may be required if there is doubt about the diagnosis, or the patient is not improving despite management in primary care. Funding for inpatient care will not be provided.

All specialist treatment for chronic fatigue syndrome / myalgic encephalomyelitis (CFS/MS) is accessed through a referral from the patient's clinician to the Essex CFS/ME Service. Patients can be referred for unexplained fatigue lasting at least 4 months once the following alternative diagnosis have been considered and excluded:

- Obesity (BMI _40kg/m2).
- Organ failure.
- Chronic infections.
- Chronic inflammatory diseases.
- Major neurological diseases.
- Systemic treatment for neoplasms.
- Untreated endocrine diseases.
Primary sleep disorders.
- Alcohol/Substance abuse.
- Reversible causes of fatigue (medications, infections or recent major surgery).
- Psychiatric conditions.

CFS/ME is a debilitating disorder characterised by profound tiredness or fatigue. Patients may become exhausted with only light physical exertion. They most often function at a level of activity substantially lower than their capacity before the onset of illness. In addition to these key defining characteristics, patients generally support various non-specific symptoms, including weakness, muscle aches and pains, excessive sleep, malaise, fever, sore throat, tender lymph nodes, impaired memory and/or mental concentration, insomnia and depression.

### Policy statement:

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This policy does not apply to:

Suspected penile malignancy, use the 2 week cancer referral pathway.
Traumatic foreskin injury where it cannot be salvaged.

Male circumcision is defined as the surgical removal of all or part of the foreskin of the penis.

Circumcision is considered a low priority treatment and will only be provided for therapeutic reasons if the patient meets one of the following criteria:

- Phimosis (inability to retract the foreskin due to a narrow prepuceal ring) in children with spraying, ballooning and/or recurrent infection.
- Adult phimosis.
- Recurrent balanitis, balantitis xerotica obliterans (chronic inflammation leading to a rigid fibrous foreskin).
- Paraphimosis ((inability to pull forward a retracted foreskin).
- Suspicion or evidence of malignancy, dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment, where biopsy is required and occasionally for selected patients with urinary tract infections (normally referred by a paediatrician).
- Balanoposthitis (recurrent bacterial infection of the prepuce).

### References:


### Patient Information:
Policy statement: Cochlear Implants

Status: Funding responsibility of NHS England

This service is now the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link: http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/

Policy statement: Complementary and Alternative Therapies

Status: Not Funded

The south Essex CCGs will not fund the following complimentary/alternative therapies unless there are exceptional circumstances (via IFR) because there is insufficient evidence of clinical benefit in selected conditions:

**Acupuncture**

See Acupuncture

**Osteopathy**

- Children with spastic cerebral palsy
- Paediatric dysfunctional voiding
- Adults with Lumber or Cervical pain not warranting surgical referral.
- Adults with large joint pain as part of a care pathway that may lead to joint replacement.

**Biofeedback**, for:

- Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation).
- Irritable bowel syndrome.
- Levator ani syndrome.
- Migraine and tension headaches (muscle, thermal or skin biofeedback);
- Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators).
- Raynaud's disease.
- Refractory severe subjective tinnitus – See Tinnitus.
- Temporomandibular joint (TMJ) syndrome – See TMJ.
- Urinary incontinence.

**Electrical stimulation**

As an adjunct or as an alternative to the use of drugs either in the treatment of acute postoperative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as
appropriate, physical therapy and pharmacotherapy. A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue.

**Selected use in palliative care**
- Mistletoe in cervical cancer.
- Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95).

**Hypnotherapy**
- Severe chronic insomnia.
- IBS.

**Manipulation and Stretching**
- Selected cases of osteoarthritis of the hip as an adjunct to core treatment.
- Sub-acute and chronic low back pain of more than six weeks duration.
- Acute low back pain of less than six weeks.
- Mobilisation of the neck.

**Complementary and Alternative Therapies**

The south Essex CCGs will **NOT** fund the following therapies because of lack of sufficient evidence of effectiveness*:

- Homeopathy
- Aromatherapy
- Herbal remedies
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium Phenylbutyrate
- Antineoplastons -- see CPB 240 - Antineoplaston Therapy and Sodium Phenylbutyrate
- Apitherapy
- Applied kinesiology
- Art therapy
- Autogenous lymphocytic factor
- Auto urine therapy
- Bioenergetic therapy
- Biofield Cancell (Entelev) cancer therapy
- Bioidentical hormones
- Brain integration therapy
- Carbon dioxide therapy
- Cellular therapy
- Chelation therapy for Atherosclerosis -- see CPB 234 - Chelation Therapy
- Chiropractic services
- Chung Moo Doe therapy
- Coley's toxin
- Colonic irrigation
- Clinical ecology
- Active release technique
- Acupressure
- Alexander technique
- AMMA therapy
- Conceptual mind-body techniques
- Craniosacral therapy
- Cupping
- Dance/Movement therapy
- Digital myography
- Ear Candling
- Egoscue method
- Electrodiagnosis according to Voll (EAV)
- Equestrian therapy -- see CPB 151 - Hippotherapy
- Essential Metabolics Analysis (EMA)
- Essiac
- Feldenkrais method of exercise therapy (also known as awareness through movement)
- Flower essence
- Fresh cell therapy
- Functional intracellular analysis (also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing).
- Gemstone therapy
- Gerson therapy
- Glyconutrients
- Graston technique
- Greek cancer cure
- Guided imagery
- Hair analysis - see CPB 300 - Hair Analysis
- Hako-Med machine (electromedical horizontal therapy)
- Hellerwork
- Hoxsey method
- Human placental tissue
- Hydrolysate injections
- Humor therapy
- Hydrazine sulfate
- Hypnosis
- Hyperoxygen therapy
- Immunoaugmentive therapy
- Infratronic Qi-Gong machine
- Insulin potentiation therapy
- Inversion therapy
- Iridology
- Iscador
- Juvent platform for dynamic motion therapy
- Kelley/Gonzales therapy
- Laetrile
- Live blood cell analysis
- Macrobiotic diet
- Magnet therapy
- MEDEK therapy
- Meditation/transcendental meditation
- Megavitamin therapy (also known as orthomolecular medicine)
- Meridian therapy
- Mesotherapy
- Moxibustion (except for fetal breech presentation) - see CPB 135 - Acupuncture
- MTH-68 vaccine
- Music therapy
- Myotherapy
- Neural therapy
- Ozone therapy
- Pfrimmer deep muscle therapy
- Polarity therapy
- (Poon's) Chinese blood cleaning
- Primal therapy
- Psychodrama
- Purging
- Qigong longevity exercises
- Ream's testing
- Reflexology (zone therapy)
- Reflex Therapy
- Reiki
- Remedial massage
- Revici’s guided chemotherapy
- Rife therapy/Rife machine
- Rolfing (structural integration)
- Rubenfeld synergy method (RSM)
- 714-X (for cancer)
- Sarapin injections
- Shark cartilage products
- Telomere testing
- Therapeutic Eurythmy-movement therapy
- Therapeutic touch
- Thought field therapy (TFT) (Callahan Techniques Training)
- Trager approach
- Visceral manipulation therapy
- Whitcomb technique
- Wurn technique/clear passage therapy
- Yoga
Complimentary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and ‘natural’ approach to dealing with a variety of complaints. Attractions include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health. However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered ‘alternative’ or ‘complimentary’ therapies will be considered in the same way. Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services.

Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

Evidence Base
The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS. The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007 and more recent reviews by AETNA are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of research and hundreds of studies.

There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends Acupuncture for up to ten sessions for the treatment of subacute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, subacute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck.

Patient information:
http://www.nhs.uk/Search/Pages/Results.aspx?q=alternative+therapy

References:

Policy statement: Correction of Privately Funded Treatments
Status: Not Funded
Correction of privately funded treatments which are causing clinical problems for the patient will be considered on a case by case basis by the CCGs Individual Funding Request panel.

Policy statement: Cosmetic Surgery – General Principles
Status: Not Funded
Referrals for plastic surgery from both primary and tertiary sources will be assessed in line with the relevant section of the Service Restriction Policy and the clinical evidence provided.

For an authorised first appointment, the Plastic Surgery Specialist to whom the referral is subsequently passed should decide whether the patient would benefit from plastic surgical intervention, and if so, establish that the patient fully understands the risks and benefits of surgery.

All referrals should be assessed for both first Outpatients Department appointments and subsequent procedure appointments, in line with this policy and clinical evidence.

The Mental Health Transformational Delivery Board has recently decided that it does not support commissioning cosmetic surgery to treat mental health symptoms. It concluded that this would be considered a low priority mental health intervention and that there was insufficient evidence to support the effectiveness of the intervention in terms of treating mental health conditions.

Assessment of patients being considered for referral who have an underlying conditions e.g. genetic or endocrine should have had this fully investigated by a relevant specialist prior to the referral to plastic surgery being made.

Surgery should be supported where a patient has been accepted onto an NHS waiting list prior to taking up residence in south Essex, providing the existing clinical evidence has remained the same. Referrals within the NHS for the revision of treatments originally performed outside the NHS will not usually be permitted unless the patient meets the local
criteria for the original treatment. Referrers should be encouraged to re-refer to the practitioner who carried out the original treatment for resolution first where not endangering the health of the individual.

Where a patient has previously had NHS funded treatment, procedures necessary for dealing with complications or an outcome that, because of complications or technical difficulties, has resulted in cosmetic or physical problems that, from a professional point of view, are severe enough to oblige the NHS to fund corrective treatment, should be supported.

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004)), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.

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**Policy statement:** Cosmetic Surgery – Mental Health Grounds

**Status:** Not Funded

Referrals will only be reviewed by the Individual Funding Request panel on an exceptional case basis.

The Mental Health Transformational Delivery Board has recently decided that it does not support commissioning cosmetic surgery to treat mental health symptoms. It concluded that this would be considered a low priority mental health intervention and that there was insufficient evidence to support the effectiveness of the intervention in terms of treating mental health conditions.

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**Policy statement:** Cyberknife

**Status:** Funding Responsibility of NHS England

This service is now the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link: [http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/](http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/)
Policy statement: Dental Procedures
Status: Funding Responsibility of NHS England

This service is now the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link: http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/

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Policy statement: Dilatation and Curettage (D&C) / Hysteroscopy
Status: Threshold Approval

Hysteroscopy will be funded in the investigation and management of heavy menstrual bleeding only when it is carried out:

- As an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive, for example to determine the exact location of a fibroid or the exact nature of the abnormality.
  or
- Where dilatation is required for non-hysteroscopic ablative procedures.
  or
- Hysteroscopy should be considered immediately prior to the ablative procedure to ensure correct placement of the device (unless pre-operative ultrasound assessment has already been undertaken).
  or
- Postmenopausal women who have had a pelvic scan and endometrial biopsy and who present with further bleeding 6 months later should be offered hysteroscopy to be sure no small cancer has been missed without a mandatory preliminary scan.

Dilation and Curettage will **not** be funded in the following circumstances:

- As a diagnostic tool for heavy menstrual bleeding.
  or
- As a therapeutic treatment for heavy menstrual bleeding.

**Rationale:** D&C and hysteroscopy will only be used in line with NICE guidance (CG44, 2007).

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**Patient Information:**
Policy statement: Dupuytren’s Contracture
Status: Threshold Approval

See Minor Hand Conditions

Policy statement: Dysthyroid eye disease / Proptosis
Status: Threshold Approval

Surgery for proptosis is commissioned on a restricted basis.
Funding will be provided to treat proptosis, arising from thyroid disease, as a result of enlargement of muscles in the socket and increased fatty tissue or abnormality of position of eyelid which causes extra exposure to the eye surface.
Surgery will only be offered for abnormality of the eyelid position after artificial tears have been tried for at least 6 months and failed.

Policy statement: Ear Lobes
Status: Not Funded

For policy see Repair of ear lobes.

Policy statement: Ear Wax Removal
Status: Threshold Approval

For policy see Microsuction

Policy statement: Endoscopic laser spinal surgery
Status: Not Funded

The only indications for this spinal surgery to be considered are those from NICE guidance (IPG027, IPG031, IPG061, IPG088, IPG081) and must conform to this guidance i.e. should not be used without special arrangements for audit consent and research.
• IPG027 Laser lumbar disectomy considered when there is nerve compression or persistent symptoms that are unresponsive to conservative treatment. Laser disectomy can be performed when the prolapse is contained. It is one of several minimally invasive surgical techniques which are alternatives to open repair procedures such as open lumbar disectomy or laminectomy.

• IPG031 Endoscopic laser surgery for aminoplasty for chronic back and leg pain from a variety of causes.

• IPG061 Percutaneous endoscopic laser thoracic disectomy is used to treat symptomatic thoracic disc hemiation.

• IPG088 Endoscopic division of epidural adhesions for lower back pain, particularly when radiculopathy (a disorder of the spinal nerve roots) is present.

• IPG081 Percutaneous intradiscal electrothermal therapy for discogenic back pain.

Patients should have a BMI of between 20kg/m2 and 27kg/m2. Evidence will be required that the patient’s weight has been stable for a period of not less than two years.

Rationale: Endoscopic laser spinal surgery for chronic back pain is of unproven benefit. Referral and treatment should only be considered under exceptional circumstances, in settings which meet the requirements of NICE guidance (IPG027, IPG031, IPG061 and IPG088).

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South Essex CCGs commission Exogen ultrasound bone healing system for long bone fracture on a restricted basis in line with NICE guidance Medical Technology Guidance 12 found at:

NICE Medical Technology Guidance 12 found at: guidance.nice.org.uk/mtg12.

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Referral to a hospital consultant for Facet Joint Injections for lower back pain are considered low priority, and will only be provided under the NHS in line with the guidance below.


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These procedures will be considered for the treatment of:

- Congenital face abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery

They will not be available to treat the natural processes of ageing.

---

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Fibroid embolisation/uterine artery embolisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Not Funded</td>
</tr>
</tbody>
</table>

The south Essex CCGs will not fund unless there are exceptional circumstances (via IFR)

---

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Functional Electrical Stimulation (FES) Status</th>
</tr>
</thead>
</table>
Status: Not Funded

South Essex CCGs will fund functional electrical stimulation (FES) for drop foot of central neurological origin only.

Patients should have been assessed by a multidisciplinary team specialising in rehabilitation prior to referral.

Funding is not available for:
- Upper limbs or foot-drop due to lower motor neurone diseases (such as motor neurone disease, polio, Guillain–Barre syndrome, peripheral neuropathy, traumatic injury etc.).
- There is a lack of evidence for FES for shoulder pain, shoulder subluxation or reaching or grasping and so FES will not be funded for these indications.
- Patients who are already receiving treatment will only be considered for on-going funding if the following criteria apply:
  - Documented history of tripping, falling, or gait problems;
  - Patient has a full range of ankle dorsal flexion/good calf tone/absence of severe spasticity and lower limb oedema.

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<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Gall Stones/Cholecystectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>

Cholecystectomy is routinely approved for symptomatic gallstones.

Treatment is not routinely approved for asymptomatic gallstones because the risks of prophylactic cholecystectomy outweigh the benefits.

Asymptomatic gallstones are defined as the presence of gallstones detected incidentally in patients who do not have any abdominal symptoms, or have symptoms that are not thought to be due to gallstones.

The following tables indicate appropriateness of indication versus risk due to patient comorbidity.

**Indications for cholecystectomy:**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Investigative Findings</th>
<th>Comorbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vague Symptoms</td>
<td>Stone in CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Multiple attacks of biliary colic</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Confirmed acute cholecystitis</td>
<td>Stone(s) in GB or CBD or non-functioning GB</td>
<td>No+low</td>
</tr>
<tr>
<td>Suspected acute cholecystitis</td>
<td>Stone(s) in GB or CBD</td>
<td>No+low</td>
</tr>
<tr>
<td>Indication</td>
<td>Investigative Findings</td>
<td>Comorbidity</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Single stone in GB</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Multiple stones in GB, chronic acalculus cholecystitis, or stone in CBD</td>
<td>Med/high</td>
</tr>
<tr>
<td>Vague Symptoms</td>
<td>Stone in GB or chronic cholecystitis</td>
<td>Med+high</td>
</tr>
<tr>
<td></td>
<td>Any</td>
<td>High</td>
</tr>
<tr>
<td>Single attack of biliary colic</td>
<td>Stone(s) in GB or non-functioning GB</td>
<td>High</td>
</tr>
<tr>
<td>Suspected acute cholecystitis</td>
<td>No Stones</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Stones but no complications</td>
<td>High</td>
</tr>
<tr>
<td>Porcelain gall bladder</td>
<td></td>
<td>Med + high</td>
</tr>
<tr>
<td>Silent onset of jaundice</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>Low+med</td>
</tr>
<tr>
<td></td>
<td>Stone in CBD only</td>
<td>High</td>
</tr>
<tr>
<td>Acute pancreatitis with and without appreciable alcohol intake</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>High</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – no significant alcohol intake</td>
<td>No Stones</td>
<td>Med+high</td>
</tr>
<tr>
<td>Acute recurrent pancreatitis – appreciable alcohol intake</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>High</td>
</tr>
<tr>
<td>Incidental cholecystectomy + Asymptomatic</td>
<td>No Stones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Stones in GB only</td>
<td>High</td>
</tr>
<tr>
<td>Long term TPN</td>
<td>Symptoms only</td>
<td>Med + high</td>
</tr>
<tr>
<td></td>
<td>Stones only</td>
<td>Med + high</td>
</tr>
<tr>
<td></td>
<td>Symptoms + stones</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Incidental findings</td>
<td>Med + high</td>
</tr>
<tr>
<td>Asymptomatic cholecystenteric fistula</td>
<td></td>
<td>Med + high</td>
</tr>
</tbody>
</table>

**Exceptions** to this policy could include patients with asymptomatic gallstones and
- Sickle cell disease.
- Calcified 'porcelain' gallbladder or a family history of gallbladder carcinoma immunosuppression, as they would be at higher risk if they develop an infective complication i.e. cholecystitis or cholangitis.

**Policy statement:** Ganglion

<table>
<thead>
<tr>
<th>Status</th>
<th>South east Essex</th>
<th>South west Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual Prior Approval</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>

For policy see Minor Hand Conditions.

**Patient Information:**
http://www.nhs.uk/conditions/excisionofganglion/Pages/Introduction.aspx

**Policy statement:** Gastroelectrical Stimulation

| Status            | Not Funded |

Gastric stimulation / gastroelectrical stimulation is not routinely funded for use in intractable nausea and vomiting from idiopathic or diabetic gastroparesis in accordance with NICE guidance IPG103 which can be found at [http://www.nice.org.uk/Guidance/IPG103](http://www.nice.org.uk/Guidance/IPG103)

**Policy statement:** Gender Dysphoria

| Status                          | Funding Responsibility of NHS England |

This service is now the commissioning responsibility of NHS England, please refer to their specialist service policies held within the attached link: [http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/](http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/)

**Policy statement:** Grommets

| Status            | Threshold Approval |

South Essex CCGs commissions grommet insertion on a restricted basis. Patients will be funded for grommet (ventilation tube) insertion if they meet the following criteria:
- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).

OR

- Children who have had at least 5 occurrences of acute otitis media in the last year with additional complications such as perforations, persistent discharge, febrile convulsions, sensor neural deafness or cochlear implantation.

The persistence of bilateral OME and hearing loss needs to be confirmed over a period of 3 months before surgical intervention will be considered. The child’s hearing should be re-tested at the end of this time. During this active observation period of 3 months, advice on educational and behavioural strategies to minimise the effects of the hearing loss should be offered.

Patients will be considered for funding if they meet one of the following criteria:

- A child with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- Adjuvant adenoïdectomy will not be considered in the absence of persistent and/or frequent upper respiratory tract symptoms in the child.
- Children with Down’s Syndrome or cleft palate, as an alternative to hearing aids for treating persistent bilateral OME with hearing loss (and/or significant impact on child’s developmental, social or educational status).

For children with Down’s Syndrome, the following factors need to be considered before the intervention is offered:

- The severity of hearing loss.
- The age of the child.
- The practicality of ventilation tube insertion.
- The risks associated with ventilation tubes.
- The likelihood of early extrusion of ventilation tubes.

Patient Information Leaflet:
http://www.nhs.uk/conditions/glue-ear/pages/treatment.aspx

References:
2. NICE Clinical Guidance 60, Surgical Management Of OME, by the Collaborating Centre for Women’s and Children’s Health

Policy statement: Gynaecomastia

<table>
<thead>
<tr>
<th>Status</th>
<th>South east Essex</th>
<th>South west Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual Prior Approval</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>
All men have breast tissue and a breast bud. This policy intends to provide treatment for extreme/severe breast contour resulting from true breast development. This policy excludes treatment for excess skin folds in the breast following weight loss.

True gynaecomastia is benign enlargement of male breast tissue. It can be defined as the presence of >2cm palpable, firm, subareolar gland and ductal tissue (not fat) which should be confirmed by ultrasound.

True gynaecomastia will be funded (i.e. true breast tissue is present not just adipose tissue – pseudogynaecomastia). The clinician should ensure that the following are confirmed:

- Breast cancer has been ruled out.
- Testicular cancer has been ruled out.
- Underlying endocrine or liver abnormality has been ruled out.
- The condition is not due to the abuse of drugs with bodybuilding.
- The condition is not a side effect of medication or drugs e.g. spironolactone, cimeditidine, digoxin or cannabis.

Surgery to correct unilateral or bilateral gynaecomastia should be funded if the patient:

- Is post pubertal (stable height for past 6 months).
- Has BMI < 25 kg/m2 with evidence that the patient’s weight has been stable for 2 years.
- Has breast enlargement on at least one side which is Grade III or above using Cordova’s classification system OR has unilateral breast enlargement with a difference of at least 2 grades (e.g. normal and Grade II differential).

Scarring, contour irregularities and moderate asymmetry (including dog-ears, nipple direction or position, breast size and shape disparity) are predictable following surgery. Any post-surgical revision for cosmetic irregularities will not be funded by the CCG.

Applications must include at least 2 colour photographs of the chest. Photographs should go from the top of the chest down to the umbilicus. One should be taken from directly in front of the patient and another at an angle of 45 degrees(e.g. Grades II – IV).

**Patient Information:**

**References:**
Policy statement: Haemorrhoids

Status: Threshold Approval

This policy does not apply to referrals for suspected cancer and acute, profuse rectal bleeding.

Haemorrhoidectomy will be funded for patients with first or second degree haemorrhoids who do not respond to:

- Conservative treatment (e.g. lifestyle changes and pharmacological treatment).
- Other techniques (e.g. rubber band ligation, sclerotherapy, or infra-red photocoagulation).

Haemorrhoidectomy will be funded for patients with third or fourth-degree haemorrhoids that are either too large for other measures or have not responded to them.

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Policy statement: Hair Depilation

Status: Not Funded

Hirsutism/hair depilation is not routinely funded including hair depilation procedures or medication. Hair depilation will only be considered via IFR route.

Suggested Link: Medicine Management

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Policy statement: Hair Transplantation

Status: Not Funded

Hair transplantation, as treatment for alopecia and or chronic pattern baldness will not be funded, regardless of gender. Hair transplantation will only be considered for reconstruction via IFR route. in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma.

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Policy statement: Hernia

Status: Threshold Approval

If emergency treatment is required e.g. strangulation is suspected then the referring clinician should refer the patient.

South Essex CCGs commissions surgical treatment of hernias on a restrictive basis for patients meeting the defined criteria below. This Service Restriction Policy covers the
management of;
  • Inguinal
  • Femoral
  • Umbilical
  • Ventral
  • Incisional hernias

Criteria for referrals/treatment as below:

**Inguinal:**
For asymptomatic or minimally symptomatic hernias, a watchful waiting approach is advocated with informed consent.
Surgical treatment should only be offered when one of the following criteria is met:

  • Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living

  or

  • The hernia is difficult or impossible to reduce

  or

  • Inguino-scrotal hernia

  or

  • The hernia increases in size month on month

  or

  • The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications.

**Femoral:**
All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation

**Umbilical:**
Surgical treatment should only be offered when one of the following criteria is met:

  • pain/discomfort interfering with activities of daily living

  or

  • increase in size month on month

  or

  • to avoid incarceration or strangulation of bowel

  or

  • The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is an increased risk of strangulation and future complications
Incisional:
Surgical treatment should only be offered when BOTH of the following criteria are met:

- Pain/discomfort interfering with activities of daily living

And
Appropriate conservative management has been tried first e.g. weight reduction where appropriate

or

- The patient is currently asymptomatic but works in a heavy manual occupation (for e.g. in removal firms lifting heavy weights) and there is a risk of strangulation and future complications.

Patient Information:
http://www.nhs.uk/conditions/hernia/pages/introduction.aspx

References:

Policy statement: Hip Arthroscopy

<table>
<thead>
<tr>
<th>Status</th>
<th>South east Essex</th>
<th>South west Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual Prior Approval</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>

For policy see Arthroscopy.

Policy statement: Hip Injections

<table>
<thead>
<tr>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Prior Approval</td>
</tr>
</tbody>
</table>

Current evidence on safety and efficacy does not appear adequate to routinely recommend hip injections. On this basis south Essex CCGs only fund Hip injections in the following circumstances:

- Diagnostic aid.
- To introduce contrast medium to the joint as part of hip arthrogram.
- Babies for hip arthrography.
children and adults with inflammatory arthropathy.
Investigation of infection in biological and replaced hips.

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Policy statement: Hip Replacement

<table>
<thead>
<tr>
<th>Status</th>
<th>South east Essex</th>
<th>South west Essex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual Prior Approval</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>

South Essex CCGs commission surgery for hip replacement on a restricted basis.

Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed. South Essex CCGs will only fund hip joint replacement surgery if:

- The patient complains of severe joint pain AND has radiological features of severe disease AND has severe functional limitation irrespective of whether conservative management has been trialled, OR
- The patient complains of severe joint pain AND has radiological features of severe disease AND has minor to moderate functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.
- The patient complains of mild to moderate joint pain AND has radiological features of severe disease AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies AND is assessed to be at low surgical risk.
- The patient has completed a self-assessment score, e.g. the Oxford Hip Score as part of their pre-assessment provided by secondary care prior to surgery.

http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

- Has supporting clinical diagnostics and other assessments to support the decision to operate

Please refer to the classification of pain levels and functional limitations in the table below.

Evidence suggests that the following patients would be INAPPROPRIATE candidates for hip joint replacement surgery:

- Where the patient complains of mild joint pain AND has minor or moderate functional limitation
- Where the patient complains of moderate to severe joint pain AND has minor functional limitation AND has not previously had an adequate trial of conservative management as described above

Hip replacement: Classification of Pain Levels and Functional Limitations
<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Level</td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>Pain interferes minimally on an intermittent basis with usual daily activities. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Pain occurs daily with movement and interferes with usual daily activities. Vigorous activities cannot be performed. Not related to rest or sleep. Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses</td>
</tr>
<tr>
<td>Severe</td>
<td>Pain is constant and interferes with most activities of daily living. Pain at rest or interferes with sleep. Pain not controlled, even by narcotic analgesics.</td>
</tr>
<tr>
<td>Previous non-surgical treatments</td>
<td></td>
</tr>
<tr>
<td>Correctly Done</td>
<td>NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done.</td>
</tr>
<tr>
<td>Incorrectly Done</td>
<td>NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight or no physical therapies done.</td>
</tr>
<tr>
<td>Functional Limitations</td>
<td></td>
</tr>
<tr>
<td>Minor</td>
<td>Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Functional capacity adequate to perform only a few or none of the normal activities and self-care. Walking capacity of about one half hour. Aids such as a cane are needed.</td>
</tr>
<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

Relevant OPCS(s):
W38 – Total replacement of hip joint not using cement.
W39 – Other total replacement of hip joint.

For policy see Hair Depilation

Policy statement: Hirsutism
Status: Not Funded

For policy see Hair Depilation

Policy statement: Hymenorrhaphy
Status: Not Funded

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded. This policy does not apply to genital reconstruction for gender dysphoria which is covered by the East of England Gender Dysphoria Policy.

Refer to policy for vaginal labia refashioning.

Policy statement: Hyperhidrosis / Sweating
Status:
- South east Essex: Individual Prior Approval
- South west Essex: Threshold Approval

A trial of Iontophoresis is funded for second line treatment of palmar and plantar (palms and feed) hyperhidrosis; it is not routinely funded for axillae.

Primary Focal Hyperhidrosis diagnosis criteria:
- Excessive sweating occurring in at least one of the following sites: axillae, palms, soles or craniofacial region
- Documentation that the patient has failed a 6 month trial of conservative management including the use of topical aluminium chloride or extra strength antiperspirants and oral anticholinergic medication where appropriate;
- Without apparent secondary causes (e.g. medications, endocrine disease and neurological disease)
- HDSS* score 3-4 for over at least 6 months
- Including two or more of the following characteristics:
  - Bilateral and relatively symmetric
  - Age of onset less than 25 years
o Frequency of episodes at least once per week
o Positive family history
o Cessation of focal sweating during sleep
o Impairment of daily activities

*Hyperhidrosis Disease Severity Scale (HDSS) available at www.SweatHelp.org

**STEPWISE MANAGEMENT SUMMARY**

First-line treatment of hyperhidrosis (axillae, palm or feet) includes aluminum chloride 20% solution or extra-strength antiperspirants.

Second line treatment - Iontophoresis is funded for palmar and plantar (palms and feet) hyperhidrosis; it is not routinely funded for axillae. The addition of antimuscarinic drugs (e.g. glycopyrronium bromide) to the water is not routinely funded. Up to 10 sessions will be funded in the hospital setting; home treatment machines can be purchased after initiation of treatment in secondary care.

Hyperhidrosis treatment with Botulinum Toxin for Axillary Hyperhidrosis See Medicine management and Botox sections.

**Policy statement:**

<table>
<thead>
<tr>
<th>Hysterectomy for heavy menstrual bleeding – Non Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status:</strong> Threshold Approval</td>
</tr>
</tbody>
</table>

Hysterectomy for non-cancerous heavy menstrual bleeding will **only** be funded by south east Essex CCGs within NICE guidance and when:

- There has been an unsuccessful trial and appropriate clinical assessment, with a levonorgestrel-releasing intrauterine system LNG-IUS, e.g. Mirena®, unless contraindicated, for at least 12 months which has not successfully relieved symptoms or has produced unacceptable side effects.

and

- At least one alternative treatment has failed, is not appropriate or is contra-indicated in line with NICE guidelines.

**Alternative hormonal treatment**

Other hormone methods (e.g. combined oral contraceptives, injected progesterons, Gn-RH analogue).

- In line with NICE guidance.
- NSAIDs and Tranexamic Acid.

and

- The following are not clinically appropriate:
  1. Endometrial ablation if normal uterus or if LNG-IUS contraindicated or if ablation is contraindicated e.g. previous multiple caesarea section
  2. Uterine Artery Embolisation (for fibroids under 3cm)
  3. Myomectomy (for fibroids over 3cm)
Contraindications to the levonorgestrel intrauterine system are:

- Distorted or small uterine cavity (with proven ultrasound measurements; Uterocervical canal length < 5cm).
- Genital malignancy.
- Active trophoblastic disease.
- Active pelvic inflammatory disease.
- Large cavity over 10cm length.

References:


Policy statement: Hysteroscopy
Status: Threshold Approval

See Dilatation and Curettage

Policy statement: Knee Replacement
Status: South east Essex Individual Prior Approval, South west Essex Threshold Approval

Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted and failed. This will include weight reduction, NSAIDs and analgesics, changing activity, and introducing a walking aid.

South Essex CCGs will only fund knee replacements (total knee replacement: patello-femoral (PFJ) and unicompartmental) if:

- The patient complains of intense or severe symptomatology AND has radiological features of severe disease AND has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental). OR
- The patient complains of intense or severe symptomatology AND has radiological features of moderate disease AND is troubled by limited mobility or stability of the knee joint.

- The patient has completed a self-assessment score, e.g. the Oxford Hip Score as part of their pre-assessment provided by secondary care prior to surgery.

http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

- Has supporting clinical diagnostics and other assessments to support the decision to operate

**Knee replacement**: classification of pain levels and functional limitations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Level</td>
<td></td>
</tr>
</tbody>
</table>
| Mild              | Pain interferes minimally on an intermittent basis with usual daily activities.  
|                   | Not related to rest or sleep.                                              
|                   | Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses |
| Moderate          | Pain occurs daily with movement and interferes with usual daily activities.  
|                   | Vigorous activities cannot be performed.                                   
|                   | Not related to rest or sleep.                                              
|                   | Pain controlled by one or more of the following: NSAIDs with no or tolerable side effects, aspirin/paracetamol at regular doses |
| Severe            | Pain is constant and interferes with most activities of daily living.       
|                   | Pain at rest or interferes with sleep.                                     
|                   | Pain not controlled, even by narcotic analgesics.                          |

**Previous non-surgical treatments**

<table>
<thead>
<tr>
<th>Correctly Done</th>
<th>NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrectly Done</td>
<td>NSAIDs, paracetamol, aspirin or narcotic analgesics at inadequate doses or less than 6 months with no pain relief; or no weight control treatment if overweight or no physical therapies done.</td>
</tr>
</tbody>
</table>

**Functional Limitations**

<table>
<thead>
<tr>
<th>Minor</th>
<th>Functional capacity adequate to conduct normal activities and self-care. Walking capacity of more than one hour. No aids needed.</th>
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<tbody>
<tr>
<td>Moderate</td>
<td>Functional capacity adequate to perform only a few or none of the normal activities and self-care. Walking capacity of about one half hour. Aids such as a cane are needed.</td>
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<tr>
<td>Severe</td>
<td>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.</td>
</tr>
</tbody>
</table>

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### Policy statement: Labia Reduction / Refashioning

| Status       | Not Funded |

For policy see Vaginal Labia Refashioning.

### Policy statement: Laser treatment for Hirsutism

| Status       | Not Funded |

For policy see Hirsutism.

### Policy statement: Laser treatment for Rosacea

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<tr>
<td>South east Essex</td>
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Rosacea is a syndrome of the facial skin consisting of a combination of cutaneous signs including flushing, erythema, papules (small solid elevation of the skin), pustules (a small collection of pus), telangiectasia's, oedema (abnormal accumulation of fluid beneath the skin), ocular lesions and rhinophyma. These signs typically involve the convexities of the central face (cheeks, chin, nose and central forehead).

**Eligibility Criteria:**

Laser treatment for moderate to severe rosacea on the face and neck area which is erythemato-telangiectatic in nature will be considered for patients with the following:

- Frequent severe and troublesome flushing, moderate to pronounced persistent erythema, many prominent telangiectasia's, possible burning, stinging or scaling of the skin.

and

- All other treatments have been attempted and have failed. These include trigger identification, lifestyle management, and drug therapies such as topical metronidazole or oral tetracycline for papules and pustules.

Surgery is a more effective treatment for rhinophyma, therefore, laser therapy should **not** be offered. See policy for Rhinophyma for more information.
Policy statement: Laser treatment for skin lesions
Status: Individual Prior Approval

For policy see Benign skin lesions.

Policy Statement: Laser treatment for soft palate
Status: Not Funded

This procedure is considered a low priority treatment and is not normally provided under the NHS. Laser treatment for snoring is considered a low priority treatment and will only be provided on exceptional cases. In contrast, specialist assessment and appropriate treatment for OSA sufferers will normally be provided.

Definition:
Palatal flutter is thought to be the main contributor to snoring. This may be corrected by the procedure called “laser uvulopalatoplasty” which aims to cause fibrosis and stiffen the palate by removing a central strip of palatal mucosa with a laser. There is still a lack of good long-term trial based evidence about this procedure.

Note: Obstructive Sleep Apnoea (OSA) is a different and more serious condition. This involves the periodic reduction or cessation of breathing due to the narrowing of the upper airways during sleep. OSA sufferers have an irregular snoring pattern with short and shorter sounds leading to a period of silence. This is usually followed by an episode of struggling for air associated with sudden awakening. As a result, these patients experience daytime somnolence. (This policy does not apply to patients suffering from OSA)

Risks:
Although laser treatment is possible associated with less risk side effects such as post-nasal regurgitation and pain than more conventional surgery it remains a painful procedure and carries the same dangers associated with normal surgery.

IFR applications for funding will be reviewed in line with NICE Guidance: http://guidance.nice.org.uk/IPG476

The submission would need to outline how many procedures and how often the clinician was intending to repeat the course.

Policy statement: Laser treatment for Tattoo Removal
Status: Threshold Approval

The funding for removal of tattoos will be considered in the following circumstances:
- Funding may be considered for tattoos inflicted under duress during adolescence. In such instances, tattoo removal will only be considered where the tattoo is on the face or visible parts of the body.

**OR**

- In unusual circumstances where the tattoo causes marked limitations of psychosocial function

Psychiatric/psychological reports will need to be provided with the initial referral.

**OPCS Codes:**
- SO9 Laser therapy
- SO91 Laser destruction of lesion of skin of head or neck.
- SO92 Laser destruction of lesion of skin NEC.
- SO93 Photodestruction of lesion of skin of head or neck NEC
- SO94 Infrared photocoagulation of lesion of skin of head or neck.
- SO95 Infrared photocoagulation of lesion of skin NEC
- SO98 Other specified photodestruction of lesion of skin
- SO99 Unspecified photodestruction of lesion of skin

**Policy statement:**
- **Liposuction / Liposculpture / Body Contouring**
- **Status:** Not Funded

Liposuction will not be funded simply to correct the distribution of fat. Liposuction is sometimes an adjunct to other surgical procedures and may be useful for contouring localised fat atrophy or pathological hypertrophy e.g. multiple lipomatosis, lipodystrophies.

This procedure will **not be funded for cosmetic purposes.**

**Policy statement:**
- **Lycra Dynamic Splinting**
- **Status:** Not Funded

Requests for funding will only be considered on an individual patient basis by exceptional treatment panels. The referral needs to come from a local lead specialist physiotherapist or occupational therapist. The expected benefits for that patient over other treatments must be clearly quantified.

Expert opinion suggests that younger children with athetoid disorders (involuntary movements), those with quadriplegic palsy and those with neuromuscular disorders benefit
the most. Lycra dynamic splinting is not suitable for clients who have fixed deformities of a bony nature which are not amenable to change.

Compliance has a significant role to play in determining outcome, as it does for all therapy and medical interventions. The client and family or carers, who may be assisting them to apply the splints, must be made fully aware of the commitment required to ensure success.

Provision of subsequent garments will depend on clear, quantifiable demonstration of benefit for the individual patient which has been set up front.

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<tr>
<th>Policy statement:</th>
<th>Lymphoedema</th>
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Treatment of patients with Lymphoedema should be carried out through south Essex Lymphoedema services. Treatment of Lymphoedema by specialist units in the private sector will only be funded in exceptional circumstances following involvement of appropriate local services and completion of the Individual Funding Request process.

Definition:
Lymphoedema is swelling due to excess accumulation of fluid in the tissues caused by inadequate lymphatic drainage. It can affect any part of the body, but most commonly affects the arms and legs. There is no agreement on the quantitative definition of Lymphoedema. Lymphoedema can be classified as primary or secondary. Primary lymphoedema is due to abnormality intrinsic to the lymphatic system. Secondary Lymphoedema is due to damage/obstruction of the lymphatic system. This can be caused by cancer or cancer treatment, but there are a variety of other, non-cancer causes. Historically, Lymphoedema services have often developed in relation to cancer services and have extended their scope to treat other types of Lymphoedema.

Lymphoedema is essentially incurable as it represents end-stage failure of lymph drainage and will invariably progress unless controlled. Skin infections occur which can necessitate hospital admissions and there is increasing lack of mobility if patients are untreated.

Symptoms include the weight and discomfort of the affected limb, recurrent inflammation and infection, and the psychological distress caused by the appearance on the limb.

Criteria:
As Lymphoedema is only one cause of oedema the GP should ensure:

- the correct diagnosis (remembering that most causes of peripheral oedema are cardiac, renal, hepatic or venous in origin, rather than lymphoedema)
- The oedema is persistent or greater than 3 months duration; or
- Patient is at known risk of lymphedema.
- Patient must have tried and failed all available conservative management options before referral to a community based lymphedema service.
Once correct diagnosis has been established, the patient should be referred on to a local Lymphoedema service.

Where children or younger adults present with limb swelling, the GP may wish to refer to the appropriate specialist to exclude diagnosis such as malignant or vascular causes, dependant on the exact clinical picture. If Lymphoedema is diagnosed following investigation, these patients should be regarded as high priority by local Lymphoedema services, to prevent avoidable deterioration.

GPs must include evidence of meeting these requirements and confirm before referral to a community based lymphedema service.

**Policy statement:** Magnetic Resonance Ultrasound for Uterine Fibroids

**Status:** Not Funded

South Essex CCGs will not fund magnetic resonance guided ultrasound (MRgFUS) treatment for uterine fibroids for the purposes of fertility preservation due to lack of evidence of effectiveness.

South Essex CCGs will not routinely fund MRgFUS treatment for symptomatic relief except in exceptional circumstances via the individual funding request (IFR) route.

**Policy statement:** Mastopexy

**Status:**

- South east Essex: Individual Prior Approval
- South west Essex: Threshold Approval

For policy see Breast Procedures.

**Policy statement:** Mears Irlen Syndrome

**Status:** Not Funded

For policy see Scotopic Sensitivity Syndrome.
Policy statement: Medicines Management

Status: Threshold Approval

Rationale:
- To advise on the managed entry of new drugs, indications, formulations and devices which will have a significant impact on the local health economy.
- To develop a work plan for the improvement of prescribing practice ensuring that prescribing takes place in the setting which is most appropriate for patient care.
- To ensure that prescribing is underpinned through robust governance guidelines e.g. shared care documents and antimicrobial guidance.

For further information on the following criteria for funding, please see the Medicines Management section of each CCG website at:
- Brentwood and Basildon CCG: http://www.basildonandbrentwoodccg.nhs.uk/
- Castle Point and Rochford CCG: https://www.castlepointandrochfordccg.nhs.uk/
- Southend CCG: http://www.southendccg.nhs.uk/
- Thurrock CCG: http://www.thurrockccg.nhs.uk/

Criteria for funding:
**New Drugs/devices/ formulations/indications** – these drugs/devices are highlighted through the horizon scanning process and evaluated through the Medicines Management Committee in a planned programme of review.

- **Guidelines** – these indicate the preferred drugs options at various points in the treatment pathway as a guide to prescribers for different conditions e.g. diabetes, stable angina, generic or antibiotic prescribing.

- **NICE TA’s** – funding agreed within the NICE criteria as detailed in the Technical Appraisal (TA) document in conjunction with the local decision tree/policy which has been agreed through the Medicines Management Committee processes. The outcome including the date agreed is added to the “NICE Technology Appraisals About Medicines: Formulary Adherence Checklist” and the updated document published on the website in compliance with Innovation, Health & Wellbeing.

- **Governance guidelines** – These documents ensure that prescribers are supported to ensure that the risk to patients are minimised through a defined protocol for prescribing and where relevant monitoring the patient.

- **Shared care guidelines**

- **Antimicrobial prescribing guidance**

- **High cost drugs**

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• To advise on the managed entry of new drugs and devices that will have a significant impact on the local health economy.
• To develop a work plan for the improvement of prescribing practice ensuring that prescribing takes place in the setting which is most appropriate for patient care.
• To ensure that treatment meeting the criteria is funded by the appropriate body i.e. CCG, provider or NHSE
• To ensure that prescribing is underpinned through robust governance guidelines/pathways e.g. Rheumatoid Arthritis treatment algorithm, WetAMD Initiation, Continuation and Discontinuation policy

For further information on the following criteria for funding, please see the Medicines Management section of each CCG website at:

• Brentwood and Basildon CCG: http://www.basildonandbrentwoodccg.nhs.uk/
• Castle Point and Rochford CCG : https://www.castlepointandrochfordccg.nhs.uk/
• Southend CCG: http://www.southendccg.nhs.uk/
• Thurrock CCG: http://www.thurrockccg.nhs.uk/

Criteria for funding:

• **New Drugs/ devices/ formulations/indications** – these drugs/devices are highlighted through the horizon scanning process and evaluated through the Medicines Management Committee in a planned programme of review.

• **NICE TA’s** – funding agreed within the NICE criteria as detailed in the Technical Appraisal (TA’s) document in conjunction with the local decision tree/policy which has been agreed through the Medicines Management Committee processes.

The agreed commissioning criteria are defined in a specific funding request proforma for each drug and indication for initiation and continuation of treatment. Funding is agreed for a specified period of time for those individuals that meet the criteria, with continuation of funding being dependant on achieving and maintaining a suitable response to the treatment.

• **PbR excluded drugs and devices** - The criteria for the majority of these drugs and devices are defined through a NICE TA which is commissioned as detailed above. The responsible commissioner for funding is defined in the documents which are integral as part of the contract with providers.

• **Guidelines/pathways** – these define the agreed drug/device options at various points in the treatment pathway, and specifies to clinicians, the commissioning criteria for funding for various conditions e.g. Rheumatoid arthritis, WetAMD, botulinum

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Policy statement: Microsuction/Ear Wax Removal

Status: Threshold Approval

Removal of ear wax in secondary care will not be funded unless a patient’s condition warrants Microsuction. Patients should have had ear drops/olive oil for at least 3-4 weeks plus or minus irrigation to try to solve the problem prior to micro suction being attempted unless irrigation is contraindicated.

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Policy statement: Minor Hand Conditions

Status: South east Essex Individual Prior Approval

South west Essex Threshold Approval

Referral to a hospital consultant for minor hand conditions such as those mentioned below are considered low priority, and will only be provided under the NHS in line with the guidance below.

Wrist Ganglia
Ganglia are caused by cystic degeneration of a joint capsule or tendon sheath. Lesions at the base of the digits are often small but very tender (seed ganglion). Mucoid cysts arise at the distal interphalangeal joint and may disturb nail growth. Ganglia arising at the level of the wrist are rarely painful and most will resolve spontaneously within 5 years. The recurrence rate after excision of wrist ganglia is between 10-45%.

Surgery for ganglion of the wrist will only be funded for patients who have fulfilled the criteria as follows:
- there are symptoms associated with the ganglia such as pain, loss of sensation in certain parts of the hand, neurological loss or weakness of the wrist with the ganglion, and restriction of work or hobbies because of the ganglia
- patients are aware that most ganglia resolve spontaneously over time
- Patients are aware of the complications of excision such as scar tenderness, stiffness or numbness, and likelihood of recurrence.

Rationale:
Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of south Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

- Ganglia arising at the level of the wrist are rarely functionally impairing and about 50% will resolve spontaneously within 5 years. In the longer term approximately 60% of ganglia remain resolved following aspiration and about 70% following surgery. When other complications of surgery such as scar sensitivity, joint stiffness or distal numbness are taken into account operating is usually an unattractive option. Appropriately counselled patients will often not request surgical referral. Patients with asymptomatic ganglia should not be referred to secondary care. They can be
reassured in primary care and asked to seek assistance if the ganglion becomes symptomatic.

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**Trigger Finger**
A tender nodule in the flexor tendon at base of a finger or thumb causing a snapping of the finger/thumb as it is extended from a flexed position.

Referrals for surgery for trigger finger will only be funded for patients who have fulfilled one or more of the criteria as follows:-

- Failure to respond to conservative measures [e.g. up to 2 hydrocortisone injections]
- When the patient has a fixed deformity that cannot be corrected
- Patients for whom corticosteroid treatment is not suitable such as multiple digits affected.

**Rationale:**
Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of south Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

- Trigger finger and thumb in adults is caused by thickening of the A1 pulley. It is most common in middle aged women, is more frequent in diabetics but is usually idiopathic. Patients complain of the finger becoming stuck bent. When the digit is straightened there is a palpable clunk which is painful. Examination reveals a tender thickening over the A1 pulley which is at the level of the distal palmar crease in the fingers and at the base of the thumb.

Conservative treatment includes rest and avoiding precipitating activities. Non-steroidal anti-inflammatory drugs will often settle early cases. Injection of hydrocortisone is safe and can provide lasting relief in up to 70% of cases.

Trigger thumb is also very common and often more painful. It also occurs in infants due to a lump in the tendon rather than pulley thickening. In adults trigger thumb seems to respond less well to injections than fingers but it is still worthwhile. In infants surgery is often required if the deformity persists after 1 year.

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**Dupuytren’s Contracture**
Nodular or cord-like thickening of the palmar fascia causing a tethering of the digits and a loss of range of extension.

Surgery for Dupuytren’s contracture will only be funded for patients who have a flexion contracture exceeding 30 degrees at the metacarpophalangeal joint and/or a contracture exceeding 10 degrees at the proximal interphalangeal joint. Needle apronecтомy will not be funded (this may be reviewed in light of any published NICE guidance for the treatment) Simple nodules in the palm are not an indication for referral.
Rationale:
Many hand conditions occur commonly, cause few serious symptoms and will generally resolve spontaneously. Given the potential complications of surgical procedures and the duty of the CCGs to use its limited resources to provide the greatest benefit to the population of south Essex, the below criteria for referral have been developed. These criteria are aimed at offering treatment to those who need it most and who are most likely to benefit from surgical treatment.

- Most patients with Dupuytren's disease do not need treatment, but regular follow-up is needed to detect early joint contracture. Intervention is almost exclusively surgical and should be considered when the patient is having functional difficulties.

Recurrence is very common after surgery (up to 50%) but some patients with a ‘Dupuytren’s diathesis’ are particularly at risk. A recent review regarding this found that with a family history, bilateral disease, Garrod’s pads, male sex and onset less than 50 years the risk of recurrent disease was 71%. With none of these risk factors the rate was 23%.

Policy statement: MRI - Open
Status: Not Funded
For Policy see Open MRI

Policy statement: Myopia
Status: Not Funded
South Essex CCGs will not fund laser eye surgery for the correction of Myopia, only in exceptional circumstances.

Policy statement: Nipple Inversion
Status: South east Essex Individual Prior Approval
South west Essex Threshold Approval
South Essex CCGs commissions surgery to correct nipple inversions on a restricted basis. Nipple inversion may occur as a result of underlying breast malignancy. If the inversion is newly developed, it requires urgent referral and assessment.

Surgical correction of nipple inversion should only be available for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-
invasive suction device. GPs who refer must ensure that patients comply with this criteria. **Individual prior approval will be required within south east Essex.**

### Policy statement: Open MRIs

| Status: | Individual Prior Approval |

Referral for open MRIs in secondary care is commissioned by south Essex CCGs on a restricted basis.

Cases will only be funded if they meet the criteria below:

- Morbidly obese patients unable to access local MRI services because of their size i.e. obesity

Patients with claustrophobia are **not** eligible for open MRI scans unless an oral, prescription sedative has not been effective (GPs are expected to support Extended Scope Practitioners (ESPs) in prescription of sedatives in this situation).

### Policy statement: Orthodontics

| Status: | Funding Responsibility of NHS England |


### Policy statement: Otoplasty

| Status: | Threshold Approval |

For policy see Pinnaplasty.

### Policy statement: Penile Implants

| Status: | Not Funded |

This procedure will not be funded other than post cancer reconstruction.
### Photodynamic Therapy for Age Related Macular Degeneration

**Status:** Not funded

South Essex CCGs commission Photodynamic therapy (PDT) for Age-Related Macular Degeneration on a restricted basis, requests will be considered on a case by case basis by the CCGs Individual Funding Request panel.

### Pinnaplasty/Otoplasty

**Status:** Threshold Approval

South Essex CCG commissions Pinnaplasty/Otoplasty surgery on a restricted basis.

Pinnaplasty/Otoplasty will not be considered unless there is evidence of significant impact upon ability to lead a normal life, and the child expresses concern, rather than the parents alone,

Cases will **only be funded if they meet BOTH of the criteria below:**

- Patient is aged between 10 and 16 years old and has expressed concern about their appearance.
- The prominence is of a severity that it presents as disfigurement which is having a significant detrimental impact upon the child’s ability to lead a normal life.

All applications for funding should be accompanied by photographs.

**Patient Information:**

### Plagiocephaly

**Status:** Not Funded

South Essex CCGs commission treatment for Plagiocephaly on a restricted basis, requests will be considered on a case by case basis by the CCGs Individual Funding Request panel.

Plagiocephaly may be divided into craniosynostosis, which results from premature closure of one or more of the cranial sutures, and nonsynostotic or positional plagiocephaly (also referred to as deformational plagiocephaly, non-synostotic plagiocephaly, positional plagiocephaly, flat-head syndrome and occipital plagiocephaly).
This distinction is highly important as craniosynostosis carries a significant risk of raised intracranial pressure, therefore requiring interventional surgery. Interventions for craniosynostosis are covered by NHS England specialist commissioning arrangements.

Positional plagiocephaly, however, has not been shown to be associated with any long term developmental problems and its treatment has been described as entirely cosmetic and is therefore not funded.

Policy statement: Platelet Rich Plasma Injections for Tendinopathy

Status: Threshold Approval

South Essex CCGs commission Autologous Blood Injections for Tendinopathy on a restricted basis in accordance with NICE Guidance 438 guidance.nice.org.uk/ipg438.

Requests for this procedure will only be considered where:
- conservative methods of management* have failed,
- the patient suffers significant functional impairment** as a result of the Tendinopathy,

*Conservative measures include:
Rest, analgesics, anti-inflammatory medication, use of orthotic devises eccentric exercise and physiotherapy.

**Significant functional impairment is defined as:
The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.

Policy statement: Repair of Ear Lobes – Post Trauma

Status: Not Funded

Funded for primary suture post trauma at the time of trauma e.g. the patient is automatically eligible for emergency treatment when he/she presents for repair at Emergency Department at the time of trauma.

Post trauma applications will only be considered where there are clinically exceptional circumstances.
**Policy statement:** Reversal of Sterilisation

**Status:** Not Funded

Reversal of sterilisation (both male and female) is considered a low priority treatment and will not normally be provided under the NHS.

Sterilisation is provided under the NHS on the understanding that it is an irreversible procedure. Patients are informed and written consent is sought before the operation is carried out. Provider clinical governance systems should continue to embrace good practice guidelines from the Royal Colleges regarding the giving of information and informed consent prior to sterilisation.

**Definition:**
Sterilisation is a procedure by which a person is rendered permanently unable to produce children. This is called a vasectomy in men and operative occlusion of the fallopian tubes in women. Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes in women and vas deferens in men.

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**Policy statement:** Rhinophyma

**Status:**
- South east Essex Not Funded?
- South west Essex Threshold Approval

South Essex CCGs will **not** fund cosmetic correction of rhinophyma.

The first-line treatment of the nasal skin condition is medical. Severe cases or those that do not respond to medical treatment may be considered for surgery or laser treatment on a case by case basis via the individual funding request route. **For policy see Laser Treatment for Rhinophyma.**

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**Policy statement:** Rhinoplasty

**Status:**
- South east Essex Individual Prior Approval
- South west Essex Threshold Approval

**For policy see Aesthetic Facial Surgery.**
Policy statement: Scar Revision - Keloid

Status: Not Funded

Funding will not be available for:

- Keloid scars on parts of the body other than the face (see below)
- Keloid scars secondary to body piercing procedures

In all cases, medical photography will be required to support the IFR submission.

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Policy statement: Scar Revision – Other

Status: Not Funded

Funding may be available via Individual Funding Request panel for the following criteria:

[In all cases, medical photography will be required for the individual prior approval]

- Scars as a result of self-harm

These are very difficult to treat and usually the only achievable outcome is to make the scars resemble trauma or burns rather than be obviously due to self-harm. Treatment will only be funded when there has been a minimum period of three years where there has been no self-harm and where there is a supporting report from a psychiatrist indicating that the behaviour would be unlikely to recur.

- Scars secondary to trauma/accidents
  - Scars on the face that are ragged, or can otherwise be regarded as particularly disfiguring will be funded.
  - Scars on the rest of the body. Scar revision for cosmetic purposes will not be funded unless the disfigurement can be regarded as particularly grave. Cases will be judged on an individual basis.

- Other
  - Keloid scars that result in physical distress due to significant pain or pruritis.
  - Significant keloid scarring on the face.
  - Scars that are resulting in physical disability due to contraction, tethering or recurrent breakdown will be funded.

Scar revision will only be offered after 2 years to allow the natural healing process to complete.

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Policy statement: Scotopic Sensitivity Syndrome / Mears Irlen Syndrome / Coloured Filtered Lenses

Status: Not Funded

Provision of coloured filters/tinted lenses for specific reading difficulty (SRD) is not funded.

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Policy statement: Septoplasty/Septorhinoplasty

Status: South east Essex Individual Prior Approval
        South west Essex Threshold Approval

South Essex CCGs will not fund Septorhinoplasty procedures for cosmetic reasons.

Criteria for Septoplasty include:
- Problems caused by obstruction of the nasal airway amenable to the procedure
- Deviated nasal septum

Criteria for Septorhinoplasty for functional reasons include:
- Patient has a deviated septum causing significant and persistent nasal blockage
- A septoplasty alone will not improve functional impairment
- Septorhinoplasty is not being performed for cosmetic reasons

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Policy statement: Shoulder Arthroscopy

Status: South east Essex Individual Prior Approval
        South west Essex Threshold Approval

See Arthroscopy

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Policy statement: Skin Lesions

Status: Individual Prior Approval

For policy see Benign Skin Lesions.
South Essex CCGs commission sleep studies for patients with suspected sleep apnoea, or where necessary to confirm a diagnosis of narcolepsy.

If sleep apnoea is suspected, the following must be present prior to referral to the sleep unit.

- Daytime sleepiness (rather than tiredness) assessed by Epworth score (>15)

AND

- One or more of the following:
  - Witnessed regular or frequent nocturnal apnoeic episodes of stopping breathing.
  - Waking with sensations of choking/obstruction.
  - Neck circumference 17ins or over.
  - Significant retrognathia.
  - Small oedematous pharynx on visual inspection.

Patients referred for sleep studies, where nasal obstruction is an issue, should also have a nassoendoscopic assessment of their upper airways prior to referral to exclude any structural cause for obstruction.

South Essex CCGs do not commission sleep studies for parasomnia, periodic limb movement disorder, chronic insomnia or snoring.

Obstructive Sleep Apnoea (OSA) involves the periodic reduction or cessation of breathing due to the narrowing of the upper airways during sleep. OSA sufferers have an irregular snoring pattern with short and shorter sounds leading to a period of silence. This is usually followed by an episode of struggling for air associated with sudden awakening. As a result, these patients experience daytime somnolence.
- Reduction of evening alcohol if relevant.
- Stop smoking.
- Self-training to alter their sleep position to avoid lying on their back. Please indicate in any referral, how the patient has altered sleep position.
- Use of a mandibular device (not funded by the NHS).

Please also refer to policy on Septoplasty, Rhinoplasty and Laser Treatment for Soft Palate.

### Policy statement: Sperm and Egg Storage

**Status:** Threshold Approval

**For policy see Assisted Conception Using IVF/ICS/IUI for infertility**

### Policy statement: Spinal Cord Stimulation

**Status:** Individual Prior Approval

NHS England fund spinal cord stimulators for those patients receiving care in specialised centres.

The south Essex CCGs only fund applications for spinal cord stimulators for patients who meet the pro-forma (appendix 2) requirement in line with NICE Guidance:


The south Essex CCGs currently will fund spinal cord stimulators or batteries for those patients who already are in receipt of this treatment. IFR submissions will be required for high frequency stimulators and re-chargeable batteries as these are considered an exceptionality.

### Policy statement: Spinal Surgery for Non-Acute Lumbar Conditions

**Status:** Individual Prior Approval

**South Essex CCGs only commission spinal surgery for non-acute lumbar conditions on a restricted basis.**

Funding for patients to receive non-acute spinal surgery will only be made available under the following circumstance:
**Surgical discectomy** (standard or microdiscectomy) in selected patients with sciatica secondary to disc prolapse where conservative management for at least 4-6 weeks has failed.

South Essex CCGs do not fund spinal surgery for lower back pain.

NHS England commissions the following and their policies can be found at the following link [http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/](http://www.england.nhs.uk/ourwork/d-com/spec-serv/policies/)

- All spinal deformity surgery (adults and children).
- All spinal reconstruction surgery (adults and children).
- Palliative or curative spinal oncology surgery (adults and children).
- Revision surgery for which the primary surgery is specialist, for example,
  - Revision surgery with instrumentation for over 2 levels.
  - All primary thoracic and primary anterior lumbar surgery.
  - Posterior cervical decompression surgery using instrumentation.
  - Cervical corpectomy.

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**Policy statement:** Surgical Treatment of Hernia

**Status:** Threshold Approval

For policy see Hernia

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**Policy statement:** Synthetic Mesh

**Status:** Prior Approval For prior approval form click here

See Biological Mesh

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**Policy statement:** Tattoo Removal

**Status:**
- South east Essex: Individual Prior Approval
- South west Essex: Threshold Approval

See policy for Laser Treatment for Tattoo Removal.
Temporalmandibular Joint Replacement (TMJ)

Status: Not Funded

Temporomandibular Joint Replacement is considered a LOW PRIORITY due to limited evidence of clinical effectiveness.

Criteria:
The affected patients usually have severe disease of the temporomandibular joint which may be more serious if patients cannot open their mouths adequately, as dentistry, anaesthesia and resuscitation may be severely complicated and even life-threatening. In such rare cases, TMJ replacement may be considered.

Contraindications:
- Active or chronic infection
- Patient conditions where there is insufficient quantity or quality of bone to support the components
- Systemic disease with increased susceptibility to infection
- Patients with extensive perforations in the mandibular fossa and/or bony deficiencies in the articular eminence or zygomatic arch that would severely compromise support for the artificial fossa component
- Partial TMJ joint reconstruction
- Known allergic reaction to any materials used in the components; patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions
- Skeletally immature patients
- Patients with severe hyper-functional habits (e.g. Clenching, grinding etc.).

Rationale
There is limited evidence of effectiveness for this procedure. There are no RCTs, no agreed diagnostic classification scheme or universally accepted outcome measures or evidence on the relative cost effectiveness of total TMJ replacement. The research community in the USA have expressed caution about using irreversible surgery for TMJ disorders.

In rare cases of patients with extremely severe cases of TMJ disorder with re-ankylosis who cannot open their mandible and who are at great risk from failure to maintain the airway, there may be a case for total TMJ replacement. If this surgical service development were to proceed then it must be on condition that all patients should give full informed consent and be included in a national register using valid outcome measures. The surgery should only be offered by specialist reconstructive maxillo-facial units.

Back to Index

Temporalmandibular Joint (TMJ) Retainers & Appliances

Status: Not Funded

South Essex CCGs will not fund TMJ appliances unless in exceptional cases.
For example, the following situations might be considered exceptional:

- Patient has unsuccessfully tried alternative, cheaper treatments including: analgesics, muscle relaxants, stress reduction and self-massage, soft diet.

### Policy statement: Tier Three Weight Management

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<thead>
<tr>
<th>Status:</th>
<th>Policy:</th>
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</thead>
<tbody>
<tr>
<td>South east Essex</td>
<td>Individual Prior Approval</td>
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<tr>
<td>South west Essex</td>
<td>Threshold Approval</td>
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</tbody>
</table>

South Essex CCGs commission Tier Three Weight Management on a restricted basis in line with the NHS England criteria for Bariatric Surgery (see policy for bariatric surgery) as below:

- Patients aged 17 years or over.
- Registered with a Practice within South Essex, or if unregistered, residing in South Essex.
- Morbid or severe obesity has been present for at least four years.
- Record of previous success/attempt to lose weight during last 12 months.
- Meeting the following criteria:
  - a BMI of $\geq 35$ kg/m$^2$ and type 2 diabetes
  - In exceptional circumstances a patient with BMI $< 35$ kg/m$^2$ may be referred
  - a BMI of 40 or $\geq 35$ kg/m$^2$ and obesity-related comorbidity eg metabolic syndrome, hypertension, obstructive sleep apnoea (OSA), functional disability, infertility and depression if specialist advice is needed regarding overall patient management.
  - Willingness to commit to changing their behaviours.

### Policy statement: Tinnitus

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<thead>
<tr>
<th>Status:</th>
<th>Policy:</th>
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<tr>
<td></td>
<td>Threshold Approval</td>
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</table>

South Essex CCGs provides funding for investigation of tinnitus if the patient has:

- Consistent bilateral tinnitus (persistent for over 20 weeks) and hearing loss.
- Unilateral tinnitus (persistent over 2 months).
- Bilateral tinnitus (persistent over 2 months)

### Policy statement: Tonsillectomy

<table>
<thead>
<tr>
<th>Status:</th>
<th>Policy:</th>
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<tbody>
<tr>
<td>South east Essex</td>
<td>Individual Prior Approval</td>
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<tr>
<td>South west Essex</td>
<td>Threshold Approval</td>
</tr>
</tbody>
</table>
Suspected or confirmed malignancy – this is an absolute indication to refer, please use the two week cancer referral form.

South Essex CCGs commission tonsillectomy on a restricted basis for those patients who meet the SIGN Guidance 117 (April 2010) http://www.sign.ac.uk/pdf/sign117.pdf or one of the conditions listed below:

A period of 6 months watchful waiting by the GP is recommended prior to tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of operation.

Patients must meet **ALL** of the following criteria:
- Sore throats that are due to acute tonsillitis
- Episodes of sore throat that are disabling and prevent normal functioning
- Seven or more well documented clinically significant, adequately treated sore throats in the preceding year.
- Five or more such episodes in each of the preceding two years.
- Three or more such episodes in each of the preceding three years.
- Failure to thrive in pediatrics patients where recurrent tonsillitis is considered a contributory factor.

**OR** the patient should have one of the following conditions:
- Intractable cough with a high level of streptococcal antibody for longer than one year;
- Severe halitosis which has been demonstrated to be due to tonsil crypt debris for longer than one year. (diagnosed by an ENT surgeon)
- Lymphoma and Ca tonsil,
- Obstructive sleep apnoea where the patient has had one or more of a positive sleep study, demonstrable significant impact on quality of life and/or a strong clinical history suggestive of sleep apnoea.
- Peritonsillar abscess not responding to antibiotics and incisional drainage.

GPs should not refer unless the above criteria have been met, and referrals must include objective information to demonstrate this.

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

**Rationale:**
Tonsillectomy offers relatively small clinical benefits compared with non-surgical treatment, measured best in terms of time off school. The benefit in the year after the operation is roughly 2.8 days less taken away from school.

Tonsillectomy carries a risk of mortality estimated to lie between 1 in 8,000 and 1 in 35,000 cases.
A Cochrane systemic review concluded that: “There is no evidence from randomised controlled trials to guide the clinician in formulating the indications for surgery in adults or children”.

The frequency of sore throat episodes and upper respiratory infections reduces with time whether Adenotonsillectomy has been performed or not.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Transcranial Magnetic Stimulation</th>
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</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Not Funded</td>
</tr>
</tbody>
</table>

South Essex CCGs do not routinely commission Transcranial magnetic stimulation for treating and preventing migraine, this treatment should only be used with special arrangements for clinical governance, consent and audit or research. http://publications.nice.org.uk/transcranial-magnetic-stimulation-for-treating-and-preventing-migraine-ipg477

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Trigger Finger</th>
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<tbody>
<tr>
<td>Status:</td>
<td>South east Essex Individual Prior Approval</td>
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<td></td>
<td>South west Essex Threshold Approval</td>
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</table>

For policy see Minor Hand Conditions.

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Vaginal Labia Refashioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Not Funded</td>
</tr>
</tbody>
</table>

South Essex CCGs do not routinely commission elective vaginal labia reduction/refashioning or vaginoplasty as this is considered to be a cosmetic procedure, except in the circumstances outlined below.

Any referrals will be reviewed on an exceptional treatment case basis by the Individual Funding Request panel.

In all cases, medical photography will be required as part of the IFR submission.

Labiaplasty

Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely funded.
Requests for labiaplasty will be considered for the following indication:
- Where repair of the labia is required after trauma.
- Where the labia are directly contributing to recurrent disease or infection

**Vaginoplasty**

Non-reconstructive vaginoplasty or "vaginal rejuvenation" is used to restore vaginal tone and appearance and is not routinely funded.

Requests for vaginoplasty will be considered for the following indications:
- Congenital absence or significant developmental/endocrine abnormalities of the vaginal canal.
- Where repair of the vaginal canal is required after trauma
- Female genital mutilation.

**Hymenorrhaphy** – refer to policy for Hymenorrhaphy.

Or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded.

**Policy statement:**

<table>
<thead>
<tr>
<th>Vaginal/Uterovaginal Prolapse</th>
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<tbody>
<tr>
<td><strong>Status:</strong> Threshold Approval</td>
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</tbody>
</table>

South Essex CCGs will only fund surgical interventions for Uterovaginal Prolapse in the following circumstances:

- In cases of mild to moderate symptomatic cystoceles where trial of a pessary has failed.
- In cases of mild to moderate symptomatic rectoceles.
- In severe cases of prolapse or procidentia

Initially, patients should be assessed and managed conservatively in primary care. **Also refer to sections below on vaginal pessaries and surgery.**

1. **Watchful waiting**, with observation for the development of new symptoms or complications is appropriate if the prolapse is minimal (Stage I), or asymptomatic

2. **Conservative treatment options**

   2.1 **Lifestyle modification**
   - Treatment of conditions that increase intra-abdominal pressure: constipation, chronic cough, overweight/obesity; reduction of heavy lifting (while POP has been associated with these factors, the role of lifestyle modification in prevention/treatment has not been investigated)

   2.2 **Pelvic floor muscle exercises**
   - Role in managing prolapse unclear; probably not useful if the prolapse extends to or beyond the vaginal introitus.
• Cochrane review 2006: concluded evidence was insufficient (from 3 randomised trials) to judge the value of conservative management of POP, & that further trials were needed
• The pilot study for the Pelvic Organ Prolapse Physiotherapy (POPPY) multi-centre trial suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic Stage I or II POP women in an outpatient setting may reduce the severity of prolapse

2.3. Local (vaginal) oestrogen creams and oral treatments see CCG formulary
See Medicines Management and further information on criteria for funding, please see the Medicines Management section of each CCG website at:

• Brentwood and Basildon CCG: http://www.basildonandbrentwoodccg.nhs.uk/
• Castle Point and Rochford CCG: https://www.castlepointandrochfordccg.nhs.uk/
• Southend CCG: http://www.southendccg.nhs.uk/
• Thurrock CCG: http://www.thurrockccg.nhs.uk/

3. Vaginal pessary insertion – those participating in active vaginal intercourse should be offered surgery once occult urodynamic stress incontinence has been explored.

• Cochrane review 2004: no RCTs of pessary use in women with prolapse; there is no consensus on the use of different types of device, the indications, nor the patterns of replacement & follow-up care; evidence or pessary selection and management is incomplete so trial and error, expert opinion, and experience remain the best guides for use and management of the pessary
• Although not supported by definitive evidence, current opinion is that pessaries are effective1 & should be considered before surgery in women who have symptomatic prolapse; they can be attempted in all POP cases irrespective of stage
  o For short-term relief before surgery, or in the long-term if surgery is not wanted or recommended
  o To predict surgical outcomes or unmask occult urodynamic stress incontinence before surgery, as part of the investigation of continent women with POP (so that the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored)
• Risk factors for unsuccessful fitting include: short vaginal length <6 cm and wide introitus fingerbreadths; local oestrogens may play a role in successful fitting
• Failure to retain the pessary has been associated with increasing parity and previous hysterectomy; and discontinuation with history of hysterectomy or prolapse surgery, and stress incontinence;
• Follow-up: no clear consensus on how often to follow up1; after 3 months & then every 6 months, if there are no complications, has been suggested;
• Complications tend to occur in women who are not regularly followed up1; self- care of pessary is also important to minimise adverse events16; however, many patients find insertion & removal of most pessary types challenging

4. Surgery - those participating in active vaginal intercourse should be offered use of pessaries prior to surgical intervention for those women who have symptomatic prolapse. Or
to unmask occult urodynamic stress incontinence before surgery Refer to section on use of vaginal pessaries above

- Assessed as effective, but with a close risk/benefit in mild cases; a combination of procedures may be required and reoperation is required in 29% of cases
- Types of repair surgery vary depending on type of POP & associated symptoms, whether the woman is sexually active & her fitness for surgery

4.1. Reconstructive surgery (abdominal or vaginal approach)

- 2010 Cochrane review of surgical management of POP: found 40 RCTs with a variety of types of POP5
  - There was not enough evidence on most types of common prolapse surgery nor about the use of mesh or grafts in vaginal prolapse surgery
  - Impact of POP surgery on bowel, bladder and sexual function can be unpredictable and may make symptoms worse or result in new symptoms such as leakage of urine (unmask occult SI) or problems with intercourse
  - Uterine/vaginal vault prolapse: abdominal sacral colpopexy may be better than vaginal sacrospinous colpopexy – it was associated with a lower rate or recurrent vault prolapse and dyspareunia; these benefits must be balanced against a longer operating time, longer time to return to activities of daily living and increased cost of the abdominal approach
  - Posterior vaginal wall prolapse/rectocele: posterior vaginal wall repair may be better than transanal repair in terms of recurrence of prolapse (limited evidence)
  - Value of the addition of a continence procedure to a prolapse repair operation in women who are dry before operation remains to be assessed

- Use of mesh/graft inlays (biological or synthetic):
  - 2010 Cochrane review: use of mesh or grafts at the time of anterior vaginal wall repair reduces the risk of recurrent anterior wall prolapse on examination; however, evidence of benefit to the woman, including symptoms and quality of life improvement, is lacking for the use of grafts over native tissue repairs
  - 2008 NICE guidance: surgical repair of vaginal wall prolapse using mesh

See Synthetic Mesh and Biological Mesh

4.2 Obliterative Surgery

- Corrects POP by moving the pelvic viscera back into the pelvis & closing of the vaginal canal; vaginal intercourse is no longer possible

<table>
<thead>
<tr>
<th>Clinical scenarios where surgery will not be routinely funded</th>
<th>Clinical scenarios where referral for specialist assessment is necessary to determine suitability for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic pelvic organ prolapse</td>
<td>Failure of pessary</td>
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</tbody>
</table>
Mild pelvic organ prolapse (unless combined with urinary/faecal incontinence) | Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence) | Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence | Women with moderate to severe prolapse who want definitive treatment

### Recommendations

- Initially, patients should be assessed and managed conservatively in primary care
- All patients should have a trial of ring pessary, including suitable candidates for surgery, as part of the investigation of continent women with prolapse; the decision to perform a concomitant continence procedure along with pelvic reconstruction can then be individually tailored

### Patient information:

http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx

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<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Varicose Veins</th>
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<tr>
<td>Status:</td>
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<tr>
<td>South east Essex</td>
<td>Individual Prior Approval</td>
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<tr>
<td>South west Essex</td>
<td>Threshold Approval</td>
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</table>

South Essex CCGs commission surgery for varicose veins in accordance with Nice Guidance CG168

http://guidance.nice.org.uk/CG168

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<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Vasectomies – General Anaesthetic</th>
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<tr>
<td>Status:</td>
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<tr>
<td>South east Essex</td>
<td>Individual Prior Approval</td>
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<td>South west Essex</td>
<td>Threshold Approval</td>
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</table>

South Essex CCGs commission vasectomies under general anaesthetic on a restricted basis.

This policy is for circumstances when vasectomy should be performed under general anaesthetic. In other cases a referral should be made to a Primary Care Provider.
Only in the following circumstances will a vasectomy under general anaesthetic be funded:

- Previous documented adverse reaction to local anaesthesia.
- Scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or control of the spermatic cord through the skin difficult to achieve.

**Policy statement:**

<table>
<thead>
<tr>
<th>Policy statement:</th>
<th>Wisdom Teeth</th>
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<tbody>
<tr>
<td>Status:</td>
<td>Funding Responsibility of NHS England</td>
</tr>
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</table>

See Dental Procedures.
Appendix 1

Prior Authorisation for Restricted Procedures – Assisted Conception

A decision should be made and returned within 3 working days

Please confirm funding for this patient’s treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Fertility Treatment and Assisted Conception</th>
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<tr>
<th>Patient Name</th>
<th>CCG</th>
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<tr>
<td>NHS Number</td>
<td>GP</td>
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<tr>
<td>Referrer</td>
<td>Consultant</td>
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<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
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</table>

Clinicians completing prior approval should refer to:
Please tick as applicable

<table>
<thead>
<tr>
<th>Eligibility criteria for accessing fertility services</th>
<th>Tick as applicable</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Any treatment cycle will not be commenced before the female is 23 years of age but must be commenced before the female reaches her 40th birthday. Any treatment cycle must be commenced before the male is 55 years of age.</td>
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</tbody>
</table>

| 2  | Couples must be resident within the east of England for 12 months prior to treatment. Active forces personnel are exempt from the 12 month east of England residency requirement. |

| 3  | The woman must have a body mass index of between at least 19 and up to and including 30 prior to referral for fertility treatment and at any time throughout treatment |

| 4  | A maximum FSH level of 15U/L on day 2 of any menstrual cycle. Where couples are eligible for IUI treatment with |

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<td>donor eggs, the female must not have menstruated for 9 months.</td>
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<tr>
<td>5</td>
<td>The criterion in this policy apply to couples who have an identified cause for their fertility problems or have infertility of at least three years duration</td>
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</tr>
<tr>
<td>6</td>
<td>Previous privately funded treatment will not preclude patients from being eligible to NHS funded cycles up to a maximum of 6 embryo transfers or 3 fresh cycles. However previous cycles, whether NHS or privately funded, will be taken into account by the responsible clinician in determining the clinical appropriateness of commencing further cycles. In line with current clinical evidence, couples should undergo no more than 5 fresh cycles in total</td>
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<td>7</td>
<td>Where couples smoke, only those who agree to take part in a supportive programme of smoking cessation will be accepted on the IVF treatment waiting list, and should be non-smoking at the time of treatment.</td>
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<tr>
<td>8</td>
<td>There should be no living child from the couples current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships</td>
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<tr>
<td>9</td>
<td>Couples are ineligible if previous sterilisation has taken place (either partner), even if it has been reversed</td>
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<tr>
<td>10</td>
<td>Treatment may be denied on other medical grounds not explicitly covered in this document</td>
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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not included info in referral</th>
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<tbody>
<tr>
<td>Those couples who do not have a living child from their current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships; this will apply to adoptions either in or out of the current or previous relationships</td>
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<tr>
<td>IVF</td>
<td>For couples requiring IVF or ICSI, this policy supports a maximum of 6 embryo transfers with a maximum of three fresh cycles, this includes abandoned cycles. Where couples have previously self-funded an IVF cycle without PGD and pronucleate or cleavage stage frozen embryos (not blastocysts) exist, then the couples must utilise the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again</td>
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</tbody>
</table>
An embryo transfer is from egg retrieval to transfer to the uterus. The fresh embryo transfer would constitute one such transfer and each subsequent transfer to the uterus of frozen embryos would constitute another transfer. In all fresh cycles for women under the age of 37 years of age only one embryo, or blastocyst, will be transferred, unless there are medical mitigating circumstances.

A fresh cycle would be considered completed once administration of drugs for the purpose of superovulation has occurred, or if no drugs are used, with the attempt to collect eggs.

For couples where the woman is under 38 years of age, there should be a six month period between completion of the pregnancy test and commencement of drugs for the next fresh cycle.

If a cycle is commenced and ovarian response is poor, a clinical decision would need to be taken as to whether a further cycle should be attempted, or if the use of a donor egg may be considered for further IVF cycles.

Couples will be advised at the start of the treatment that this is the level of service that is available on the NHS in the East of England and that the NHS will fund storage of the embryos for one year only. Patients must be counselled by the clinician and infertility counsellor to this effect. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple.

If any fertility treatment results in a live birth, then the couple will no longer be considered childless and will not be eligible for further NHS funded fertility treatments, including the implantation of any stored embryos. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple.

Sperm Recovery and Intra-Cytoplasmic Sperm Injection (ICSI)

Spermatozoa can be retrieved from both the epididymis and the testis using a variety of techniques with the intention of achieving pregnancies or couples where the male partner has obstructive or non-obstructive azoospermia. Sperm recovery is also used in ejaculatory failure and where only non-motile spermatozoa are present in the ejaculate.

In obstructive azoospermia, sperm needs to be obtained directly from the testis by aspiration.
(TESA) or biopsy (TESE). In some men sperm can be recovered from naturally occurring spermatoceles by percutaneous puncture.

In non-obstructive azoospermia, sperm needs to be obtained directly from the testis by aspiration (TESA) or biopsy (TESE). The chance of finding sperm is reduced. PESA and TESA can be performed under local anaesthesia in an outpatient clinic. Percutaneous epididymal Sperm Aspiration (PESA) does not jeopardise future epididymal sperm retrieval.

Sperm recovery techniques outlined in this section are not available to patients who have undergone a vasectomy.

**Intra Uterine Insemination (IUI)**

Due to poor clinical evidence, IUI will only be offered under exceptional circumstances. Therefore an IFR application will have to be submitted.

**Donor insemination**

Male infertility affects about 25% of couples. Until ICSI became available the main technique for treating male factor infertility where azoospermia or severe abnormalities of semen quality were present was insemination with donated sperm. The need to prevent transmission of sexually transmitted diseases (including HIV) by donor insemination has led to the mandatory quarantine of donor sperm for six months by cryopreservation prior to its use in the UK. Donor insemination may be indicated where the male partner is likely to pass on an inheritable genetic condition or severe rhesus incompatibility has been a problem because of the male partner’s homozygous status.

**Egg and Sperm storage for patients undergoing cancer treatments – Eligibility criteria**

**Egg donation where no other treatment is available**

The patient may be able to provide an egg donor; alternatively the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.

This will be available to women who have undergone premature ovarian failure due to an identifiable pathological or iatrogenic cause before the age of 40 years or to avoid transmission of inherited disorders to a child where the couple meet the other eligibility criteria.

**Pre-implantation Genetic Diagnosis (PGD)**
This policy does not include pre-implantation genetic screening as it is not considered to be within the scope of fertility treatment. This is specialist commissioning – See NHS England

### Chronic Viral Infections

The need to prevent the transmission of chronic viral infections, during conception, such as HIV, Hep C etc requires the use of ICSI technology

This may not be a fertility treatment, but should be considered as a risk reduction measure for a couple who wish to have a child, but do not want to risk the transmission of a serious pre-existing viral condition to the woman and therefore potentially her unborn baby.

### Privately funded care

This policy covers NHS funded fertility treatment only. For clarity, Patients will not be able to pay for any part of the treatment within a cycle of NHS fertility treatment. This includes, but is not limited to, any drugs (including drugs prescribed by the couple’s GP), recommended treatment that is outside the scope of the service specification agreed with the Secondary or Tertiary Provider or experimental treatments.

Where a patient meets the eligibility criteria but agrees to commence treatment on a privately funded basis, they may not retrospectively apply for any associated payment relating to the private treatment.

### Surrogacy

Surrogacy is not commissioned as part of this policy. This includes part funding during a surrogacy cycle.

Please supply further information evidencing how the patient meets the above criteria
Prior authorisation requested by:

Consultant Name

Contact number

Date

Procedure/Device authorised by:

Name

Signature

Date
Prior Authorisation for Restricted Procedures –
Benign Skin Lesions/Laser Treatment for Skin Lesions/Skin Lesions

A decision should be made and returned in **3 working days**

The below patient is currently awaiting Benign Skin Lesions/Laser Treatment for Skin Lesions/Skin Lesions.

**Please confirm funding for this patient’s treatment**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Benign Skin Lesions/Laser Treatment for Skin Lesions/Skin Lesions</th>
</tr>
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<table>
<thead>
<tr>
<th>Patient Name</th>
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<td>Consultant</td>
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<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
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</tbody>
</table>

South Essex CCGs do not commission removal or treatment of clinically benign skin lesions/conditions for purely cosmetic reasons

N.B. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate setting for assessment – this may be a 2 week wait clinic (for suspected melanoma/Squamous Cell Carcinoma).

Surgery or treatments to improve appearance alone is not provided for normal changes such as those due to ageing.

**Lesions included in this policy include:**

- Benign pigmented naevi (moles)
- Comedones
- Corn/callous
- Dermatofibromas (skin growths)
- Lipomas
- Milia
- Molluscum contagiosum
- Sebaceous cysts (epidermoid and pilar cysts)
- Seborrhoeic keratoses (benign skin growths, basal cell papillomas)
- Skin tags including anal tags
- Spider naevus (telangiectasia)
- Thread veins
- Warts and plantar warts
- Xanthelasma (cholesterol deposits underneath the skin)
- Neurofibromata
South Essex CCGs commission the removal of benign skin lesions on a restricted basis only. This applies to GPs providing Directed Enhanced Services for Minor Surgery under GMS/APMS contracts as well as secondary care consultants. Practices should not submit, and the CCG reserves the right not to fund, claims for procedures that would be classified as exclusions under this service restriction.

<table>
<thead>
<tr>
<th>Threshold Approval does not need prior approval</th>
<th>Yes</th>
<th>No</th>
<th>Unknown-GP has not included info in referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a benign skin lesion of the eye obscures vision or is causing a separate ocular problem then the patient can be referred to an appropriate service for removal</td>
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</tbody>
</table>

**Individual Prior Approval - Requests for the removal of benign skin lesions will be considered for:**

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<tr>
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<th>Tick as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sebaceous cysts where there has been more than one episode of infection</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Lesions which cause functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities</td>
<td></td>
</tr>
<tr>
<td><strong>OR</strong> Lesions on the face where the extent, location and size of the lesion can be regarded as considerable disfigurement, and which sets them apart from the cohort of people with lesions</td>
<td></td>
</tr>
</tbody>
</table>

Evidence that previous treatment has been pursued before referral has been made will be required. Evidence that previous treatment has been pursued before requesting approval to refer will be required. For those requiring prior approval this evidence must be provided with the request for funding.
Please supply further information evidencing how the patient meets the above criteria

<table>
<thead>
<tr>
<th>Prior authorisation requested by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Name</td>
</tr>
<tr>
<td>Contact number</td>
</tr>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Procedure/Device authorised by:</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
Prior Authorisation for Restricted Procedures – Carpal Tunnel

A decision should be made and returned in **3 working days**

The below patient is currently awaiting Carpal Tunnel. Please confirm funding for this patient’s treatment

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Carpal Tunnel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td><strong>CCG</strong></td>
</tr>
<tr>
<td><strong>NHS Number</strong></td>
<td><strong>GP</strong></td>
</tr>
<tr>
<td><strong>Referrer</strong></td>
<td><strong>Consultant</strong></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td><strong>Hosp No</strong></td>
</tr>
</tbody>
</table>

Patients must meet the following criteria to be added to the waiting list
Please tick as applicable

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Unknown-GP has not included info in referral</th>
</tr>
</thead>
</table>
| **1** Community based conservative treatment should be initiated for **ALL** patients with suspected Carpal Tunnel Syndrome for a period of 6 months, excluding those noted below. Conservative treatment will include the following:  
- Analgesia  
- Splinting with Futuro-type cock up splint (night time only or constant)  
- Steroid injection – should be administered twice prior to referral for consideration of surgery | |

Patients with Carpal Tunnel Syndrome should be referred if any of the following criteria apply:
Severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, significantly interfering with daily activities.

OR Neurological deficit i.e. constant sensory blunting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).

OR Unclear diagnosis or dual pathology

OR Rheumatoid

OR Recent trauma

OR Previous surgery

OR Uncomplicated cases who have **NOT** responded to conservative management for 6 months should be referred.

---

**Please supply further information evidencing how the patient meets the above criteria**

---

**Prior authorisation requested by:**

Consultant Name

Contact number

Date

**Procedure/Device authorised by:**

Name

Signature

Date
Prior Authorisation for Restricted Procedures – Exogen

A decision should be made and returned in 3 working days

The below patient is currently awaiting Exogen

Please confirm funding for this patient’s treatment

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exogen</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>CCG</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NHS Number</th>
<th>GP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Consultant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Hosp No</th>
</tr>
</thead>
</table>

Essex CCGs commission Exogen ultrasound bone healing system for long bone fracture on a restricted basis in line with NICE guidance Medical Technology Guidance 12 found at guidance.nice.org.uk/mtg12

The case for adopting the EXOGEN ultrasound bone healing system to treat long bone fractures with non-union (failure to heal after 9 months) is supported by the clinical evidence, which shows high rates of fracture healing.

On this basis south Essex CCGs only funds Exogen in the following circumstances:

The EXOGEN 4000+ is intended for use in patients with non-union fractures (Fractures that have failed to heal after 9 months). The device delivers a minimum of 191x20 minute treatments (more than 6 months’ treatment).

The EXOGEN Express is intended for use in patients with delayed healing fractures (fractures that have no radiological evidence of healing after 3 months). The device delivers a maximum of 150x20 minute treatments (less than 5 months’ treatment).
Please supply further information evidencing how the patient meets the above criteria

<table>
<thead>
<tr>
<th>Prior authorisation requested by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Name</td>
</tr>
<tr>
<td>Contact number</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure/Device authorised by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
Prior Authorisation for Restricted Procedures – Hip Injections

A decision should be made and returned in 3 working days

The below patient is currently awaiting Hip Injections

Please confirm funding for this patient’s treatment

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Hip Injections</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>GP</td>
</tr>
<tr>
<td>Referrer</td>
<td>Consultant</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
</tr>
</tbody>
</table>

Current evidence on safety and efficacy does not appear adequate to routinely recommend hip injections.

On this basis south Essex CCGs only funds hip injection in the following circumstances:

- Diagnostic aid
- To introduce contrast medium to the joint as part of hip arthrogram
- Babies for hip arthrography
- Children and adults with inflammatory arthropathy
- Investigation of infection in biological and replaced hips.

Please supply further information evidencing how the patient meets the above criteria
Prior authorisation requested by:

Consultant Name

Contact number

Date

Procedure/Device authorised by:

Name

Signature

Date
Prior Authorisation for Restricted Procedures – Open MRI/MRI Open

A decision should be made and returned in 3 working days

The below patient is currently awaiting an Open MRI.

Please confirm funding for this patient’s treatment

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Open MRIs/MRI Open</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>CCG</td>
</tr>
<tr>
<td>Referrer</td>
<td>Consultant</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
</tr>
</tbody>
</table>

Patients must meet the following criteria to be added to the waiting list
Please tick as applicable

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Unknown-GP has not included info in referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Open MRI scans will only be funded for morbidly obese patients unable to access local MRI services because of their size.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patients with claustrophobia are NOT eligible for open MRI scans unless an oral, prescription sedative has not been effective (GPs are expected to support Extended Scope Practitioners (ESPs) in prescription of sedatives in this situation)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please supply further information evidencing how the patient meets the above criteria

Prior authorisation requested by:

Consultant Name

Contact number

Date

Procedure/Device authorised by:

Name

Signature

Date
The under mentioned patient is currently on our waiting list for Spinal Cord Stimulation. Devices used in this procedure are excluded from Payment by Results and are chargeable separately. Could you please confirm your agreement to proceed.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No</td>
<td>GP</td>
</tr>
<tr>
<td>Referrer</td>
<td>Pain Consultant</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
</tr>
</tbody>
</table>

**Pain Diagnosis:**

<table>
<thead>
<tr>
<th>Neuropathic Pain (non CRPS)</th>
<th>Complex Regional Pain Syndrome (CRPS) Failed Back Surgery Pain (FVSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic radicular pain</td>
<td>CRPS may happen after a harmful event or period of immobilisation (type I)</td>
</tr>
<tr>
<td>(FBSS)</td>
<td></td>
</tr>
<tr>
<td>Peripheral Mononeuropathy</td>
<td>Nerve injury (type II).</td>
</tr>
<tr>
<td>Phantom pain</td>
<td></td>
</tr>
<tr>
<td>Plexopathy</td>
<td></td>
</tr>
<tr>
<td>Peripheral polyneuropathy</td>
<td></td>
</tr>
<tr>
<td>Stump pain</td>
<td></td>
</tr>
</tbody>
</table>

Spinal cord stimulation is not recommended as a treatment option for adults with chronic pain of ischaemic origin except in the context of a clinical trial. Such research should be designated to generate robust evidence about the benefits compared with standard care (NICE TA 159 recommendation. (1.2)

**Assessment – the prior approval should include evidence to support the following for each patient**

- NICE TA 159 recommendation. (1.3) Spinal cord stimulation should be provided only after an assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of on-going monitoring and support of the person assessed.

**Evidence of 1.3:**
**NICE TA 159 recommendation. (1.1)** Spinal cord stimulation is recommended for adults with chronic pain of neuropathic origin who:
- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management, and
- who have had a successful trial of stimulation as part of the assessment specified in recommendation 1.3.

**Evidence of 1.1:**

**NICE TA 159 recommendation. (1.4)** When assessing the severity of pain and the trial of stimulation, the multidisciplinary team should be aware of the need to ensure equality of access to treatment with spinal cord stimulation. Tests to assess pain and response to spinal cord stimulation should take into account a person’s disabilities (such as physical or sensory disabilities), or linguistic or other communication difficulties, and may need to be adapted.

**Evidence of 1.4:**

**NICE TA 159 recommendation. (3.9)** People selected for SCS normally have a stimulation trial to determine suitability for permanent implantation of a neurostimulator. This usually involves implanting the electrode(s) and leads with a temporary external device, which is used to mimic the effects of an implanted neurostimulator. A stimulation trial will assess tolerability (for example, of the stimulation sensation or the stimulation device) and the degree of pain relief likely to be achieved with full implantation.

**Evidence of 3.9:**
NHS Constitution - Nationally approved treatments, drugs and programmes:
You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.

Meeting legal requirements
All NHS organisations have a legal requirement to implement NICE guidance.

Technology appraisals
In 1999, the Department of Health issued a health circular (1999/176) making it clear that the NHS should continue with local procedures for managing technologies where a NICE appraisal was on-going or where NICE was not looking at a technology.

Once technology appraisal guidance has been published, the Department of Health has directed that the NHS should provide funding for recommended medicines and treatments within three months, unless instructed by the Secretary of State.

On December 14 2006 the Department of Health issued good practice guidance on managing the introduction of new healthcare interventions. This updates the health circular 1999/176 and further clarifies the guidance on the funding of technology appraisals guidance. A link to the good practice guidance is below.
http://www.nice.org.uk/usingguidance/benefitsofimplementation/meetinglegalrequirements/meeting_legal_requirements.jsp

Planned Procedure

<table>
<thead>
<tr>
<th></th>
<th>SCS 2</th>
<th></th>
<th>SCS 3</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(A07 and A08 included within Pbr)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Excluded devices authorised by:

Name: ____________________________
Signature: _______________________
Date: ___________________________

Should you have any enquiries, please contact ___________________________contact number _____________________.(to be added by person completing the form to authorise funding)

Please fax to:
Please address all correspondence regarding any clinical queries for this individual case to:
(to be completed by clinician completing the form on behalf of the patient)

<table>
<thead>
<tr>
<th>Name of clinician Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Fax</td>
</tr>
</tbody>
</table>
Prior Authorisation for Restricted Procedures – Therapeutic Spinal Injections for Pain Related to the Lumbar Spine

A decision should be made and returned in
3 working days

The below patient is currently awaiting Therapeutic Spinal Injections for Pain Related to the Lumbar Spine

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Therapeutic Spinal Injections for Pain Related to the Lumbar Spine</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td>GP</td>
</tr>
<tr>
<td>Referrer</td>
<td>Consultant</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
</tr>
</tbody>
</table>

Essex CCGs do not commission facet joint/back pain or spinal injections routinely unless patient meets either criteria (1) or (2) below.

Surgical treatment will only be funded for those meeting the criteria set out below in section (1) and (2)

(1) Any spinal therapeutic injection for patients with chronic pain

- Injections of therapeutic substances for pain related to the lumbar spine are not routinely commissioned for patients with chronic non-specific back pain.

  The Commissioner will:

  - Commission spinal therapeutic injections for chronic radicular pain only where recommended as part of a specialist multidisciplinary pain clinic management plan

AND

  - A programme of conservative management has been unsuccessful or is not possible due to coexisting physical or mental illness or frailty.

Conservative management must include the following: advice and information on back pain management; group or customised exercise programme and where appropriate (according to specialist reassessment) manual therapy, acupuncture or...
(1 continued) On referral to the specialist multidisciplinary pain clinic, patients must be informed that the referral is for assessment and development of a personalised pain management plan. Patients should not be under the impression that the decision to provide injections has already been made or repeat injections are routinely available – please evidence below the personalised pain management plan and stages completed prior to initiating therapeutic injections

(2) Therapeutic epidural injections, sacroiliac injections and nerve root blocks in patients with acute episodes of pain (including acute on chronic)

Commissioning of single injections is restricted to the following indications:

• The patient needs urgent relief of severe acute spinal pain.

OR

• A specialist pain clinician judges that a single injection is necessary and appropriate to enable participation in a conservative pain management programme.

OR

• The patient is unable to participate effectively in conservative pain management due to coexisting physical or mental illness or frailty.

Repeat injections should not be routinely provided as there is a lack of high quality supporting evidence for long term pain relief and clinical advice suggests diminishing returns with increased risk of adverse events.

Please supply further information evidencing how the patient meets the above criteria and indicate (1) or (2)

Repeat injections are commissioned:
• If a specialist pain clinician taking account of multi-disciplinary team assessment, concludes that benefits outweigh harms:

AND
• The patient has been clinically assessed as having had a substantial and sustained benefit from their first injection;

AND
• The patient has been assessed as continuing to be unable to benefit from conservative management;

On referral to the specialist multidisciplinary pain clinic, patients must be informed that the referral is for assessment and development of a pain management plan. Patients should not be under the impression that the decision to provide an injection has already been made or that repeat injections are routinely available.

Please supply further information evidencing how the patient meets the above criteria for repeat injections.

Facet Joint injections and medial branch blocks are not routinely commissioned and are only commissioned for:

For diagnostic assessment, only in patients being assessed for surgical management of chronic spinal pain.

Please supply further information evidencing how the patient meets the above criteria for facet injections.

Prior authorisation requested by:

Consultant Name

Contact number

Date

Procedure/Device authorised by:

Name

Signature

Date
Prior Authorisation for Restricted Procedures – Synthetic Mesh

A decision should be made and returned in 3 working days

The below patient is currently awaiting surgical use of synthetic mesh

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Surgical use of synthetic mesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>CCG</td>
</tr>
<tr>
<td>NHS Number</td>
<td>GP</td>
</tr>
<tr>
<td>Referrer</td>
<td>Consultant</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Hosp No</td>
</tr>
</tbody>
</table>

Do not commission use of synthetic mesh unless patient meets criteria below.

**Surgical use of synthetic mesh will only be funded for those meeting the criteria set out below**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult hernia repair (when hernia surgery meets SRP criteria/restrictions)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Abdominal surgery for apical organ prolapse and is being performed by a surgeon specialising in pelvic organ prolapse and female urinary incontinence</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

**Surgical use of biological mesh will only be funded via IFR**

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will only be funded via individual funding request, indications for these individual funding request applications (IFR application would need to be completed) see below:</td>
</tr>
<tr>
<td>Complex abdominal wall reconstruction in conjunction with plastic surgeons</td>
</tr>
<tr>
<td>Rectal cancer patients requiring ELAPE (extra-leavator abdominal perineal excision) procedure, whose resulting defect may require filling with biological mesh</td>
</tr>
</tbody>
</table>
Please supply further information evidencing how the patient meets the above criteria for use of synthetic mesh

Prior authorisation requested by:

<table>
<thead>
<tr>
<th>Consultant Name</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact number</td>
<td>__________________________</td>
</tr>
<tr>
<td>Date</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

Procedure/Device authorised by:

<table>
<thead>
<tr>
<th>Name</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>__________________________</td>
</tr>
<tr>
<td>Date</td>
<td>__________________________</td>
</tr>
</tbody>
</table>
Appendix 3.1

INDIVIDUAL FUNDING REQUEST (IFR) - Application Template

For Consultants

Please ensure that you have your patient’s consent for patient identifiable data (i.e. name, DOB etc.) to be shared on a need to know basis with appropriate professionals who may be involved in the patient’s care. This will be required in cases where further investigation to gain a fuller picture is needed. All data is stored in line with Data Protection Regulations.

Contact details for IFR Queries – see section below for information on submitting requests

Individual Funding Request Team
Fundingrequests.south@nhs.net
01268 594480 or 01268 594553

INDIVIDUAL FUNDING REQUEST

Guidance for the use of the individual funding request submission form

Individual funding requests should only be made where the patient has exceptional clinical circumstances, and will be subject to audit.

Completing the form:

- This form must be completed by the requesting clinician for all off-protocol requests requiring CCG funding (for example: procedures that are not on the approved list).
- The form must be completed electronically giving full details. Boxes will expand. Failure to provide full information may result in a delay in reaching a final decision.
- Your submission will be greatly supported if you directly answer these two ‘tests’ of exceptionality in section 10, and give appropriate evidence in the other sections.

<table>
<thead>
<tr>
<th>The patient</th>
<th>1) Is clinically significantly different from the general population of patients with the same diagnosis/condition in question.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AND</td>
</tr>
<tr>
<td></td>
<td>2) As a result of this clinical difference is more likely to benefit from this treatment/intervention than might be expected for the average patient with the diagnosis/condition.</td>
</tr>
</tbody>
</table>

- The fact that the diagnosis is very rare, or that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality. If a patient's clinical condition matches the ‘accepted indications’ for a treatment that is not funded, they are by definition, not exceptional.
• Only evidence of clinical exceptionality will be taken into consideration.
• It is the responsibility of the requesting clinician to demonstrate exceptionality.

1. Requests can only be made on an individual, named patient basis and should be completed by an appropriate referring clinician prior to referral for treatment. It is not guaranteed that such treatment will be necessarily funded in the case of similar subsequent cases if the CCG does not consider it as clinically effective or cost effective.

2. The CCG will not normally fund a patient’s treatment to continue following a clinical trial. In line with the Medicines Act 2004 and the Declaration of Helsinki, the responsibility for ensuring a clear exit strategy from a trial and that those benefiting from treatment will have on-going access to it, lies with those conducting the trial.

3. CCGS will not normally fund novel or uncertain treatments. Funding for new, rarely used, unlicensed and/or investigational drugs outside of a research trial will remain the responsibility of the provider unless a business case is submitted in advance to the commissioner to take through the due process.

4. The following criteria should be used to identify how urgent a request is:

- **Urgent/Fast track** response within 5 working days (refer to policy for definition/criteria)
- **Routine** application received to decision 2 months

5. The requesting clinician is asked to provide clinical feedback on the outcomes of treatment (ideally following clinical review in 3 months or as appropriate).

**Submitting the form:**

<table>
<thead>
<tr>
<th>Applications to be sent to:</th>
<th>South East all IFR funding applications including drugs IFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please note that emails must be sent from an nhs.net address to an nhs.net address.</td>
<td><a href="mailto:Fundingrequests.south@nhs.net">Fundingrequests.south@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>South West Essex funding applications ((non-medicines/drug requests)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Fundingrequests.south@nhs.net">Fundingrequests.south@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>South West Essex IFR (drug applications only)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:CECSU.IFR-ECC@nhs.net">CECSU.IFR-ECC@nhs.net</a></td>
</tr>
</tbody>
</table>
INDIVIDUAL FUNDING REQUEST FORM (Acute Provider)

Is this application urgent/fast-track?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Copy and paste this tick if you need to. ✓

**CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Column</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Name</td>
<td></td>
</tr>
<tr>
<td>Address (in full)</td>
<td></td>
</tr>
<tr>
<td>Applicant Details</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Designation:</td>
<td></td>
</tr>
<tr>
<td>Department:</td>
<td></td>
</tr>
<tr>
<td>Telephone No.:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>ONLY NHS or nhs.net addresses</td>
<td></td>
</tr>
<tr>
<td>Patient Details</td>
<td></td>
</tr>
<tr>
<td>Initials:</td>
<td></td>
</tr>
<tr>
<td>NHS No.:</td>
<td></td>
</tr>
<tr>
<td>Hospital ID number:</td>
<td></td>
</tr>
<tr>
<td>DoB:</td>
<td></td>
</tr>
<tr>
<td>Male:</td>
<td>Female:</td>
</tr>
<tr>
<td>BMI:</td>
<td></td>
</tr>
<tr>
<td>Registered Consultant:</td>
<td></td>
</tr>
<tr>
<td>Registered GP name:</td>
<td></td>
</tr>
<tr>
<td>Registered GP postcode:</td>
<td></td>
</tr>
<tr>
<td>Responsible CCG:</td>
<td></td>
</tr>
<tr>
<td>Referred by (other than GP):</td>
<td></td>
</tr>
</tbody>
</table>
## For a drug intervention - Application reviewed by Chief Pharmacist or nominated deputy e.g. relevant specialist pharmacist

<table>
<thead>
<tr>
<th>Referred from:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of referral:</td>
<td></td>
</tr>
<tr>
<td>Chief Pharmacist /deputy Name:</td>
<td>(Must be copied into all drug related correspondence)</td>
</tr>
<tr>
<td>Chief Pharmacist /deputy email:</td>
<td></td>
</tr>
<tr>
<td>Chief Pharmacist /deputy telephone number:</td>
<td></td>
</tr>
<tr>
<td>Pharmacist name:</td>
<td>(for any queries if different to above)</td>
</tr>
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<td></td>
</tr>
<tr>
<td>Pharmacist telephone number:</td>
<td></td>
</tr>
</tbody>
</table>

## INTERVENTION REQUESTED
(NB: Intervention refers to requested treatment, investigation, etc)

<table>
<thead>
<tr>
<th>Patient Diagnosis (for which intervention is requested)</th>
<th>Name of intervention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of intervention (for which funding is requested)</td>
<td>Dose and frequency:</td>
</tr>
<tr>
<td></td>
<td>Route of administration:</td>
</tr>
</tbody>
</table>

### Costing information

- Anticipated monthly cost, or cost per cycle (inc VAT) *(Seek advice from Pharmacy)*
- Related monitoring costs
- Related monitoring frequency
- Any other additional on costs including reasons

### Intervention information

- (a) Planned duration of intervention?
(b) How will you monitor the effectiveness of the intervention?  

(c) What are the criteria for stopping treatment?  

(d) What would you consider to be a successful outcome for this intervention in this patient?  

(e) How would this outcome be measured?  

<table>
<thead>
<tr>
<th>Is requested intervention part of a clinical trial?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Yes, give details: (e.g. name of trial, is it an MRC/National trial?)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) Is there a standard intervention at this stage?  

If Yes include details / standard algorithm of care for disease type:  

<table>
<thead>
<tr>
<th>Deviations</th>
<th>Additional</th>
<th>Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b) Is the requested intervention additional to the standard intervention(s) or a deviation from the standard?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate where the patient fits into the standard algorithm:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the WHO performance status?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of previous intervention(s) this patient has received for the condition  

<table>
<thead>
<tr>
<th>Dates</th>
<th>Intervention (eg. drug / surgery)</th>
<th>Reason for stopping* / Response achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
* Reasons for stopping may include:
  - Course completed
  - No or poor response
  - Disease progression
  - Adverse effects/poorly tolerated

| Anticipated start date | Processing requests can take up to 2–4 weeks (from the date received by the CCG). If the case is more urgent than this, please state clinical reason why: |

<table>
<thead>
<tr>
<th>CLINICAL EVIDENCE</th>
</tr>
</thead>
</table>

**Is requested intervention licensed in the UK for use in the requested indication?**

<table>
<thead>
<tr>
<th></th>
<th>Tick as appropriate (refer to pharmacy if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>If <strong>No</strong> is it licensed for use in another indication:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Has the Medicines Management Committee or equivalent Committee approved the requested intervention for use? (if drug or medical device)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>If <strong>No</strong>, Committee Chair or Chief Pharmacist approved:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Evidence must be supplied e.g. minutes, Chairs actions, etc. NB the CCG cannot consider the case in the absence of this evidence

**Give details of National or Local Guidelines/ recommendations or other published data supporting the use of the requested intervention for this condition.**  
(***Full published papers, rather than abstracts, should be submitted, unless the application relates to the use of an intervention in a rare disease where published data is not available. Electronic copies of the papers / web links for peer-reviewed papers must be supplied, where available***)
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the anticipated benefit/outcome of the intervention compared to the standard?</td>
<td></td>
</tr>
<tr>
<td>What is the anticipated toxicity of the intervention for this patient?</td>
<td></td>
</tr>
<tr>
<td>What are your criteria for stopping treatment? Define fully using objective measurements or recognised assessment scales.</td>
<td></td>
</tr>
<tr>
<td>Are there any patient factors (clinical or personal) that need to be considered?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>If Yes, please give details:</td>
</tr>
</tbody>
</table>

| Date form completed:                                                    |        |
| Trust reference number:                                                 |        |
| (Pharmacy to complete)                                                  |        |

**CCG/CSU use only**

| Record of communication:                                               |        |
Points for Discussion:

Recommendation:

Date:

For appeals process please refer to IFR policy.
Appendix 3.2

INDIVIDUAL FUNDING REQUEST FORM
(Community Provider)

Is this application urgent/fast-track?

Yes

No

Copy and paste this tick if you need to. ✓

INDIVIDUAL FUNDING REQUEST (IFR) - Application Template
For Clinicians
Please ensure that you have your patient’s consent for patient identifiable data (i.e. name, DOB etc.) to be shared on a need to know basis with appropriate professionals who may be involved in the patient’s care. This will be required in cases where further investigation to gain a fuller picture is needed. All data is stored in line with Data Protection Regulations.

Contact details for IFR Queries – see section below for information on submitting requests
Team
Fundingrequests.south@nhs.net
01268 594480 or 01268 594553

INDIVIDUAL FUNDING REQUEST

Guidance for the use of the individual funding request submission form

Individual funding requests should only be made where the patient has exceptional clinical circumstances, and will be subject to audit.

Completing the form:

- This form must be completed by the requesting clinician for all off-protocol requests requiring CCG funding (for example: procedures that are not on the approved list).
- The form must be completed electronically giving full details. Boxes will expand. Failure to provide full information may result in a delay in reaching a final decision.
- Your submission will be greatly supported if you directly answer these two ‘tests’ of exceptionality in section 10, and give appropriate evidence in the other sections.

The patient

1) Is clinically significantly different from the general population of patients with the same diagnosis/condition in question.

AND

2) As a result of this clinical difference is more likely to benefit from this treatment/intervention than might be expected for the average patient with the diagnosis/condition.
The fact that the diagnosis is very rare, or that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality. If a patient’s clinical condition matches the ‘accepted indications’ for a treatment that is not funded, they are by definition, not exceptional.

Only evidence of clinical exceptionality will be taken into consideration.

It is the responsibility of the requesting clinician to demonstrate exceptionality.

1) Requests can only be made on an individual, named patient basis and should be completed by an appropriate referring clinician prior to referral for treatment. It is not guaranteed that such treatment will be necessarily funded in the case of similar subsequent cases if the CCG does not consider it as clinically effective or cost effective.

2) The CCG will not normally fund a patient’s treatment to continue following a clinical trial. In line with the Medicines Act 2004 and the Declaration of Helsinki, the responsibility for ensuring a clear exit strategy from a trial and that those benefiting from treatment will have on-going access to it, lies with those conducting the trial.

3) CCGS will not normally fund novel or uncertain treatments. Funding for new, rarely used, unlicensed and/or investigational drugs outside of a research trial will remain the responsibility of the provider unless a business case is submitted in advance to the commissioner to take through the due process.

4) The following criteria should be used to identify how urgent a request is:
   - Urgent/Fast track response within 5 working days (refer to policy for definition/criteria)
   - Routine application received to decision 2 months

5) The requesting clinician is asked to provide clinical feedback on the outcomes of treatment (ideally following clinical review in 3 months or as appropriate).

**Submitting the form:**

<table>
<thead>
<tr>
<th>Applications to be sent to:</th>
<th>South East all IFR funding applications including drugs IFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please note that emails must be sent from an nhs.net address to an nhs.net address.</td>
<td><a href="mailto:Fundingrequests.south@nhs.net">Fundingrequests.south@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>South West Essex funding applications ((non-medicines/drug requests))</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Fundingrequests.south@nhs.net">Fundingrequests.south@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>South West Essex IFR (drug applications only)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:CECSU.IFR-ECC@nhs.net">CECSU.IFR-ECC@nhs.net</a></td>
</tr>
<tr>
<td>CONTACT INFORMATION</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Trust Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address (in full)</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Applicant Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Designation:</td>
</tr>
<tr>
<td>Department:</td>
</tr>
<tr>
<td>Telephone No.:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>ONLY NHS or nhs.net addresses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initials:</td>
</tr>
<tr>
<td>NHS No.:</td>
</tr>
<tr>
<td>Hospital ID number:</td>
</tr>
<tr>
<td>DoB:</td>
</tr>
<tr>
<td>Male:</td>
</tr>
<tr>
<td>Female:</td>
</tr>
<tr>
<td>BMI:</td>
</tr>
<tr>
<td>Registered Consultant:</td>
</tr>
<tr>
<td>Registered GP name:</td>
</tr>
<tr>
<td>Registered GP postcode:</td>
</tr>
<tr>
<td>Responsible CCG:</td>
</tr>
<tr>
<td>Referred by (other than GP):</td>
</tr>
<tr>
<td>Referred from:</td>
</tr>
<tr>
<td>Date of referral:</td>
</tr>
</tbody>
</table>

<p>| For a drug intervention - Application reviewed by Chief Pharmacist or depot Name: |
| Chief Pharmacist /deputy Name: (Must be copied into all drug related correspondence) |</p>
<table>
<thead>
<tr>
<th>Nominated deputy e.g. relevant specialist pharmacist</th>
<th>Chief Pharmacist /deputy email:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chief Pharmacist /deputy telephone number:</td>
</tr>
<tr>
<td></td>
<td>Pharmacist name: (for any queries if different to above)</td>
</tr>
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<td></td>
<td>Pharmacist email:</td>
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### INTERVENTION REQUESTED
(NB: Intervention refers to requested treatment, investigation, etc)

<table>
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<tr>
<th>Patient Diagnosis (for which intervention is requested)</th>
<th>Name of intervention:</th>
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<tr>
<td>Details of intervention (for which funding is requested)</td>
<td>Dose and frequency:</td>
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<td>Route of administration:</td>
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<tr>
<td>Costing information</td>
<td>Anticipated monthly cost, or cost per cycle (inc VAT) <em>(Seek advice from Pharmacy)</em></td>
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<tr>
<td></td>
<td>Related monitoring costs</td>
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<tr>
<td></td>
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<td></td>
<td>Any other additional on costs including reasons</td>
</tr>
</tbody>
</table>

### Intervention information

(a) Planned duration of intervention?

(b) How will you monitor the effectiveness of the intervention?

(c) What are the criteria for stopping treatment?

(d) What would you consider to be a successful outcome for this intervention in this patient?

(e) How would this be measured?
<table>
<thead>
<tr>
<th>Is requested intervention part of a clinical trial?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, give details: (e.g. name of trial, is it an MRC/National trial?)

<table>
<thead>
<tr>
<th>(a) Is there a standard intervention at this stage?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes include details / standard algorithm of care for disease type:

<table>
<thead>
<tr>
<th>(b) Is the requested intervention additional to the standard intervention(s) or a deviation from the standard?</th>
<th>Additional</th>
<th>Deviation</th>
</tr>
</thead>
</table>

Please indicate where the patient fits into the standard algorithm:

<table>
<thead>
<tr>
<th>(c) What are the exceptional circumstances that make the standard intervention inappropriate for this patient?</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Dates</th>
<th>Intervention (eg. drug / surgery)</th>
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* Reasons for stopping may include:
- Course completed
- No or poor response
- Disease progression
- Adverse effects/poorly tolerated

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<td>--------------------</td>
<td></td>
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<td><strong>Is requested intervention licensed in the UK for use in the requested indication?</strong></td>
<td></td>
</tr>
<tr>
<td>Tick as appropriate (refer to pharmacy if required)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
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<tr>
<td><strong>If No is it licensed for use in another indication:</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Has the Medicines Management Committee or equivalent Committee approved the requested intervention for use?</strong> (if drug or medical device)</td>
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<td></td>
</tr>
<tr>
<td><strong>What is the anticipated benefit/outcome of the intervention compared to the standard?</strong> (In case of intervention for cancer please provide details of expected survival benefit, quality of life, life expectancy etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>What is the anticipated toxicity of the intervention for this patient?</strong></td>
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<tr>
<td><strong>What are your criteria for stopping treatment? Define fully using objective measurements or recognised assessment scales.</strong></td>
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</table>
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<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please give details:

Date form completed:

Trust reference number: (Pharmacy to complete)

CCG/CSU use only

Record of communication:

Points for Discussion:

Recommendation:

Date:

For appeals process please refer to IFR policy.
Appendix 3.3

**INDIVIDUAL FUNDING REQUEST (IFR) - Application Template**

**For GPs**

**Individual funding request (IFR)**

Individual funding requests should only be made where the patient has *exceptional clinical circumstances*, and will be subject to audit.

Return to: **IFR Team, Central Eastern Commissioning Support Unit, Phoenix Court, Christopher Martin Road, Basildon, Essex, SS14 3HG** or email to fundingrequests.south@nhs.net.

Incomplete applications will be returned and may result in a delay in the decision making process.

**What needs to be filled out:**

1. If you are seeking funding for a treatment that is usually excluded or partially excluded from the NHS as indicated in the Service Restriction Policy (SRP), **only complete Section 1.**

2. If you are seeking funding for a new treatment/technology you must **complete in full Sections 1 and 2** of this application.

- The fact that the diagnosis is very rare, or that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality. If a patient’s clinical condition matches the ‘accepted indications’ for a treatment that is not funded, they are by definition, not exceptional.

- Only evidence of clinical exceptionality will be taken into consideration.

**The patient**

1) **Is clinically significantly different from the general population of patients with the same diagnosis/condition in question.**

   AND

2) **As a result of this clinical difference is more likely to benefit from this treatment/intervention than might be expected for the average patient with the diagnosis/condition.**

- It is the responsibility of the requesting clinician to demonstrate exceptionality.

- Requests can only be made on an individual, named patient basis and should be completed by an appropriate referring clinician **prior** to referral for treatment. It is not guaranteed that such treatment will be necessarily funded in the case of similar...
subsequent cases if the CCG does not consider it as clinically effective or cost effective.

- The following criteria should be used to identify how urgent a request is:
  - **Urgent/Fast track** response within 5 working days (refer to policy for definition/criteria)
  - **Routine** application received to decision 2 months

### A: Patient details

Patient NHS Number: 
Patient first names: 
Patient last name: 
UBRN: 
Date of birth (DD/MM/YY): 
Gender: □ Female □ Male
Patient address (1st Line): 
Patient town: 
Patient postcode: 

Patient contact number (home): 
Patient contact number (mobile): (not mandatory)
Patient email address: (not mandatory)
Interpreter required: □ No □ Yes, language: 
Transport required: □ No □ Yes, state type: 

### B: GP details

GP name: 
GP Practice address: 
GP practice code: 
GP contact no.: 
GP email address: 

### C: Applicant clinician details

GP/Consultant’s name: 
Address: 
Contact no.: 
Section 1: All applicant clinicians must complete this section

1. What is the patient’s condition/diagnosis?

2. Patient BMI: (if relevant)

3. What is the proposed treatment?

4. What treatments has the patient received to date for this condition?

5. Exceptionality Test 1
How is the patient significantly different from other patients in this patient population? (The onus is on the applicant clinician to demonstrate that this patient is significantly different from other patients in a similar situation to justify deviation from the usual clinical management)

6. Exceptionality Test 2
Will this patient benefit to a greater degree from receiving this treatment than others in this patient population/cohort? (The onus is on the applicant clinician to demonstrate that there are factors about this specific patient that indicate a departure from the usual clinical management will result in a gain for this patient that is significantly greater than that normally expected of this patient population in general.)
7. How many patients in a 12 month period would you expect to seek similar treatment for?

8. How much does the intervention cost?

Section 2: Must be completed for applications involving new treatments or techniques

The proposed intervention should have a high likelihood of success or should substantially reduce the risk associate with the standard intervention. Please provide evidence (e.g. papers outlining the intervention outcome with patient specific information sufficient to identify the proposed patient as being similar to the study in which the benefit was seen).

The Panel will base its deliberations on the information provided.

1. Safety
   a. Is the proposed intervention safe?
   b. Is the treating clinician adequately qualified/experienced to perform this treatment?
      Please provide evidence.
   c.
2. Effectiveness
   a. Is the intervention effective?
   Why is the proposed intervention thought to be superior to the standard treatment in this patient’s case?
   b. Have clear outcomes been set with the patient?
   c. What level of response will be considered ineffective?
   d. How is response to the intervention to be monitored?
   e. What is the end point at which the intervention will stop?
   f. What are the longer-term follow-up arrangements?
   g. Are these the responsibility of the unit in which the intervention took place or a unit more local to the patient’s home?
   h. Do the follow-up arrangements attract additional resource?

3. Equity and fairness
   a. What are the local treatment options for this patient?
   b. What is the cost of the standard intervention vs. the proposed intervention?
Treatment Requested:

Clinical Information:

Patient BMI: (if relevant) 

Other Clinical Information: (please attach prescription history, clinical letters, etc.)

To obtain an electronic copy of this form, please email 
Fundingrequests.south@nhs.net
For appeals process please refer to IFR policy.
Appendix 4

SRP EIA Feb 2014.docx

Full equality impact assessment.

Appendix 5

Appendix 5 - SRP Codes April 14.xlsx

List of applicable ICD10 and OPCS codes.