Choosing Wisely Policies 2017-18

APRIL 2017
**Version Control:**

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<td>1.0</td>
<td>• Incorporation of 22 policies authorised by Croydon CCG Governing Body in January 2017, rest of the policies as agreed by SWL still effective</td>
<td>• Urgent need to review policies</td>
<td>Albert De Souza &amp; SWL</td>
<td>February 2017</td>
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**Policy Update Tracker**

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Introduction

This document has 60 procedure thresholds which include 22 that have been revised from the 2014-15 SWL ECI policy document. The remainder have not been amended and remain as per the 2014-15 SWL ECI policy document.

All procedures are now subject to funding approval either via a Prior Approval process or subject to an Individual Funding Request (IFR). The process that needs to be followed is detailed in Appendix A (flowchart).

The policies within this document are a set of patient criteria to inform the commissioning of clinical interventions in Croydon. For some procedures, such as dental implants and aesthetics, all cases need to be reviewed through an individual application via Individual Funding Request (IFR) including Exceptional Circumstances application.

Aesthetic surgery for cosmetic purposes will not normally be funded by CCGs.

This document includes the criteria (with rationale/supporting evidence) that are required to be met in order to receive approval for funding.

In order for funding to be agreed for an Choosing Wisely procedure outside of the criteria (or for procedures where no specific criteria are given), the applicant must make a case for exceptional circumstances (Individual Funding Request) by demonstrating that there is some unusual clinical factor about the patient that suggests that they are:

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

The fact that the treatment is likely to be efficacious for a patient is not, in itself, a basis for exceptionality. Also the patient’s social circumstances including family or work-related factors are not taken into consideration by the Individual Funding Request panel, which will consider the evidence and decide upon funding. The IFR form is available as an appendix to this Document (Appendix B).

Applications for funding should be made on behalf of the patient by primary or secondary care clinicians.

The Croydon CCG Choosing Wisely Policy is driven by the need to ensure that NHS funded treatments are effective and evidence-based and that access to treatment throughout the Croydon area is equal for patients with similar need. It also attempts to define more clearly and openly the limits of NHS funding for procedures with social but not physical benefits cosmetic procedures. Although not the main driving force, it is also linked to the need to ensure that the NHS provides value for money and achieves financial balance.

The current procedures included in the Croydon CCG Choosing Wisely Policy document can broadly be classified into four groups:

- Procedures with limited evidence of effectiveness.
- Procedures where initial conservative therapy is possible.
- Effective procedures where a threshold for intervention may be appropriate.
- Procedures where NHS provision may be inappropriate.

Criteria for funding of procedures is included in the Croydon CCG Choosing Wisely document are developed on the basis of current evidence of best practice and in consultation with local clinical teams.

A rolling programme is in place to ensure that criteria for procedures are up to date, are based on best available evidence, and that new procedures are added to the document.
Homeopathic/Complementary therapies

These therapies are not funded by the NHS (Appendix C).

Procedures with limited evidence of benefit

This includes grommet insertion and tonsillectomy. For these procedures, the available evidence suggests limited benefit and significant risks.

Procedures where initial conservative therapy is effective

This includes procedures such as hysterectomy for heavy menstrual bleeding where surgical treatment may be considered but conservative therapy is effective and can avoid the risks associated with surgery.

Procedures where a threshold for intervention may be appropriate

This includes cataract surgery. For these procedures, it is possible to select patient groups who are unlikely to benefit from treatment.

Procedures where NHS provision may be inappropriate

This includes all cosmetic surgery and removal of some minor skin lesions. They are procedures for which the primary purpose is to improve appearance and the evidence for other benefits, including psychological, is limited.

It should be noted that procedures that have been the subject of NICE Technology Appraisals will be amended without going through the usual consultation period. A list of those procedures amended will be published as they occur.
Aesthetic Surgery

Definition

In this guidance aesthetic or cosmetic surgery is defined as surgery undertaken to improve one’s appearance or reshape normal body parts to improve appearance. This differs from reconstructive surgery which is undertaken to reshape abnormal structures of the body, from accidents, injuries, infections, cancers or other diseases, as well as congenital deformities.

Aesthetic surgery for cosmetic purposes will not normally be funded by the CCG. All proposals need to be approved as per local agreement (this may be Individual Funding Request (IFR) (See appendix B) including Exceptional Circumstances application or other prior approval process e.g. referral review via a Clinical Assessment Service (CAS)).

Note: Minor skin lesions are covered in a separate section of this document.

National Aesthetic Surgery Guidelines were published in Action on Plastic Surgery ‘Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in Plastic Surgery’. The SWL Public Health ECI network reviewed these guidelines, existing NHS policies and evidence of effectiveness for individual procedures to produce a set of guidelines/criteria. Where the group found no robust evidence, the guidelines/criteria in the table below represent a consensus view of who might be considered appropriate for surgery and the actions which need to be taken before sending a proposal to the IFR/exceptions/prior approvals panel. The table below describes the criteria/guidelines for aesthetic procedures and should be considered against requests for procedures as indicated in this policy document.

General Principles

1. Patients should be at least 18 years of age for most procedures (where this is the case the procedure is annotated with ‘***’). It should be demonstrated that the conservative treatments/options had been exhausted.

2. CCGs will not generally fund cosmetic procedures solely to improve appearance in the absence of the following:
   
   - Disease, e.g. recurrent infection;
   - Congenital deformity (this does not include normal variation);
   - Limitation of function;
   - Impaired ability to perform activities of daily living.

3. Psychological distress alone will normally not be accepted as a reason to fund surgery.

4. In exceptional circumstances psychological distress alone may be considered as a reason for cosmetic surgery if it may alleviate severe and enduring psychological dysfunction. In these cases a NHS psychiatrist or psychologist must provide demonstrable evidence of treatment(s) used to alleviate/improve the patient’s psychological wellbeing, including impact and duration of treatment(s). Patients should be currently engaged or have undergone appropriate psychological or psychiatric treatment. Patients should NOT be referred into mental health services specifically to support an application for aesthetic surgery.

5. Clinicians are requested to refer to NICE CG31 Obsessive-compulsive disorder (OCD): Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder† prior to referring on psychological grounds alone.

6. For patients with anxiety or depression, clinicians should consider a referral to the local Improving Access to Psychological Therapies service before requesting cosmetic surgery.

References:

1. National Institute for Health & Clinical Excellence (NICE) CG31 Obsessive-Compulsive

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1. Breast Procedures

These criteria do not apply to cosmetic surgery following breast cancer treatment as this is covered by cancer network commissioning policies and pathways.

1.1 Reduction mammoplasty

** (Female breast reduction)

Funding may be considered in the following circumstances:

- The patient should be 18 or over at the time of application.
- Gross asymmetry of at least 2 cup sizes* difference between the breasts.
- BMI equal to or below 27;
- The patient has a bra cup size of F or more or requires at least 500g of tissue to be removed from each breast**;
- If the patient has at least TWO of the following for at least one year (and documented evidence of GP visits for these problems)¹:
  - Pain in the neck
  - Pain in the upper back
  - Pain in shoulders
  - Pain / discomfort / ulceration from bra straps cutting into shoulders;
- Pain symptoms persist as documented by the physician despite a 6-month trial of therapeutic measures including all of the following:
  - Supportive devices (e.g., appropriate bra/support bra fitted by a trained bra fitter, wide bra straps).
  - Analgesic / non-steroidal anti-inflammatory drugs (NSAIDs) interventions.
  - Physical therapy / exercises / posturing
  - manoeuvres.

Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless all of the above are met and the patient has failed to respond to 6 months of conservative treatment.

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

** 500g estimates to a 4 cup size reduction in patients with chest sizes 30 to 34 or 2 cup size reduction in patients with wider chests 34-40+.
1.2 Gynaecomastia

** (Male breast reduction for gynaecomastia) (liposuction may form part of the treatment plan for this condition)

It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.

The patient should meet the following criteria:

- The patient should be 18 or over at the time of application;

AND

- BMI of equal to or below 27;

AND

- Have gynaecomastia of Grade III * i.e. Gross breast enlargement with skin redundancy and ptosis so as to simulate a pendulous female breast;

AND

- Have been screened for endocrinological or drug related causes.

Notes:

*Simon’s classification for gynaecomastia
IIa Minor but visible breast enlargement without skin redundancy. IIa Moderate breast enlargement without skin redundancy
IIb Moderate breast enlargement with minor skin redundancy
III Gross breast enlargement with skin redundancy and ptosis so as to simulate a pendulous female breast.


1.3 Augmentation/ Mammooplasty

** (Breast enlargement)

Criteria

- The patient should be 18 or over at the time of application;

AND

- Has significant asymmetry. (Significant asymmetry will be defined as a difference of at least 2 full cup sizes*) to the extent that they cannot get a bra to fit;

OR

- There is complete absence of breast tissue unilaterally or bilaterally.

*AA, A, B, C, D, DD, E, F, FF, G, GG, H, HH, J, JJ, K, L
1.4 Revision of breast augmentation

**

Criteria

The patient should be 18 or over at the time of application.

AND

Removal of implants will be considered, but not replacement, if at least one of the following criteria are met:

- Rupture of silicone-filled implant.
- Implants complicated by recurrent infections.
- Extrusion of implant through skin.
- Implants with Baker Class IV contracture associated with severe pain.
- Implants with severe contracture that interferes with mammography.

Replacement of implants will be considered, for clinical reasons, if the original implants were funded by the NHS for non-cosmetic reasons.

1.5 Mastopexy

** (Breast lift)

The patient should be 18 or over at the time of application.

Mastopexy (Breast lift) will not be funded for purely cosmetic/aesthetic purposes such as post-lactational ptosis.

NB for asymmetry see breast augmentation, for back pain as a result of breast size, see breast reduction.

1.6 Surgical correction of nipple inversion

**

The patient should be 18 or over at the time of application.

See General Principles above.

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

2.1 Rhytidectomy

** (Face lifts)

The patient should be 18 or over at the time of application.

See General Principles Above

2.2. Rhinoplasty

This policy does not apply to immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and does not require IFR approval from the Commissioner.

1. Rhinoplasty surgery is not routinely commissioned by the CCG
2. Septo-rhinoplasty is not routinely commissioned by the CCG
3. Septoplasty is only funded where there is evidence of a clinical blockage
4. Nasal surgery to correct the following is not routinely funded by the CCG:
   - to stop snoring
   - cosmetic appearance of the nose
   - for patients who are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers)
5. Consideration may be given for the following:
   - post-traumatic nasal injury causing continuous and chronic bi-lateral nasal airway obstruction associated with septal/bony deviation of the nose which as part of reconstructive head and neck surgery (including traumatic deformity)

AND

- there is significant functional impairment demonstrated d) applications put forward must demonstrate some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:
- Significantly different to the general population of patients with the condition in question
- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition
- Applications should be supported by photographs. The CCG will accept patients own photographs
- the CCG will NOT reimburse the costs of medical photography

2.3. Nasal Surgery (including Rhinoplasty, Septoplasty and Septorhinoplasty)

Policy Statement Nasal surgery to correct deformity and the cosmetic appearance of the nose, including Rhinoplasty and Septorhinoplasty is not routinely funded by the commissioner.

Rhinoplasty & Septoplasty requests via IFR, will only be considered where the patient has:

Post-traumatic nasal injury causing continuous and chronic bi-lateral nasal airway obstruction associated with septal/bony deviation of the nose which is causing significant functional impairment.
**Significant functional impairment is defined as:**
- Symptoms prevent the patient fulfilling routine work or educational responsibilities
- Symptoms prevent the patient carrying out routine domestic or carer activities

**Septoplasty** is allowed via criteria based access for the criteria stated below:

- Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (e.g. ethmoidectomy)
- Documented recurrent sinusitis, causing moderate to severe facial pain, felt to be due to a deviated septum not relieved by appropriate medical and antibiotic therapy after at least 6 months of medical therapy to include budesonide, mometasone, fluticasone and nasal douching (see patient information sheet).
- Recurrent epistaxis (nosebleeds) related to a septal deformity which have not responded to 3 attempts at cautery

Prior Approval should be sought by the secondary care clinician for Septoplasty for the following indication.

- Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty not responding to 6 or more months of documented appropriate medical therapy.

Croydon CCG will not normally approve funding for patients for snoring or are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers).

NB: This policy does not apply to immediate post trauma nasal manipulation which normally occurs two to three weeks after the trauma and does not require prior approval from the Commissioner.

**Smoking cessation is recommended for all patients considering the possibility of surgery.**

### 2.4 Pinnaplasty

Cartilage moulding devices are advised in infants up to 6 months of age.

Surgery in the NHS should be available for children with significant deformity or asymmetry, where the prominence measures >30mm (using the measuring guide below)

AND

Where there is evidence of psychological distress (presenting as documented episodes of bullying and or school refusal) in children and adolescents with prominent ears in whom corrective surgery should help to resolve these issues. Details should be provided in the referral letter.

- Surgery below the age of 5 should only be offered if correction of prominence will help in retaining hearing aids securely, in children for whom they are required.
- It is recommended that surgery is only offered to children above 5 years of age and below 18 years of age, i.e. the upper age limit for referral is 17 years and 364 days. Children under the age of 5 are less likely to tolerate the procedure well or be compliant with dressings care.
Psychological distress is unlikely to have developed prior to the age of 5 and surgery can therefore be delayed until later.

- NHS surgery for prominent ears should not be offered to adults over the age of 18 years.

Supporting Information for consideration of exceptionality Where surgery is requested outside of the policy criteria above, the following supporting information is required:

- The size of the prominence, using the measuring guide below.
- Details of any psychological distress, this should include documented evidence of, for example, bullying or school refusal to support the application.
- Details of any functional problems.
- Non-identifiable photographs, preferably medical illustrations if available to support the decision making process. Photographs will be considered but will not form the sole basis of the decision. It is not mandatory for photographs to be provided by a patient. If photographs are submitted then the measuring device should not be touching the ear and thereby aiding the prominence.
- Details of any clinical exceptional circumstances.

It is important that it is the child who desires surgical correction; referral should not be made for children who appear indifferent or opposed to the idea of surgery. Parents requesting surgery for their child in order to prevent psychological distress when their child starts school or at some time in the future should be advised that referral should wait until their child specifically requests treatment.

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

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

Measure from the posterior aspect of the Helix.
Prominence = H-M distance > 20mm, but

Pinnaplasty will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids.

DO NOT REFER for prophylactic or cosmetic reasons for any case (Adult or Paediatric) as these applications will automatically be refused.

### 2.5 Repair of external ear lobes
(Lobules)

| Consideration will be given to completely split ear lobes as a result of direct trauma.  
Note: If a previously repaired earlobe is pierced and the split recurs, no further treatment will be offered.  
If approved, Panels will agree funding for one episode of repair only |

### 2.6 Hair replacement techniques to correct hair loss
(e.g. due alopecia or male pattern baldness)

| This procedure is not routinely funded by the NHS. If clinical exceptional circumstances exist, applications for funding can be made in the form of an individual application (such as an Individual Funding Request (IFR)).  
In certain circumstances wigs may be considered clinically appropriate. Some patients, |

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3. Body Contouring Procedures

3.1 Apronectomy or Abdominoplasty

** (Tummy tuck)

The patient should be 18 or over at the time of application.

AND

At the time of the application the patient should have a BMI of between 18 and equal or less than 27 kg/m² and must have maintained a BMI in this range for at least 24 months.

OR

Further consideration may be given to people who have had very significant weight loss post bariatric surgery who should have lost at least 50% of their original excess weight* and maintained this weight for at least 6 months, and be at least 18 months post-surgery.

AND

Have severe functional problems which should include at least one of the following:

- Severe difficulties with daily living i.e. ambulatory restrictions.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least 6 months.

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

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

3.2 Body contouring

** (Other skin excision for contour e.g. buttock lift, thigh lift, arm lift (brachioplasty)

(For apronectomy/abdominoplasty in respect of body contouring see criteria for apronectomy/abdominoplasty above)

The patient should be 18 or over at the time of application;

AND

At the time of the application the patient must have a BMI of equal to or below 27 kg/m² and must have maintained a BMI in this range for at least 18 months;

AND

Have severe functional problems which may include:

- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate conservative treatment for at least 6 months.
• Severe difficulties with daily living i.e. ambulatory restrictions.

3.3 Liposuction

Liposuction will not be routinely funded to correct the distribution of fat. If clinical exceptional circumstances exist, applications for funding can be made in the form of an individual application (such as an Individual Funding Request (IFR)).

4. Skin and Subcutaneous Lesions

4.1 Facial skin procedures

Skin resurfacing and other surgical interventions for scarring, including laser, dermabrasion and chemical peels)

Skin resurfacing procedures for cosmetic purposes or purely to improve appearance will not be routinely funded.

Individual requests will be considered on an exceptional basis where there is evidence that the procedure will improve clinically significant signs and symptoms.

4.2 Tattoo removal

See General Principles above.

4.3 Treatment of skin hyperpigmentation

(including laser therapy, chemical peels etc.)

See General Principles above.

4.4 Treatment of vascular lesions

See General Principles above.

Individual requests will be considered on an exceptional basis which may include evidence that facial lesions cause significant disfigurement or obstructive symptoms.

Small, benign, acquired, vascular lesions such as thread veins and spider naevi would not normally be treated.

5. Miscellaneous

5.1 Injection of facial botulinum toxin for cosmetic indications

Botulinum toxin is not routinely funded for the treatment of facial ageing or excessive wrinkles. If clinical exceptional circumstances exist, applications for funding can be made.
in the form of an individual application (such as an Individual Funding Request (IFR)).

Botulinum toxin is available for the treatment of pathological conditions by appropriate specialists in cases such as Frey’s syndrome-gustatory sweating after parotid surgery; Botox A injection is recommended as a first line treatment for Frey’s syndrome and can be used in conjunction with or instead of oral anticholinergic medication.

5.2 Hair depilation
(Hair removal by electrolysis and/ or laser)

Treatment of severe hirsutism on the facial, neck and/or chest area will be considered if standard treatments have failed and exceptionality is demonstrated.

The methods of hair removal used should be diathermy electrolysis performed by a registered electrologist or, if appropriate, laser in the following circumstances and after all standard treatments have been tried:

- Abnormally located hair-bearing skin following reconstructive surgery.
- Treatment for pilonidal sinuses to reduce recurrence.

Funding will be agreed for a course of treatment after which a review of effectiveness will be required prior to any further funding being agreed.

5.3 Cosmetic genital surgery
See General Principles above

5.4 Keloidectomy

If the keloid:

Results in significant functional impairment.

OR

Causes significant pain requiring chronic analgesic medication.

OR

Bleeding.

OR

Suspicion of malignancy.

OR

Obstruction of orifice or vision.

OR

Failure to respond to intralesional steroid injection.

Panels will take into consideration the number of previous surgeries.

If approved, Panels will agree funding for one repair only and for steroid and/or radiotherapy as clinically indicated.
6. Asymptomatic gallstones

Croydon CCG will not fund cholecystectomy for asymptomatic gallstones.

Asymptomatic gallstones are gallstones detected incidentally in patients who do not have any abdominal symptoms or have symptoms that are not thought to be due to gallstones.

Rationale

- NICE Guidelines, CG188, 2014
- NICE Clinical Knowledge Summaries (CKS)
- RCS Commissioning guide for gallstones, 2013

References:

1. Mata A; Bouza C; Salinas J; Salvatierra L D; Freire E. Asymptomatic cholelithiasis in kidney transplant recipients: Systematic review of surgery appropriateness…..Value in Health, June 2012, vol./is. 15/4(A79), 1098-3015 (June 2012).


7. Circumcision

The CCG does not commission Circumcision surgery for personal, social, cultural or religious reasons and patients or their parents seeking this procedure should not be referred for CCG funded treatment.

The CCG does not commission Circumcision surgery for the prevention of sexually transmitted diseases or where a patient is suffering from pain on arousal or interference with sexual function. Funding approval for male circumcision will only be provided by the CCG for patients with the following indications:

1. Recurrent Paraphimosis – Circumcision will be funded for patients suffering from documented, clinically significant recurrent paraphimosis

OR

2. Pathological Phimosis - a. Circumcision will be funded where there is evidence of pathological white scarring of the foreskin secondary to Balanitis Xerotica Obliterans [BXO] in a child 4yr age or older AND the patient is suffering from pain or difficulty in passing urine AND conservative management has failed or is inappropriate. b. Circumcision will be funded where a patient has an abnormal urinary tract and circumcision is proposed as part of the management of this underlying condition. Circumcision will not be funded where a patient has non-retractile ballooning of the foreskin and/or spraying of urine or non-significant balanitis (up to 3 episodes in one year).

OR

3. Balanitis or Balanoposthitis – Circumcision will be funded for patients suffering from documented, clinically significant recurrent episodes (more than 3 in one year) of Balanitis or Balanoposthitis which has not responded to appropriate conservative management such as self-care, topical treatment or medication.

OR

4. Physiological Phimosis - a. Circumcision will be funded where a patient is –
   i. suffering from recurrent urinary tract infection, AND
   ii. Over 10 years of age, AND iii. non-surgical methods have proved ineffective – a minimum of 4 weeks is recommended.

Female Circumcision

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

Rationale

1. https://www.rcseng.ac.uk/standards-and-research/nscc/commissioning-guides/topics/
8.0 Diagnostic

8.1 Open magnetic resonance imaging (MRI)

Prior approval should be sought from the CCG.

CCGs will fund:

- Low field MRI for interventional and intraoperative procedures only.
- Fund Open MRI of greater than >0.5T as an alternative to conventional MRI in the following circumstances:

  Patients who suffer from claustrophobia where taking an oral prescription sedative to support conventional MRI has been tried and was not effective.

  OR

  Patients who cannot fit safely or comfortably in a conventional MRI, due to obesity or to some other confirmed clinical condition.

1. GPs should prescribe an oral sedative before referring for an Open MRI
2. Standard MRI has a 60 cm bore and can tolerate a maximum weight of 250 kg. Latest Standard MRI machines have an 80cm bore and are able to scan obese patients. Please check before referring for an Open MRI.

CCGs will not routinely fund:

Standing, Weight-Bearing, Positional, or Upright MRI except on an exceptional basis via the IFR route.

Introduction

MRI is a widely used diagnostic imaging technology and is particularly useful in detecting soft tissue damage and disease. The patient undergoing imaging is placed in a gradient magnetic field delivering radiofrequency pulses to the patient and processing the resulting electromagnetic signals emitted from the region being examined.¹ (CADTH) The standard (closed/high-field) method of MRI requires the patient to be in a supine or recumbent position. The orientation of standard MRIs requires the patient to be horizontal and stationary. (Washington State) Magnetic resonance (MR) imaging (MRI) is particularly useful in detecting soft tissue damage or disease.

For most scanners, the patient examination table is positioned in a long, narrow tube. Some patients may experience claustrophobic reactions which might be effectively controlled by sedation or anaesthesia. Obese individuals may not fit into the tube.

Open MRIs in which patients lie, sit or stand between two plates overcome these difficulties. They are also used for intraoperative imaging or image-guided interventions where easy access to the patient is required.

The technology

The quality of MRI images is partly dependent on the field strength of the magnet which is measured in Tesla (above 1 Tesla (T) is considered high). Closed MRIs have magnet field strengths of ≥1.5 tesla whereas open MRIs have medium strengths magnets of 0.5-1.0T. The lower field strength of open MRIs results in poorer quality images in comparison to closed MRIs, with lower signal-to-noise ratios.
and more motion artefacts. The length of time required to obtain an image is also longer.

Generally low field strength is below 0.5T, mid-field strength is 0.5 T, up to 0.9 T or 1 T; and high-field strength is at/and or above 1 T. High-field devices are usually closed-bore magnets due to the fact that the stronger magnetic fields (1–3 T) require more robust shielding and gradient structure to maintain field homogeneity. The open magnet’s field strength usually varies from 0.2–1.0 T.

Evidence

- MRI studies reported in the literature are generally based on intermediate- or high-field MRI. There is insufficient evidence in the published peer-reviewed literature to support the use of low-field strength MRI for any diagnostic indication including but not limited to the following: breast (Paakko, et al., 2005); cardiac (Klein, et al., 2007; Rupprecht, et al., 2002); cerebral/stroke (Terada, et al., 2006; Mehdizade, et al., 2003); pulmonary (Abolmaali, et al., 12004; Wagner, et al., 2001); renal (Stecco, et al., 2007; Kajander, et al., 2000); multiple sclerosis (Ertl-Wagner, et al., 2001) and retrocochlear disorders (Dubrule, et al., 2002).
- An evidence review performed by the Canadian Agency for Drugs and Technologies in Health (CADTH) found several non-randomised trials which compared high and low field MRIs.
- In a prospective study comparing a 0.2 T open scanner and a 1.5 T highfield system were used to examine 401 patients. There was no significant difference in the diagnostic accuracy of the two types of scanners in examinations for patients with diseases of the kidney (n=78), shoulder (n=122), or spine (n=105), using surgical or clinical follow-up as the reference finding. In cerebral examinations (n=96), the high-field system had a statistically significant advantage in accuracy (p=0.01). The authors suggest that limitations due to field strength are relevant only in a small number of cases that warrant high-field examination.
- In a study on MRI arthrography of the shoulder, a 0.2 T open MRI and a 1.5 T high-field system were used to examine 38 patients. Correlation of surgical and MRI findings was available for 27 patients (71%). The high-field MRI produced better image quality and fewer motion artefacts than the open low-field MRI, but diagnostic accuracy in the cases with surgical correlation was the same for both systems. The authors conclude that low-field MRI compares favourably to high-field MRI in detecting major abnormalities of the shoulder, but has disadvantages because of the duration of the examination, and the increased risk of reduced image quality due to motion artifacts.
- Michel et al. compared patients’ acceptance of MRI pelvimetry that was done using open 0.5 T and closed 1.5 T systems. Of 30 women referred for pelvimetry, 60% preferred the open system, 7% the closed system, and 33% had no preference. The image quality was adequate in both systems.
- Enders et al. (2011), a randomised controlled trial was carried out to investigate whether an open panoramic MR scanner is superior to a short-bore MR scanner in reducing the occurrence of claustrophobic events. A total of 174 were enrolled, 87 in the short-bore MR group and 87 in the open MRI group. With 33 claustrophobic events in the short-bore group (39% [95% confidence interval [CI] 28% to 50%] versus 23 in the open scanner group (26% [95% CI 18% to 37%]; P = 0.08) the difference was not significant. Enders and colleagues noted that the most problematic phases of the scan were patient positioning and entry into the exam suite. The researchers also noted that the claustrophobic event rates remained consistent—at more than 25 percent—regardless of patient characteristics and the anatomical region being scanned. The conclusions were that even recent MR cannot prevent claustrophobia suggesting that further developments to create a more patient-centered MR scanner environment were needed. The claustrophobia screening tool, CLQ may be a useful tool to detect patients at risk before claustrophobia occurs.

Interventional and Intraoperative

The use of MRI in guiding interventional and intraoperative procedures has become widely accepted as standard of care in equipped facilities. There are limited comparative studies between this and conventional approaches but there are several small, observational studies which indicate that MRI can be used safely and effectively.
Low-field MRI

There is insufficient evidence in the published peer-reviewed literature to support the use of low-field strength MRI for any indication other than intervention guidance. There is a lack of data: clarifying the impact of treatment decisions—based upon low-field interpretation—on patient outcomes; addressing accuracy and impact of interpretation of low-field MR images outside the hospital setting (i.e., non-radiologist interpretation); addressing any value of dynamic or positional low-field MRI compared to conventional MRI, or impact to patient outcomes; and clarifying what role low-field imaging should hold in the diagnostic algorithm of joint conditions. Due to insufficient evidence, it remains unknown if substituting low-field strength MRI in place of conventional MRI causes a negative impact to diagnostic accuracy, treatment planning and overall patient outcomes. The limited evidence fails to prove that the use of low-field strength MRI in place of conventional MRI improves diagnostic accuracy, treatment planning and overall patient outcomes.

Open and Semi-Open MRI

Open (i.e., extremity, upright, positional) MRI allows for imaging without the patient being placed within an enclosed space. Open and semi-open MRI systems have a variety of configurations wherein the patient is not completely surrounded by the magnet. Instead of a tunnel as with standard MRI, common configurations are open along the sides and/or consist of a shorter tunnel such that only the portion of the body being imaged is surrounded by the magnet. Some designs have flared ends or two large discs separated by a pillar. Both are open on the sides, allowing for imaging in different patient positions and for axial loading. Open-design has become the standard of care when conventional design is contraindicated. Specifically, this includes patients with pulmonary and/or cerebrovascular disease as well as patients who would require sedation for a conventional MRI such as severely claustrophobic or paediatric patients.

Standing, Weight-Bearing, Positional, or Upright MRI

Upright, standing or positional MRI (uMRI) is a type of vertically open MRI that has been developed in recent years. Such systems are open at the front and top, with the magnetic poles placed on either side of the patient and allow for vertical (upright, weight bearing), horizontal (recumbent) positioning, and dynamic kinetic flexion and extension maneuvers. Current uMRI scanners generally use medium field magnets of 0.5T (e.g., GE Signa™ SP/i) or 0.6T (e.g., FONAR Upright™MRI).

Washington State published a Health Technology Assessment on Standing, Weight-Bearing, Positional, or Upright MRI (2006). Some conclusions included:

- There is limited scientific data available on the accuracy and diagnostic utility of standing, upright, weight-bearing or positional MRI.
- There is no evidence from well-designed clinical trials demonstrating the accuracy or effectiveness of weight-bearing MRI for specific conditions or patient populations.
- Due to the lack of evidence addressing diagnostic accuracy or diagnostic utility, standing, weight-bearing, positional MRI is considered investigational and experimental.

References:

2. CIGNA. Magnetic Resonance Imaging - low field. CIGNA coverage policy 0444

Date Approved: January 2017  Review Date: December 2018  Version Final 1.0


18. Washington State Department of Labor and Industries, Office of the Medical Director. Standing, weight-bearing, positional or upright MRI. Health Technology Assessment. Olympia Washington State Department of Labor and Industries; May 31 2006

8.2 Wireless capsule endoscopy and double balloon enteroscopy in obscure gastrointestinal bleeding

Criteria

CCGs will fund wireless capsule endoscopy or double balloon enteroscopy for obscure gastrointestinal bleeding when:

<table>
<thead>
<tr>
<th>Patients with gastrointestinal bleeding have undergone a gastroscopy and/or endoscopy and results are negative then</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Capsule endoscopy for investigation</td>
</tr>
<tr>
<td>A) If wireless capsule endoscopy identifies source of bleeding in small bowel then</td>
</tr>
<tr>
<td>• Where indicated, double balloon enteroscopy for treatment</td>
</tr>
<tr>
<td>B) If results of wireless capsule endoscopy are normal but there is persistent bleeding then</td>
</tr>
<tr>
<td>• Consider second look wireless capsule endoscopy</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>• Double balloon enteroscopy for investigation and treatment where appropriate</td>
</tr>
</tbody>
</table>

Rationale

- The evidence available shows that WCE and DBE are safe and effective diagnostic procedures for the detection of OGIB. Both have a higher diagnostic yield than conventional methods.
- CE and DBE have common indications but different features. CE can cover the whole GI tract, requires no sedation and is better tolerated by patients. Its major limitations are the inability to obtain a biopsy, precisely localise a lesion, or perform therapeutic endoscopy. DBE has the advantage of being controllable and enabling therapeutic treatment to take place simultaneously. The procedure is invasive and not as well tolerated as CE, requiring additional staff, typically two physicians or an additional specialist nurse.
- Cost-effectiveness modelling suggests that that CE-guided DBE may be associated with better long-term outcomes because of the potential for fewer complications and decreased utilisation of endoscopic resources.

Evidence

- NICE produced interventional procedure guidance on WCE in 2004 \(^1\).
• Guidelines produced by British Society of Gastroenterologists in 2008, state DBE should be used complementary to WCE, particularly in the context of therapeutic intervention beyond the reach of push enteroscopy.

References:


8.3 Wireless capsule endoscopy and double balloon enteroscopy in Crohn’s disease

Criteria

CCGs will fund wireless capsule endoscopy or double balloon enteroscopy for Crohn’s disease when:

| Following inconclusive ileocolonoscopy and/or small bowel radiology clinical suspicion of Crohn’s disease remains then: |
|---|---|
| A) If pain is not a significant feature or where pain is a significant feature and there is no evidence of strictures on small bowel radiography. |
| • Wireless capsule endoscopy for diagnosis |
| B) If pain is significant feature and there is evidence of strictures on small bowel radiography or wireless capsule endoscopy results are inconclusive. |
| • Double balloon enteroscopy to obtain histology |

Rationale

• The evidence available shows that WCE is a safe and effective diagnostic procedure for the detection of Crohn’s disease. WCE has a higher diagnostic yield than push enteroscopy and other conventional methods. The results suggest that it is superior to conventional radiological procedures in the detection of lesions in patients with Crohn’s disease. However, the high number of patients with strictures limits its use as a first line diagnostic test in patients previously diagnosed.

• Capsule retention remains a risk in patients with Crohn’s disease with significant strictures. The risk is greater in patients with established Crohn’s disease compared to patients suspected to have Crohn’s disease.

Evidence

• NICE produced interventional procedures guidance on WCE in 2004.

• Guidelines produced by British Society of Gastroenterologists in 2008, state DBE should be used complementary to WCE, particularly in the context of therapeutic intervention beyond the reach of push enteroscopy.

References:

9.0 ENT

9.1 (Adeno)Tonsillectomy

Commissioning position

Tonsillectomy will be automatically commissioned by the CCG in the following circumstances:

- Suspected malignancy
- Peri-tonsillectomy abscess (Quinsy)

Tonsillar enlargement causing acute upper airways obstruction The following criteria\(^1\) are indications for consideration of tonsillectomy for both children and adults

<table>
<thead>
<tr>
<th>Reccurent sore throat where the following documented evidence applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 or more episodes of tonsillitis* in the last year</td>
</tr>
</tbody>
</table>

OR

| 5 episodes per year in the preceding two years                  |

OR

| 3 episodes per year in the preceding three years                |

AND

| There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work; |

AND/OR

| Failure to thrive                                               |

The CCG will fund tonsillectomy in children where enlarged tonsils cause obstruction of the airway and cause obstructive sleep apnoea syndrome, when one or more of the following apply

- A significant impact on quality of life demonstrated by supporting evidence such as sleep studies, growth charts, letters from GPs and letters from employer and school.
- A strong clinical history suggestive of sleep apnoea

Detailed documentation of the criteria that are fulfilled is mandatory in the referral letter to secondary care. Clinically inappropriate referrals will be sent back to the GPs.

3. NICE Interventional Procedure Guidance 150 regarding safety of surgical techniques for tonsillectomy.

Recurrent sore throat where the following documented evidence applies
7 or more episodes of tonsillitis* in the last year

Date Approved: January 2017  Review Date: December 2018  Version Final 1.0
Rationale for Tonsillectomy for Tonsillitis

The frequency of sore throat episodes and upper respiratory infections reduces with time whether or not tonsillectomy has been performed. Tonsillectomy offers relatively small clinical benefits compared with non-surgical treatment. Tonsillectomy probably gives an additional, but small, reduction of sore throat episodes, days of sore throat associated school absence, and upper respiratory infections compared to watchful waiting. This benefit needs to be weighted against the risk of mortality (estimated to be between 1/8,000-1/35,000) and other surgical complications.

* Definition of tonsillitis

Using the SIGN list as indicative of bacterial infection, an eligible episode of tonsillitis must have three points, one each for any of the 5 criteria documented:

a. History of fever (>38.3°C)
b. Tender anterior cervical lymph nodes
c. Tonsillar exudate
d. Absence of cough
e. Age under 15 but age 45+ subtracts a point OR Positive culture of group A beta haemolytic streptococci

9.2 Grommets in older children (12 and above) and adults (ventilation tubes) (Insertion of)

The CCG will only fund grommet insertion in children aged (12 and above) and adults (aged 18 and over) when the following criteria are met:

- Insertion of grommets as part of a more extensive surgical procedure
- Severe retraction of the tympanic membrane and in the expert view of the consultant that this may be reversible and reversing it may help avoid erosion of the ossicular chain
- The development of cholesteatoma
- Eustachian tube dysfunction that prevents the commencement or completion of hyperbaric oxygen treatment or acute or chronic otitis media with risk of complications of facial palsy or intracranial infection eg. meningitis
- As a treatment for Ménière’s disease or in the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinunasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician.
References:
1. NICE Clinical Guideline 60 – Surgical management of otitis media with effusion in children;
3. SIGN Guideline No. 66 - Diagnosis and Management of Childhood Otitis Media in Primary Care;
5. MRC Multicentre Otitis Media Study Group Article first published online: 19 APR 2012 DOI: 10.1111/j.1749-4486.2012.02469.x

9.3 Grommets in children under 12 (ventilation tubes) (Insertion of)

Criteria
These criteria apply to children aged under 12 years only.

The CCG will fund treatment with grommets for children with persistent otitis media with effusion (OME)\(^1\) where:

| Persistent bilateral OME has been 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

| 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. |

In children with additional disabilities such as Down's Syndrome or cleft palate, involvement of a multidisciplinary team with expertise in assessing and treating OME in these children is essential\(^1\).

Rationale
- The reduced risk of serious complications of anaesthesia and surgery must be balanced against the increased hearing loss and episodes of infection requiring antibiotic treatment and time off school or playgroup. The evidence of effectiveness is limited.
- Restricting access to grommets is not a new phenomenon. A 1995 survey revealed that 23 of the 129 health authorities in England, Scotland and Wales had excluded grommets. The key points are summarised below:
  - Surgery may resolve glue ear and improve hearing in the short term compared with nonsurgical treatment, but there is less certainty about long-term outcomes and large variation in effect between children.
  - There continues to be debate about how best to select children for surgery. This issue is complicated by the high rate of resolution of glue ear, particularly in younger children\(^3\).
  - The timing of surgery may not be critical\(^2\). An initial period of watchful waiting is recommended for most children\(^4\). If watchful waiting is being considered, the child should undergo audiology to exclude more serious degree of hearing loss.
  - The benefits of surgery have to be balanced against possible harms. One third of children who have grommets have complications. Tympanosclerosis frequently occurs after grommet
insertion, infection may occur, and there is a slightly increased incidence of chronic perforation

Evidence

- Cochrane review\(^2\) showed that the benefits of grommets in children are small compared with myringotomy or non-surgical treatment. The effect of grommets on hearing diminished during the first year. It recommends an initial period of watchful waiting for most children with OME.
- A 1999 trial 4 compared 9 months 'watchful waiting' with immediate surgery and found outcomes to be similar to 18 months. However, by this time, 85% of children in the watchful waiting group had been treated with grommets.

References:

1. National Institute for Health & Clinical Excellence (NICE) CG60 Surgical Management of otitis media with effusion in children, Feb 2008
2. Cochrane review: Grommets for hearing loss associated with otitis media with effusion. January 2005
3. Cochrane review: Grommets (ventilation tubes) for recurrent acute otitis media in children. October 2008, assessed as up-to-date January 2011
6. Adjuvant adenoidectomy in persistent bilateral otitis media with effusion: hearing and revision surgery outcomes through 2 years in the TARGET randomised trial
7. MRC Multicentre Otitis Media Study Group Article first published online: 19 APR 2012 DOI: 10.1111/j.1749-4486.2012.02469.x
10.  Eyes

10.1 Blepharoplasty (surgery on the upper & lower lid)

This procedure is not routinely funded by the NHS but may be funded through the local prior approval process. Applications can be made in the form of an individual application as per local agreement (this may be Individual Funding Request (IFR) including Exceptional Circumstances application or other prior approval process e.g. referral review via a Clinical Assessment Service (CAS)) in the following situations.

<table>
<thead>
<tr>
<th>To relieve entropion or ectropion.</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>To remove lesions of the eyelid skin or lid margin in the following situations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Impairment of vision by lid as evidenced by photographs.</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>2. Impairment of the visual field by lid as evidenced by visual field test.</td>
</tr>
</tbody>
</table>

OR

<table>
<thead>
<tr>
<th>Other demonstrated complications, e.g. disruptions of the tear film, evidence of chronic compensation of ptosis through elevation of the brow.</th>
</tr>
</thead>
</table>

10.2 Brow lift

This procedure is not routinely funded by the NHS but may be funded through the local prior approval process. Applications can be made in the form of an individual application as per local agreement (this may be Individual Funding Request (IFR) including Exceptional Circumstances application or other prior approval process e.g. referral review via a Clinical Assessment Service (CAS)) in the following situations.

<table>
<thead>
<tr>
<th>Impairment of vision by lid as evidenced by photographs.</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>To correct impairment of the visual field by lid as evidenced by visual field test.</th>
</tr>
</thead>
</table>
10.3 Cataract surgery

Subject to a preapproval process, the CCG will only fund elective cataract surgery where the following apply:

The best corrected visual acuity is 6/12 or worse in either the first or second eye;

AND/OR

The patient has impairment in lifestyle such as substantial effect on activities of daily living, employment, risk of falls, or extreme glare (see attached Cataracts Surgery Checklist).

OR

Surgery is indicated for management of ocular co-morbidities such as control of glaucoma, view of fundus with diabetic retinopathy etc.

Second Eye Surgery

Patients should only be referred for surgery of the second eye when that eye meets the above criteria. If both eyes meet the criteria at the time of original referral, the patient will not require a second GP referral for repeat treatment.

Simultaneous bilateral surgery

There should be at least a week between bilateral surgery (unless there are other extreme circumstances) due to the raised possibility of bilateral infective endophthalmitis.

Exceptional Circumstances

Should a patient not meet the criteria detailed within this protocol, the CCG Policy for Independent Funding Requests recognises that there will be occasions when patients who are not considered for funding may have good clinical reasons for being treated as exceptions. In such cases the requesting clinician must provide further information to support the case for being considered as an exception making an application through the local IFR route.

Rationale

- The minimum eyesight standard for driving is a visual acuity of at least 6/12 measured on the Snellen scale (with glasses or contact lenses, if necessary) using both eyes together or, if the individual only has sight in one eye, in that eye.
- Visually impairing cataract is common in persons of 65 years and over.
- The effectiveness of cataract surgery (first and second eye) is established.
- Up to one third of cataract operations are for second eye surgery.
- Delay in second eye surgery is associated with poorer quality of life and functioning.

Evidence

- Cost utility studies based on a prospective cohort study determined a cost utility value of £1000/QALY \(^1\) for first eye and around £1300/QALY for second eye surgery.\(^1\)
- A recent cost benefit analysis used the English Longitudinal Survey of Ageing (ELSA) to explore the self-reported effect of cataract operations on eyesight. The survey did not distinguish first and second eyes. The average expected welfare gain from surgery is valued at £1,110 in the year after surgery costing £672.\(^2\)
References:


11. Minor Skin Lesions (Treatment of)

Asymptomatic skin lesions

Destructive interventions to treat benign asymptomatic skin lesions are not normally funded. This includes the treatment of:

- Warts
- Seborrhoeic keratoses (benign skin growths, basal cell papillomas, warts)
- Spider Naevi
- Benign pigmented naeves (moles)
- Dermatofibromas (skin growths)
- Skin tags
- ‘Sebaceous’ cysts (pilar and epidermoid cysts)
- Xanthelasmas (cholesterol deposits underneath the skin)

Where removal is supported, the CCG expects removal to generally be undertaken in Primary Care through the Minor Surgery Direct Enhanced Service. Treatment in secondary care will only be approved where the removal is beyond GP surgical care.

Subject to approval through the IFR route funding approval may be granted by the CCG in the case of:

- Severe disfiguring non-malignant lesions of the face
- Severe port wine stains that extend onto the face and neck

(For both the above, requests to be supported by photographic evidence or confirmation of the extent to which the face is covered, taking into account the patient’s normal hairstyle)

Lipomata

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

Referral for secondary care treatment is appropriate if the following is met and funding approval for removal of lipomata must be sought via the Prior Approval process:

- Removal cannot be undertaken in Primary Care under the Minor Surgery Direct Enhanced Service because it is beyond GP surgical care or the Practice is not signed up to the Enhanced Service (GP to confirm this at the time of application)
- Obvious/proven lipomata that are large (>5cms) or in a particularly difficult site

OR

- The patient is experiencing significant problems (details of the impact on daily activities to be included in the application)
Symptomatic skin lesions

Removal of benign symptomatic skin lesions is commissioned by the CCG subject where the lesion is associated with at least one of the following criteria. Funding approval for removal of symptomatic skin lesions must be sought via the Prior Approval funding process:

- Repeated infection, inflammation or discharge
- Bleeding in the course of normal everyday activity
- Obstruction of an orifice to the extent that function is impaired
- Pressure symptoms e.g. on an organ, nerve or tissue
- Its size or position is causing severe functional impairment of activities of daily living

For mucus/myxoid cysts to the hand please see the commissioning policy for ganglia

Biopsies

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

Other procedures not normally funded

- Keloid and hypertrophic scars, cosmetic scar revision is not normally funded, exceptions will only be considered where scarring impacts severely on physical function. Symptomatic keloid scars (itching or pain) can be treated in primary care with topical or intralesional steroids.
- Labiaplasty (unless where labia are directly contributing to recurrent urinary tract disease or infection or where repair of the labia is required after trauma)

- Vaginoplasty, hymenopathy
- Penile enlargement
- Tattoo removal (by any method)
- Skin ‘resurfacing’ e.g., dermabrasion, laser and chemical peels
- Treatments for hirsutism / hair depilation

Evidence

12. Scar Revision Surgery & Resurfacing

Commissioning position
Croydon CCG will only routinely commission scar revision surgery only in patients where ALL of the following criteria apply:

1. The scarring is a consequence of previous NHS surgery, burns or trauma;

AND

2. The scarring is causing adverse physical consequences (due to contraction, tethering or recurrent breakdown); significant functional impairment (for example obstruction of orifice or vision); bleeding or suspicion of malignancy;

AND

3. Where clinically appropriate, proactive conservative therapies (steroid injections, vitamin E creams, silicone therapy, pressure garments, medication or massage) aimed at arresting the development of adverse, keloid or hypertrophic scarring have been tried but have not been effective;

AND

4. At least 18 months of the natural healing process has passed. Where revision surgery is required in patients whose circumstances do not quite meet the above criteria, the secondary care Consultant must seek approval from NHS Croydon CCG via the IFR process.

Not Commissioned

NHS Croydon CCG will not routinely commission scar therapy or surgery, including skin resurfacing, in secondary care for any of the categories listed below:

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

In these cases, individual requests for scar treatment / revision must come from primary care, and if approved via the IFR process this would allow referral to secondary care to assess and/or treat as clinically appropriate, including surgery.

All IFR requests for scar revision must include details of the cause, appearance, size and location of the scarring (clinical photographs may help); the outcome of any previous conservative therapies and the extent and nature of the adverse effects that the scarring is causing to the individual.
References:


13. **Obstructive sleep apnoea in adults**

(surgical treatment of)

Note: Surgery for obstructive sleep apnoea will only be funded through a prior approval route. Applications for funding can be made in the form of an individual application as per local agreement. This may be Individual Funding Request (IFR) including Exceptional Circumstances application or other prior approval process e.g. referral review via a Clinical Assessment Service (CAS).

Criteria

| Patient has moderate to severe symptoms (measured for example by the Epworth Sleepiness Score: 15-18= moderate, >18 = severe); OR Patient is sleepy in dangerous situations such as driving (regardless of Epworth Sleepiness Score) Appendix E; AND Patient has significant sleep disordered breathing (as measured during a sleep study, usually by the Apnoea/Hypopnoea Index: 15-30/hr = moderate, >30/hr = severe); AND Patient has already tried continuous positive airways pressure (CPAP) unsuccessfully for 6 months prior to being considered for surgery OR patient had major side effects to CPAP such as significant nosebleeds; AND Patient has already tried an intra-oral device, with monitoring to allow device adjustment and assessment of symptom control, unsuccessfully for 3 months OR patient has been unable to tolerate intra-oral device due to recurrent dislodgement of the device during sleep or temporomandibular pain; AND A specialist believes the individual patient will benefit; |

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The patient is fully informed as to the limited effectiveness of procedures, the lack of long term outcomes and likely adverse effects including pain following surgery.

Note: Please refer to Appendix E for Epworth Sleepiness Score.

This guidance does not make detailed recommendations on the use of individual surgical procedures, although studies have shown varying levels of effectiveness in terms of outcomes and adverse effects between the different surgical procedures. However, exceptional circumstances/prior approval panels should take account of the fact that palatal surgery, such as UPPP and LAUP is not recommended by SIGN (2003) and it may compromise the patient’s subsequent ability to use nasal CPAP, although the extent of this risk is not known. Current evidence on soft-palate implants for obstructive sleep apnoea (OSA) raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist. Therefore, soft-palate implants should not be used in the treatment of this condition.

Rationale

- The prevalence of obstructive sleep apnoea/hypopnoea syndrome (OSAHS) in men is estimated between 0.3% and 4%, and in women between 0.5% and 1%.
- Untreated OSAHS can affect daily function and quality of life. Resultant excessive daytime sleepiness and impaired concentration is estimated to cause a 1-12 fold increased risk of accidents. Sleepiness at the wheel is estimated to cause 20% of road accidents, with high mortality rates due to the lack of avoidance reactions when the patient falls asleep.
- Continuous positive airways pressure (CPAP) is recommended as the first choice therapy in patients with moderate to severe OSAHS who are sufficiently symptomatic to require intervention. Minor side effects are common and intensive support may be needed to increase uptake and compliance.
- Intra-oral devices including mandibular advancement devices are recommended for patients with mild OSAHS and normal daytime sleepiness, or for patients unable to tolerate CPAP.
- Weight loss may benefit some patients according to uncontrolled studies although a Cochrane review was unable to identify any research of good enough quality to quantify the effectiveness of weight loss on sleep apnoea. Failure to lose weight should not delay the institution of other therapies of proven effectiveness such as CPAP.
- Exercise is primarily to aid weight loss and may benefit some patients, although a Cochrane review (see below) was unable to identify any research of good enough quality to quantify the effectiveness of exercise on sleep apnoea.
- Pharmacological therapies should not be used as first line treatments for OSAHS.
- ‘Sleep hygiene’ includes using a comfortable bed in a warm, dark, quiet room, mentally winding down and avoidance of evening alcohol, caffeine and hypnotics. A Cochrane review (see below) was unable to identify any research of good enough quality to quantify the effectiveness of sleep hygiene on sleep apnoea.
- The place of surgery for OSAHS is controversial.

Choice of procedure

The main surgical procedures might include:

- Tracheostomy.
- Radiofrequency tissue ablation.
- Tonsillectomy and adenoidectomy, most usually in children.
- Maxillo-mandibular osteotomy and advancement.
• Removal of local specific obstructing pathologies.

This is not a definitive list.

The CCG will only fund when the following criteria are met:

Continuous positive airways pressure (CPAP) is recommended as the first choice therapy in patients with moderate to severe OSAHS who are sufficiently symptomatic to require intervention. Minor side effects are common and intensive support may be needed to increase uptake and compliance.

Intra-oral devices including mandibular advancement devices are recommended for patients with mild OSAHS and normal daytime sleepiness, or for patients unable to tolerate CPAP. Current ECI policy on Sleep Apnoea is adequate and has already set high thresholds.

Surgical treatments specifically for Sleep Apnoea should be considered as a last resort as one off treatments where all other conservative treatments have failed. The choice of procedure should be decided based on a multi-disciplinary planning approach between all specialists treating the patient. Patient should be well informed about the consequences and the complications and should be involved in decision making.

Obstructive Sleep Apnoea (OSA) can be defined as the coexistence of excessive daytime sleepiness with irregular breathing at night. The consequences of untreated sleep apnoea on daily function are multiple and include increased daytime sleepiness, impairment of cognitive function, mood and personality changes.

OSA may be subdivided into varying degrees of breathing abnormality depending on the AHI:

- Mild- AHI 5-14/hr slept
- Moderate- AHI 15-30/hr slept
- Severe- AHI >30/hr slept

As well as the lifestyle changes, people with moderate to severe OSA usually need to use a continuous positive airway pressure (CPAP) device.

Mandibular advancement devices are clinically effective and cost-effective in mild to moderate OSAH. A semi-bespoke MAD is the appropriate first choice in most patients in the short term.

Surgery to treat OSA isn't routinely recommended because evidence shows it's not as effective as CPAP at controlling the symptoms of the condition. It also carries the risk of more serious complications.

Surgery is usually only considered as a last resort when all other treatment options have failed, and also if the condition is severely affecting quality of life.

The evidence for surgical interventions for treatment of sleep apnoea is considered to be insufficient to support routine funding. For patients presenting with severe sleep apnoea as previously defined, and who have abnormally large tonsils, tonsillectomy will be funded where considered appropriate. This decision needs to be made in consultation with an ENT physician. It is expected that this will only apply to a small number of patients. Exceptional case requests for other surgical interventions should be considered by the CCG. This will require support for the procedure from both a respiratory and ENT consultant, and a case being made for consideration as an exception (for example bariatric surgery in a patient whose OSA is due to morbid obesity).

A Cochrane Review on Surgery for Obstructive Sleep Apnoea 6 and the SIGN Guidelines on the Management of Obstructive Sleep Apnoea/Hypopnoea Syndrome in Adults (2003, last confirmed as up to date 2009) have been used as the basis for this guidance. The Cochrane review states that the place of surgery for OSAHS is controversial and that most studies recommending a particular surgery
are based on evidence from case series. The review found eight randomised controlled trials of mixed quality. The trials found an inconsistent impact on subjective and objective markers of OSAHS in patients. The individual trials do not support the widespread use of surgery as a means of improving sleep quality over other therapeutic options available. Surgery potentially offers a ‘one-off treatment’ to alleviate signs and symptoms of OSAHS, but long terms benefits are not known. It is unknown if the long terms risk of cardiovascular disease and other events are reduced by surgery, due to lack of follow up.

Policy revisions

Continuous positive airways pressure (CPAP) is recommended as the first choice therapy in patients with moderate to severe OSAHS who are sufficiently symptomatic to require intervention. Minor side effects are common and intensive support may be needed to increase uptake and compliance.

Intra-oral devices including mandibular advancement devices are recommended for patients with mild OSAHS and normal daytime sleepiness, or for patients unable to tolerate CPAP.

Current ECI policy on Sleep Apnoea is adequate and has already set high thresholds.
14. Obstetrics, Gynaecology & Reproduction

14.1 Dilatation & curettage (D&C)

Funding will NOT be routinely provided for the following indications: investigation and/or treatment of menorrhagia; investigation of dysfunctional uterine bleeding or post-menopausal bleeding; treatment of irregular periods; treatment of endometrial hyperplasia; removing unwanted tissue, endometrial polyps or benign tumours of the womb; removing an IUD that has become embedded in the wall of the womb Referral for D&C for evacuation of retained products of conception or removal of a molar pregnancy should only be considered if vacuum aspiration/suction curettage is contraindicated

Criteria

D&C for the investigation of abnormal uterine bleeding should only be considered if:

| Transvaginal ultrasound with Pipelle endometrial aspirate has failed due to cervical stenosis or pain and facilities for a hysteroscopy with targeted biopsy are unavailable |
| OR |
| Hysteroscopy with targeted biopsy has failed/is not possible due to cervical stenosis, pain or inability to dilate the cervix |
| OR |
| Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable |

Evidence

- D&C is no longer recommended as a diagnostic tool in heavy menstrual bleeding (HMB). To detect histological abnormalities in HMB endometrial sampling or hysteroscopy with directed biopsy have superseded D&C for obtaining endometrial tissue.
- Limited evidence is available on the therapeutic use of D&C for HMB. The NICE recommendation that D&C should not be used as a treatment for HMB was based on clinical expert opinion 1.
- Evacuation of retained products of conception after incomplete miscarriage or delivery has been recommended in order to reduce potential complications such as haemorrhage or infection. Surgical evacuation has been considered the most effective method by D&C or vacuum aspiration/suction curettage. A Cochrane review found that vacuum aspiration/suction curettage was safe, quick and easy to perform, and less painful than D&C. In most developed countries vacuum aspiration/suction curettage has replaced D&C for surgical evacuation of the uterus in incomplete miscarriage 2 3 4 5.
- Vacuum aspiration/suction curettage (rather than D&C/sharp metal curettage) is the preferred method of evacuation irrespective of uterine size in patients with hydatidiform mole who want to preserve fertility 6.

References:


### 14.2 Female genital prolapse/stress incontinence (assessment of)

Initially patients should be assessed and managed conservatively. Continent women with prolapse should be offered a trial of a ring pessary with a discussion of the potential benefits and risks. Evidence of this discussion should be documented in the primary and secondary care notes.

Surgical treatment is not funded for asymptomatic prolapse.

Surgical treatment of severe symptoms of prolapse/incontinence will be funded following assessment.

**Criteria**

Referral for specialist assessment is indicated for:

- Assessment and fitting of pessary only if this cannot be undertaken in primary care.
- Prolapse combined with urinary or faecal incontinence.
- Moderate to severe symptoms of prolapse.
- Failure of pessary.

**Rationale**

- Symptoms of prolapse can be classified as mechanical, sexual, lower urinary tract or bowel. Mechanical symptoms include tissue protruding from the vagina, having to manually reduce the bulge to urinate or defecate, spotting from ulceration of the protrusion and vaginal pain/discomfort. Sexual symptoms include dyspareunia, decreased sexual satisfaction and incontinence/prolapse during intercourse. Lower urinary tract symptoms include stress incontinence and urge incontinence. Bowel symptoms include faecal and flatus incontinence.
- Four main POP grading systems are currently in use – quantitative POP (POPQ), vaginal profile, grading system and severity.
- Pelvic organ prolapse (POP) is common and many women with POP are asymptomatic. POP is not always chronic and progressive. Although prolapse can be associated with varied

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symptoms few are specific to prolapse. The extent of prolapse does not correlate well with symptoms.

Evidence

- A Cochrane review in 2004 found that there were no RCTs of pessary use in women with POP and no consensus on type or use of devices. Expert opinion is that pessaries are effective and should be considered before surgery in women with symptomatic POP at any level of severity. Pessaries can be used for short term relief before surgery or as a long term non surgical option. They can also be used to predict surgical outcomes or unmask occult urodynamic stress incontinence pre-operatively. The POPPY multicentre trial pilot study suggested that pelvic floor muscle training delivered by a physiotherapist to symptomatic women could reduce the severity of prolapse. A Cochrane review on the role of pelvic floor muscle exercises in the management of POP concluded that the evidence from the 3 RCTs included were insufficient to judge their use in the conservative management of POP and that further trials were needed.

- A Cochrane review on the use of vaginal oestrogen creams found limited evidence of their effectiveness in reducing or preventing the symptoms of prolapse.

References:

10. Machana t. Ring pessary for all pelvic organ prolapse. Arch Gynecol Obstet. 2010 Sep 17


14.3 Hysterectomy for heavy menstrual bleeding

Hysterectomy for HMB will only be funded if all the following criteria are met:

<p>| |</p>
<table>
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<tr>
<td>A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has</td>
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<td>been trialed for at least 6 months (unless contraindicated* or</td>
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<td>declined by patient) and has not successfully relieved symptoms.</td>
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<tr>
<td>A trial of at least 3 months each of two other pharmaceutical</td>
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<tr>
<td>treatment options has not effectively relieved symptoms (or is</td>
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<td>contraindicated, or not tolerated).</td>
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<tr>
<td>These treatment options include:</td>
</tr>
<tr>
<td>• NSAIDs e.g. mefenamic acid</td>
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<tr>
<td>• Tranexamic acid</td>
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<tr>
<td>• Combined oral contraceptive pill</td>
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<tr>
<td>• Oral and injected progestogens</td>
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<td>Surgical treatments such as endometrial ablation, thermal balloon</td>
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<tr>
<td>ablation, microwave endometrial ablation or uterine artery</td>
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<td>embolisation (UAE)** have either been ineffective or are not</td>
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<tr>
<td>appropriate, contraindicated</td>
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*Contraindications to LNG-IUS use include suspected or confirmed untreated sexually transmitted infections (STIs), pregnancy, pelvic inflammatory disease (PID), distorted or small uterine cavity, active trophoblastic disease, genital malignancy and Immunosuppression3

**UAE may be appropriate for some women with HMB associated with uterine fibroids.

Additional recommendations:

- Patients should be provided with information on all the treatment options including their outcomes, complications and risks in a format they can understand (e.g. a leaflet).
- Patients should have the opportunity to participate in decision making that relates to their care.
- LNG-IUS fittings must only be undertaken by appropriately trained staff, and where possible this should take place in primary care/a community setting.

Rationale

- http://www.patient.co.uk/doctor/intrauterine-system-pro
- Lethaby AE, Cooke I, Rees M. Progesterone/progestogen releasing intrauterine systems for heavy menstrual bleeding. (Cochrane Review). In: Cochrane Database of Systematic Reviews 2005; Issue 4
- http://publications.nice.org.uk/liquid-filled-thermal-balloon-and-microwave-endometrial-ablation-
techniquesfor-heavy-menstrual-ta78/clinical-need-and-practice 11.


14.4 IVF/ICSI Treatment

NHS Croydon CCG will only fund In Vitro Fertilisation (IVF) and/or Intra-cytoplasmic sperm injection (ICSI) for those with exceptional clinical circumstances via the CCG’s Individual Funding Request (IFR) process.

Secondary care clinician/specialist will need to complete the IFR form (as detailed in Appendix B) to confirm the exceptionality of the request.

This will be considered by the IFR panel and the secondary care clinician/specialist will be advised of the decision.

14.5 Uterine fibroids (minimally invasive surgery for)

Criteria

The CCGs will only fund the following procedures\(^1\), \(^2\), & \(^3\) for uterine fibroids via the prior approval route. Applications for funding can be made in the form of an individual application as per local agreement (this may be Individual Funding Request (IFR) including Exceptional Circumstances application or other prior approval process e.g. referral review via a Clinical Assessment Service (CAS)).

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

CCGs will fund uterine artery embolisation when the following criteria are met:

<table>
<thead>
<tr>
<th>The fibroid is greater than 3 cm in diameter;</th>
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<tr>
<td>AND</td>
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<tr>
<td>The fibroid is causing other symptoms that have a severe impact on the woman's quality of life such as heavy or painful menstrual bleeding, problems with fertility or pressure symptoms;</td>
</tr>
<tr>
<td>AND</td>
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<tr>
<td>The woman wants to avoid surgery and / or retain uterus.</td>
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</table>

Rationale

- Uterine fibroids or leiomyomata are benign tumours that occur in the uterus. They are the most common type of female tumour and their aetiology is not fully understood. They are found anchored to the uterine wall and can vary in size from the size of the grape to large masses that can be palpated through the uterine wall\(^4\).
Current evidence\textsuperscript{5, 6} on UAE suggests that it is safe enough for routine use and there are symptomatic benefits in the majority of patients in the short term. However more evidence is required on the degree and duration of the benefits and of its effects on fertility.

Evidence review commissioned by NICE showed that\textsuperscript{3} Laparoscopic Laser Myomectomy may be suitable for small fibroids, most of which are asymptomatic, and therefore the Specialist Advisors to NICE questioned the clinical value of the procedure.

The NICE clinical guideline on heavy menstrual bleeding\textsuperscript{7} (HMB) states that when surgery for fibroid-related HMB is felt necessary, UAE, myomectomy and hysterectomy must all be considered discussed and documented. UAE should be considered in women with HMB associated with fibroids who want to retain their uterus and/or avoid surgery.

Evidence

- NICE commissioned a review of the evidence of UAE\textsuperscript{5} and found that the procedure was efficacious in reducing mean fibroid volume from between 40-70\% but the reduction in volume did not correlate with changes in symptoms. Improvement in symptoms was reported in between 62-95\% of women.

- NICE issued ‘Interventional procedure guidance\textsuperscript{2} in September 2007 which advised that MRgFUS should only be used with special arrangements for consent and for audit and research.

- Evidence on the safety and efficacy of MRI-guided percutaneous laser ablation of uterine fibroids\textsuperscript{1} is insufficient to support its use without special arrangements for consent, audit and research.

- Current evidence on the safety and efficacy of laparoscopic laser myomectomy\textsuperscript{3} does not appear adequate to support the use of this procedure without special arrangements for consent, audit or research.

References:

2. NICE MRI-guided transcutaneous focused ultrasound ablation for uterine fibroids—IPG 231 (2007)
7. NICE Heavy Menstrual Bleeding Clinical Guideline 44 July 2007
15. Orthopaedic & Pain Management

15.1 Acupuncture for Non- Specific Low Back Pain (LBP)

CCGs will only fund acupuncture if all of the following criteria are met under the following circumstances.

A maximum of 10 sessions should be offered over a period of 12\(^1\) weeks as a one-off treatment. Any additional treatments sessions will require prior approval for funding. Acupuncture is more effective if it is offered as an adjunct to other conventional treatments. The treatment may be offered in primary care.

**Criteria**

<table>
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<th>LBP exists for more than 6 months;</th>
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<td>AND</td>
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<td>LBP is severe as assessed by one of the grading systems(^2) e.g. RMDQ;</td>
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<td>AND</td>
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<tr>
<td>All other conventional treatments such as exercise, pharmacological management, physiotherapy etc. have been tried without any improvement in symptoms for a minimum of 6 months;</td>
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<tr>
<td>AND</td>
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<tr>
<td>Acupuncture is used in conjunction with other conventional treatments(^3) as part of a pain management programme.</td>
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</table>

**Rationale**

- Acupuncture is more effective for pain relief than no treatment or sham treatment, in measurements taken up to three months. The results also show that for chronic low-back pain, acupuncture is more effective for improving function than no treatment, in the short-term. Acupuncture is not more effective than other conventional and “alternative” treatments. When acupuncture is added to other conventional therapies, it relieves pain and improves function better than the conventional therapies alone\(^3\).

- There is evidence that acupuncture provides a short-term clinically relevant effect when compared with a waiting list control or when acupuncture is added to another intervention\(^4\).

- Traditional acupuncture care delivered in a primary care setting was safe and acceptable to patients with non-specific low back pain\(^5\).

- A study showed a statistically significant difference in pain scores between the acupuncture and no acupuncture groups (P <0.001 at 8 weeks). However, no significant difference in pain between the acupuncture and minimal acupuncture groups was found at 8, 26 and 52 weeks (the acupuncture group did have slightly better outcomes than the minimal acupuncture group)\(^6\).

- Estimates of the prevalence of low back pain vary considerably between studies - up to 33% for point prevalence, 65% for 1- year prevalence, and 84% for lifetime prevalence\(^7\).
• A study reported that 1 in 4 people can get localised erythema due to acupuncture as a side-effect.

• The QALY gain for the acupuncture group over 24 months was 1.453 (0.248) compared to a mean of 1.426 (0.191) for the usual care group. The mean incremental health gain from Low Back Pain acupuncture at 24 months was 0.027 QALYs, leading to a base case estimate of £4241 per QALY gained.  

References:


4. Sidney M. Rubinstein • Marienke van Middelkoop • Ton Kuijpers • Raymond Ostelo • Arianne P. Verhagen • Michiel R. de Boer • Bart W. Koes • Maurits W. van Tulder. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. European Spine Journal, August 2010, vol./is. 19/6(1213-1228), 0940-6719 (August 2010)


15.2 Autologous chondrocyte implantation

NICE has produced technical guidance on the use of autologous chondrocyte implantation (ACI)

Criteria:

| ACI is NOT recommended for the treatment of articular cartilage defects except in the context of ongoing or new clinical studies that are designed to generate robust and relevant outcome data. |

SWL CCGs will not routinely fund health care interventions that NICE has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfil the normal requirements for undertaking research.

Rationale

- If trials are undertaken patients should be fully informed of the uncertainties about the long-term effectiveness and potential adverse effects of this procedure.
- Any outcome data from trials should include measurement of health related quality of life and long-term follow up.

Evidence

NICE assessed a number of trials but found inconsistent evidence of the clinical effectiveness of ACI. The studies were heterogeneous in terms of the patients recruited, the ACI technique used and the measures used to assess outcome. In addition, comparative trial follow-up was limited to 1–2 years. The longer term case series showed similar benefits under most modes of treatment. There were no trials comparing ACI (or any of the other interventions in the studies reviewed) with conservative management.

References:

15.3 Carpal tunnel syndrome (surgical treatment of)

All referrals should be through an agreed pathway to optimise access to conservative treatment.

Criteria

The CCG will fund carpal tunnel surgery where:

- Symptoms persist for more than six months after conservative therapy with oral/local corticosteroid injections and/or splinting.

- OR

- There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction.

- OR

- Severe symptoms significantly interfering with daily activities.

• Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms significantly interfere with daily activities)*.

OR

• If there is no improvement in mild-moderate symptoms after 6 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required)

*This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.

Rationale

• Carpal Tunnel Syndrome (CTS) presents with symptoms ranging in severity and should be recognized before permanent deficits develop. Risk of nerve damage is low for most patients and the relationship between symptoms and nerve conduction study results is not strong.

• Conservative treatment offers short-term benefit (0-3 months) and symptom severity can be seen to improve after 2-7 weeks of initial treatment.

• Conservative treatment offers the opportunity to avoid surgery and have the advantage of being relatively inexpensive and without serious adverse side effects.

• Steroids (oral and local injection) and nocturnal splinting in the neutral position are considered the most effective conservative therapies.

• In the mid and longer term (6-18 months), surgery is more effective than conservative treatment.

• Open carpal tunnel release/decompression is the most common surgical treatment performed. The choice of endoscopic or open technique is usually guided by surgeon’s experience and patient’s preference.

Evidence

• This approach is supported by evidence from several recent systematic reviews, randomized control trials, guidelines (including American Academy of Orthopaedic Surgeons 2009) and recommendations.

• Studies have shown that provocative physical tests such as Phalen’s sign and Tinel's sign...
range in sensitivity (8-100%) and specificity (55-87%) and are less reliable in advanced CTS\(^7\).

- There is moderate evidence that splints are effective in decreasing symptom severity and two reviews suggests neutral position is more effective than wrist cock-up splint\(^1,3,5,6\).
- Two systematic reviews suggest strong evidence of effectiveness of oral steroids compared to placebo, but there is no evidence of difference in effectiveness of dosage\(^3,5\).
- In the short term (0-3 months), there is strong evidence of the effectiveness of steroid injections in providing symptom relief and moderate evidence local steroid injections are more effective than either oral steroids or systemic corticosteroids injections\(^1,3,5\). There is no evidence in effectiveness of short acting compared to long-acting corticosteroid injection in the short term\(^3\).
- Other non-surgical treatments, such as non-steroidal anti-inflammatory drugs, diuretics, botulinum toxin, therapeutic exercises, vitamin B6 and physical treatments (e.g. ultrasound, low power laser) have limited or no evidence that they are effective in the short term\(^3,5,6\).
- In the literature, conservative treatment is given preference in mild to moderate cases and surgical treatment is mainly applied in severe cases including nerve denervation. Surgical treatment is also indicated in cases in which initial conservative management fails\(^4\).
- Evidence suggests that surgical treatment is more effective than splinting and hand function in midterm and long term (6-18 months), but evidence is conflicting when comparing conservative treatment to surgery in the short term\(^3,4\). An RCT in 2009, showed outcomes were better in terms of hand function and symptoms at 3 months and one year compared to a control group\(^1\).
- No RCTs published at present explore the optimal timing strategy for surgery\(^4\). There is no validated evidence to identify which patients should undergo surgery as initial treatment\(^1\).
- One study found that 75% of patients surveyed (n=4000) having surgery under usual NHS conditions found the operation an unqualified success about two years after surgery\(^7\).
- There is no unequivocal evidence that suggest one surgical treatment is more effective than the other\(^1,4\).

References:

8. BSSH Evidence for Surgical Treatment Carpal Tunnel Syndrome (CTS) http://www.bssh.ac.uk/education/guidelines/carpal_tunnel Syndrome.pdf

- Decision Making Aid: http://patient.info/decision-aids/carpal-tunnel-syndrome-decision
15.4 Discectomy for lumbar disc prolapse (elective)

Criteria

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<th>The patient must be 18 years or older;</th>
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<td>AND</td>
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<tr>
<td>The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms;</td>
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<tr>
<td>AND</td>
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<tr>
<td>The patient has radicular pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement.</td>
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<tr>
<td>OR</td>
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<tr>
<td>There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise–positive between 30° and 70° or positive femoral tension sign);</td>
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<tr>
<td>AND</td>
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<tr>
<td>Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, bed rest etc.) provided that analgesia is adequate and there is no imminent risk of neurological deficit.</td>
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Rationale

- Herniated lumbar discs account for less than 5% of lower back pain but are responsible for most cases of sciatica (nerve root pain). Ninety per cent of cases of sciatica resolve with conservative management.
- The primary aim of surgery is to provide relief of symptoms in those patients who have failed to respond to conservative treatment.
- A Cochrane review concluded that surgical discectomy for carefully selected patients with sciatica due to lumbar disc prolapse, provides faster relief from an acute attack than conservative management although any positive and negative effects on the lifetime natural history of the disease are unclear.
- In the absence of clear indications for surgery, postponing surgery to further assess progress may delay recovery but does not produce long-term harm.
- There is little evidence on the optimal timing of surgery.
- Microdiscectomy is broadly as effective as open/macro discectomy. Microdiscectomy is a longer procedure than open discectomy but there are no differences in peri-operative bleeding, length of hospitalisation or formation of scar tissue.
- Discectomy is cost effective with a willingness to pay 40,000 Euros per QALY.

Evidence

- A 2008 Cochrane review concluded that surgical discectomy for carefully selected patients with sciatica due to lumbar disc prolapse provides faster relief from the acute attack than
conservative management. They also concluded that open and microdiscectomy are more effective than chemonucleolysis.

- There are several low quality RCTs that have compared discectomy with conservative management (including epidural injection, physiotherapy and education). They conclude that discectomy provides better clinical outcomes than conservative management and it is more effective than conservative management at one year. Systematic reviews undertaken in 2008 and 2009 also agreed with these findings. No significant differences were found between surgery and usual conservative care in any of the clinical outcomes after 1 and 2 years.

- The evidence for minimally invasive techniques for discectomy remains unclear. One systematic review on the effectiveness of nucleoplasty procedure concluded that nucleoplasty is potentially effective in patients with symptomatic disc herniation who are refractory to conservative treatment, but higher quality evidence is necessary to confirm efficacy and risks.

References:

15.5 Duquyten’s contracture (fasciotomy/fasciectomy)  
(surgical treatment of)

Surgery for mild Duquyten’s contracture is not normally funded.

Surgery is the only effective method of treatment for Duquyten’s contracture. However, patients must be advised that approximately 40% of people will have a recurrence following surgery: Duquyten’s contracture can return to the same place on the hand or may reappear somewhere else. Recurrence is more likely in younger patients; if the original contracture was severe; or if there is a strong family history of the condition.

**Collagenase clostridium histolyticum** is not normally funded for treating Duquyten’s contracture due to limited evidence.

**Radiation therapy** for early Duquyten’s disease is not normally funded due to limited evidence.

Duquyten’s disease is a benign, slowly progressive condition that can restrict hand function. Most patients with Duquyten’s contracture do not need treatment and can be managed expectantly. However, indications for surgical intervention as per British Society for Surgery of the Hand (BSSH) classification are moderate or severe disease (under revision).

BSSH classifies Duquyten’s disease as:

- **Mild**: no functional problems, no contracture or metacarpophalangeal joint contracture of less than 30°.

- **Moderate**: functional problems, metacarpophalangeal joint contracture of 30° to 60°, proximal interphalangeal joint contracture of less than 30°, or first web contracture.

- **Severe**: severe contracture of both metacarpophalangeal joint (greater than 60°) and proximal interphalangeal joint (greater than 30°).

This policy statement is in alignment with the recommendations by the European consensus guideline: Duquyten’s Disease - Results from the HANDGUIDE Study (2013) and the NICE Interventional Procedure Guidance IPG368 and NICE Final appraisal determination for collagenase (2015).

- **Criteria for surgical treatment**

  - Metacarpophalangeal joint contracture or proximal interphalangeal joint contracture of 30 degrees or more at least in one joint (inability to put hand flat on table) 1

  OR

  Patient has at least 10 degrees loss of extension in 2 or more joints 2
Metacarpophalangeal joint contracture or proximal interphalangeal joint contracture is less than 30 degrees AND at least in one joint

All additional risk factors for aggressive progression are present, specifically - bilateral disease, family history of condition, ectopic lesions, age under 50 and male gender

AND

There is significant threat to hand function

Evidence

- Symptoms of Dupuytren’s contracture are often mild and painless and do not require treatment. Disease progression is unpredictable; where the contractures themselves are not functionally limiting management should compose of reassurance and observation.

- Surgery should not be considered a cure and patients should be advised of the risks of recurrence when deciding whether to consider surgical intervention.

- As the condition progresses it can become difficult to fully extend the finger(s) affected, eventually becoming permanently fixed in a flexed (bent) position affecting activities of daily living.

- Treatment seeks to restore hand function and prevent progression, however the underlying disease will remain. Recurrence following surgical intervention is common, ranging from 30-40% following open partial fasciectomy to 60% following needle aponeurotomy/fasciectomy.

- Evidence is lacking on the effectiveness of non-surgical treatments for Dupuytren’s contracture such as vitamin E cream ultrasonic therapy and radiation therapy. Radiation therapy should only be used with special arrangements for clinical governance, consent and audit or research.

- There is a lack of evidence on the long-term efficacy of collagenase injections.

- Clinical consensus suggests surgical intervention is recommended when metacarpophalangeal joint contracture or proximal interphalangeal joint contracture reaches 30 degrees.

- Dupuytren’s contracture has a greater tendency for aggressive progression and recurrence after surgical treatment in the presence of 5 factors - bilateral disease, family history of condition, ectopic lesions, age under 50 and male gender.

References:


### 15.6 Epidural injections for lumbar back pain

CCGs will fund lumbar interlaminar, transforaminal and caudal epidural injections for patients with radicular pain due to herniated disc (sciatica) when the following criteria have been met.

**Criteria**

<table>
<thead>
<tr>
<th>The patient must be 18 years or above;</th>
</tr>
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</table>

AND

<table>
<thead>
<tr>
<th>The patient has radicular pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement.</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise–positive between 30° and 70° or positive femoral tension sign).</th>
</tr>
</thead>
</table>

AND

<table>
<thead>
<tr>
<th>The Patient is part of a comprehensive pain management programme and all Conservative management options (physiotherapy treatments and guided exercise programmes where a patient is able to participate, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed,</th>
</tr>
</thead>
</table>

AND

<table>
<thead>
<tr>
<th>Patient experienced moderate to severe pain, (assessed by a specialist using a Visual Analogue Pain Scale) and the impact of pain (using the Brief Pain Inventory, as per national pain audit OR Roland Morris Disability Questionaire (RMDQ) as appropriate, lasting for more than 12 months.</th>
</tr>
</thead>
</table>

**Repeat injections**

The patient must meet the following two criteria to be considered for repeat injections:

1. Positive response is defined as documented evidence of >50% pain relief for more than 4 months

   AND

2. Documented evidence of improved function using a validated tool (VAS scale) and/or functional outcome measure that can be attributed to the effects of the injection,

Patients may receive a maximum of 2 injections within a 1 year period.

Injections MUST be carried out under radiological guidance.

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

Evidence

- Epidural injection for the management of spinal pain is one of the commonest interventions performed in many countries although there is still some uncertainty regarding their effectiveness and safety\(^1\). Spinal pain is a common cause of chronic pain with lifetime prevalence 54-80%. Annual prevalence of chronic low back pain ranges from 15-45%.

- A number of systematic reviews\(^2, 3\) concluded that for sciatica or prolapsed lumbar disc with radiculopathy, there is fair evidence that epidural steroid injection is moderately effective for short-term (but not long term) symptom relief. They found insufficient evidence to determine the optimal route of administration.

- Another systematic review, by Manchikanti et al\(^4\), looked at the epidural administration by the caudal, interlaminar and transforaminal routes separately. They found strong evidence of the effectiveness of the caudal route in the short and long term, and moderate evidence for the effectiveness of the transforaminal and interlaminal approaches in the short and long term.

Complications

The most common type of complications are related to needle placement and drug administration including dural puncture, spinal cord trauma, subdural injections and abscess formation.

References:


15.7 Ganglia (Excision of ganglia)

Criteria for surgical removal

- The ganglia are painful seed ganglia\(^1\).

OR

- The ganglia are mucoid cysts arising at the distal interphalangeal joint and disturbing nail growth or discharging\(^2\).

OR

- The ganglion is causing significant functional impairment and/or pain\(^1\).

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Clinicians could consider aspiration as an alternative to excision due to its lower complication rates. The higher recurrence rates for treatment with aspiration should be considered in this assessment (20% for aspiration vs. 10% for surgical)\(^3\).

If aspiration has not been attempted, referrals may be redirected to a GP with Special Interest (GPwSI) in minor surgery for aspiration where available. Ganglia on the feet should be referred to a GPwSI in Podiatry where available\(^2\).

**Rationale**

- Most ganglia are symptom free, but some give pain, weakness, mobility disorders or pressure neuropathy\(^2\).
- The recurrence rate after excision of wrist ganglia is between 10-45\(^1,2\).

**Evidence**

The Trent regional audit (which reviewed the progress of 729 ganglions up to 10 years from attendance) indicated that 33\% of dorsal ganglions and 45\% of volar-wrist ganglia would resolve spontaneously in six years\(^2\).

**References:**

15.8 Hip replacement surgery (primary)

Criteria

The CCG will agree to fund elective surgery when any one of the following sets of criteria have been completely met:

**Group 1**
Adults where the patient’s Oxford Hip score (Appendix F) is ≤ 26 on the 0 to 48 system; or ≥ 34 on the 60 to 12 system\(^1\)

OR

**Group 2**
Patient complains of **severe** joint pain (as defined in Appendix F)\(^2\);

AND

Has **severe** functional limitation despite the use of an extended course of non-surgical treatments\(^3\) such as adequate doses of appropriate analgesia (see Appendix F), weight control treatments and physical therapies;

AND

Has **radiographic evidence** of joint damage\(^3\) (e.g. loss of joint space, marginal osteophytes)\(^3, 4\).

OR

**Group 3**
Patient complains of **severe** joint pain (as defined in Appendix F)\(^3\);

AND

Patient has **minor to moderate** functional limitation, despite the use of an extended course of non-surgical treatments\(^3\) such as adequate doses of appropriate analgesia (see Appendix F), weight control treatments and physical therapies.

AND

Has **radiographic evidence** of joint damage\(^3\) (e.g. loss of joint space, marginal osteophytes)\(^3, 4\).

OR

**Group 4**
Patient complains of **mild to moderate** joint pain (as defined in Appendix F)\(^5\);

AND

Has **severe** functional limitation, despite the use of an extended course of non-surgical treatments such as adequate doses of appropriate analgesia (see Appendix
Referral Criteria:

- The initial non-surgical management of hip pain due to osteoarthritis has been provided, i.e. a package of care that may include weight management and weight reduction, activity modification, patient specific exercise programme, adequate doses of non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics, joint injections, introducing walking aids, and other forms of physical therapies.

- Patient has a Body Mass Index of 30. Patients should be referred for weight management interventions and upon 6 months of documented weight loss if the patient fails to lose weight to a BMI <30 then consider referral through IFR process.

- Patient has moderate to severe persistent pain not adequately relieved by an extended course of non-surgical management (including weight management)

AND

- Clinically significant functional limitation (moderate to severe) resulting in diminished quality of life

AND

- Radiographic evidence of joint damage

**Note**: Please refer to the Appendix F for the classifications of symptoms, radiology and localisation

**Prior to referral**

Any other pre-existing medical conditions have been investigated and optimised.

If appropriate the patient should have been advised to reduce their BMI to less than 30 and all reasonable attempts made to reduce their weight to this level prior to surgery. Exceptions include patients whose pain is so severe and/or mobility so compromised that they are in immediate danger of losing their independence and where joint replacement would relieve this threat. An exception would also be patients in whom destruction of the joint is of such severity that delaying surgical correction would increase the technical difficulty of the procedure.

**Initial management of osteoarthritis**

Evidence from the Musculoskeletal National Service Framework (NSF), NICE, the GP Training Network and the National Institute of Health (NIH) Consensus Panel suggests that management of common musculoskeletal problems, including knee pain, should ideally be undertaken in primary care. Patients should be referred for a specialist opinion on total joint replacement when prolonged use of all conservative means has failed to alleviate the patient’s pain and disability. This initial non-surgical management of knee pain due to osteoarthritis (OA) may include (as appropriate for the individual patient) weight reduction, activity modification, patient specific exercise programmes, adequate doses of NSAIDS and analgesics, joint injections, walking aids, home adaptations, curtailment of inappropriate activities and other forms of physical therapies.
Note on Hip Resurfacing

NICE guidance for metal on metal (MoM) hip resurfacing 9,10 states that “MoM hip resurfacing arthroplasty is recommended as one option for people with advanced hip disease who would otherwise receive and are likely to outlive a conventional primary total hip replacement”. In considering hip resurfacing arthroplasty, it is recommended that surgeons take into account activity levels of potential recipients and bear in mind that the current evidence for the clinical and cost-effectiveness of MoM hip resurfacing arthroplasty is principally in individuals less than 65 years of age. This guidance indicates that resurfacing is recommended for younger patients in order to avoid future revision surgery. However, there is uncertainty over the long-term reliability of hip resurfacing.

MoM hip resurfacing should only be performed by a surgeon with specific training in this technique. As part of the consent process patients should be made aware of the medium to long term safety and reliability of MoM devices and the likely outcome of revision surgery compared to conventional total hip replacement.

References:

15.9 Knee arthroscopy

Assessment of knee pathology should include a competent clinical examination (or MRI scans if there is diagnostic uncertainty or red flag signs/symptoms/conditions). If examination and/or MRI have demonstrated clear evidence of an internal joint derangement and conservative treatment has failed, or it is clear that conservative treatment will not be effective, knee arthroscopy should be considered.

Arthroscopy will NOT be routinely funded as a primary diagnostic tool.

Criteria

CCGs will only fund arthroscopy of the knee for the following diagnostic indications:

Patients with medial knee pain with suspected Plica syndrome
OR
Suspected chondromalacia patellae
OR
When information is required on the degree and distribution of joint damage to inform the type of knee replacement that should be performed

CCGs will only fund arthroscopy of the knee for the following therapeutic indications:

Removal of loose body causing mechanical symptoms
OR
Meniscal surgery (repair or resection)
OR
Ligament repair or reconstruction (including lateral release)
OR
Synovectomy
OR
Treatment of articular defects e.g. microfracture
OR
Debridement of arthritis in younger patients under 55 years of age delaying need for total knee replacement.
The CCG will fund knee arthroscopy in adults only where:

1a. Clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (i.e. ligament rupture or loose body within the knee)

OR

1b. The patient is suffering confirmed knee osteoarthritis with regular clinically significant mechanical symptoms such as true knee locking or the knee is unstable i.e. giving way

AND

2. Conservative management over a period of at least 3 months has been fully explored, and complied with, but treatment has failed. Conservative management can include advice, physio and support from the intermediate musculoskeletal services and pain management with non-steroidal anti-inflammatory drug (NSAID) painkillers. A trial of conservative management should be the first-line treatment for all patients with degenerative meniscal tears. (Khan M, 2014)

Note: Evidence of symptoms and compliance with conservative management must be documented in the patient's clinical records and demonstrated in any referral to secondary care.

Exclusions:

Knee arthroscopy is not routinely commissioned for the following indications and funding approval with supporting clinical evidence will need to be sought via the IFR route where there are exceptional circumstances present:

1. The patient has previously had an arthroscopy to treat the affected knee.
   OR
2. Intractable knee pain even if considered likely the patient has the potential to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon.
   OR
3. For diagnostic purposes only.
   OR
4. To provide arthroscopic washout alone as a treatment for chronic knee pain due to osteoarthritis. Current evidence suggests that arthroscopic knee washout alone should not be used as a treatment for osteoarthritis because it cannot demonstrate clinically useful benefit in the short or long term. (NICE)
   OR
5. Patients without mechanical symptoms aged over 65.

Rationale

- Knee arthroscopy should not be considered a primary diagnostic tool. MRI should be used where there is diagnostic uncertainty. In the majority of cases clinical assessment (history and examination) by an experienced clinician will provide a diagnosis and demonstrate if internal joint derangement is present.
- Red flag symptoms: 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 systemically unwell, recent unexplained weight loss, persisting severe restriction of joint movement, widespread neurological changes and structural deformity
- Red flag conditions: infection, carcinoma, nerve root impingement, bone fracture, avascular necrosis
Evidence

NICE guidance states that arthroscopic lavage and debridement alone should not be used as a treatment for osteoarthritis unless the patient has knee osteoarthritis with a clear history of mechanical locking NOT swelling, giving way or X-ray evidence of loose bodies because it cannot demonstrate clinically useful benefit in the short or long term.

References:
2. IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. National Institute of Health & Clinical Excellence August 2007
15.10 Knee replacement surgery (primary)

Criteria
The CCG will agree to fund elective surgery when any one of the following sets of criteria has been completely met:

Group 1
Where the patients complains of intense or severe symptomatology (see Appendix G) not adequately relieved by an extended course of non-surgical management such as adequate doses of appropriate analgesia (see Appendix G), weight control treatments and physical therapies

AND

Has radiological features of severe disease;

AND

Has demonstrated disease within all three compartments of the knee (tricompartmental) or localised to one compartment.

OR

Group 2
Where the patients complains of intense or severe symptomatology (see Appendix G) not adequately relieved by an extended course of non-surgical management such as adequate doses of appropriate analgesia (see Appendix G), weight control treatments and physical therapies

AND

Has radiological features of moderate disease;

AND

Is troubled by limited mobility or instability of the knee joint.

OR

Group 3
The patient complains of severe symptomatology (see Appendix G) not adequately relieved by an extended course of non-surgical management such as adequate doses of appropriate analgesia (see Appendix G), weight control treatments and physical therapies;

AND

Has radiological features of slight disease;

AND

Is troubled by limited mobility or stability of the knee joint.

Referral Criteria:
- The initial non-surgical management of knee pain due to osteoarthritis has been provided, i.e. a package of care that may include weight management and weight reduction, activity.
modification, patient specific exercise programme, adequate doses of non-steroidal anti-inflammatory drugs (NSAIDs) and analgesics, joint injections, introducing walking aids, and other forms of physical therapies.

- Patient has a Body Mass Index of 30.
- Clinically significant functional limitation (moderate to severe) resulting in diminished quality of life.

Patients should be referred for weight management interventions and upon 6 months of documented weight loss if the patient fails to lose weight to a BMI < 30 then the referral should be through IFR process.

**Note:** Please refer to the Appendix G for the classifications of symptoms, radiology and localisation

**Prior to referral**

Any other pre-existing medical conditions have been investigated and optimised.

**Initial management of osteoarthritis**

Evidence from the Musculoskeletal National Service Framework (NSF), NICE, the GP Training Network and the National Institute of Health (NIH) Consensus Panel suggests that management of common musculoskeletal problems, including knee pain, should ideally be undertaken in primary care. Patients should be referred for a specialist opinion on total joint replacement when prolonged use of all conservative means has failed to alleviate the patient’s pain and disability. This initial non-surgical management of knee pain due to osteoarthritis (OA) may include (as appropriate for the individual patient) weight reduction, activity modification, patient specific exercise programmes, adequate doses of NSAIDs and analgesics, joint injection, walking aids, home adaptations, curtailment of inappropriate activities and other forms of physical therapies.

**References:**

1. Total knee replacement – Ontario Health Technology Assessment Series 2005; vol5, no.9
Appendix G: Knee Symptomatology, Radiology and Localisation and Oxford Knee Score

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility and Stability</strong></td>
<td></td>
</tr>
<tr>
<td>Preserved mobility and stable joint</td>
<td>Preserved mobility is equivalent to minimum range of movement from 0° to 90°. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td>Limited mobility and /or stable joint</td>
<td>Limited mobility is equivalent to a range of movement less than 0° to 90°. Unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td><strong>Symptomatology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Sporadic pain. Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). Medication: aspirin, paracetamol or NSAID to control pain with no side effects</td>
</tr>
<tr>
<td>Moderate</td>
<td>Occasional pain. Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Medication: aspirin, paracetamol or NSAIDS to control the pain with few or no side effects.</td>
</tr>
<tr>
<td>Intense</td>
<td>Pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches).</td>
</tr>
<tr>
<td>Severe</td>
<td>Continuous pain. Pain when resting. Daily activities significantly limited constantly. Continuous use of analgesics- narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches).</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Ahlback grade I.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Ahlback grade II and III.</td>
</tr>
<tr>
<td>Severe</td>
<td>Ahlback grade IV and V.</td>
</tr>
<tr>
<td><strong>Localisation</strong></td>
<td></td>
</tr>
<tr>
<td>Uni-compartmental</td>
<td>Excluded patello-femoral isolated.</td>
</tr>
<tr>
<td>Bi-compartmental</td>
<td>Unicompartmental plus patello-femoral.</td>
</tr>
<tr>
<td>Tri-compartmental</td>
<td>Disease affecting all three compartments of the knee.</td>
</tr>
</tbody>
</table>
15.11 Knee washout (in patients with knee osteoarthritis)

This procedure is not routinely funded by Croydon CCG and will only be considered for funding if the criteria below are met and evidenced.

Criteria for eligibility

Croydon CCG will only fund arthroscopic lavage and debridement in patients with knee osteoarthritis for the following indications:

- Patients with a clear history of true mechanical locking. NICE guidance states that arthroscopic lavage and debridement alone should not be used as a treatment for osteoarthritis unless the patient has knee osteoarthritis with a clear history of mechanical locking NOT gelling, giving way or X-ray evidence of loose bodies because it cannot demonstrate clinically useful benefit in the short or long term.

NICE Guidance https://www.nice.org.uk/guidance/ipg230

15.12 Therapeutic facet joint injections/medial branch blocks

These criteria do not relate to cancer related pain.

CCGs will fund medial branch blocks for the management of cervical, thoracic and lumbar back pain as specified below.

CCGs will fund medial branch blocks when all the following criteria are met:

<table>
<thead>
<tr>
<th>The pain has lasted more than one year and there is a reasonable clinical suspicion that the pain experienced is generated by the spinal facet joints.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AND</td>
</tr>
<tr>
<td>The pain has resulted in moderate to significant impact on daily functioning;</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>All conservative management options (bed rest, exercise, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed.</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>Patients show commitment to taking responsibility for managing their condition by demonstrating relevant lifestyle changes which include weight loss, increased fitness through exercise, physiotherapy and Weight Management Programme; diet control, avoidance of illicit drugs and alcohol, and improved engagement in activities of daily living and purposeful occupation where appropriate;</td>
</tr>
</tbody>
</table>

Date Approved: January 2017 | Review Date: December 2018 | Version Final 1.0
Croydon CCG will only commission a spinal facet joint injection (medial branch block) for lumbar pain where:

- There is a reasonable clinical suspicion that the pain experienced is generated by the spinal facet joints.
- Patients have actively participated in the decisions in respect of their treatment;
- Patients show commitment to taking responsibility for managing their condition by demonstrating relevant lifestyle changes which include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate;
- Back or neck pain is rated at a level of 7/10 on the standard pain scale;
- Back or neck pain causes significant impact on daily functioning which has been assessed using the HAD tool;

AND

- Patients have given their informed consent.

Croydon CCG will only commission a subsequent facet denervation where:

There is evidenced improvement i.e. VAS (20mm reduction), HAD (reduction of 4 or more), Oswestry & EQ-5D scores showing improvement.

A request for exceptional funding must be made if the patient is to undergo an addition injection at the same site.

CCGs will fund medial branch blocks when all the following criteria are met:

The pain has lasted for more than one year and there is a reasonable clinical suspicion that the pain experienced is generated by the spinal facet joints.

AND

The pain has resulted in moderate to significant impact on daily functioning;

AND

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

AND

Patients show commitment to taking responsibility for managing their condition by demonstrating relevant lifestyle changes which include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate;

A request for exceptional funding must be made if the patient is to undergo an addition injection at the same site.

**Clinical practice**
Prior to the administration of the medial branch blocks facet joint pain should be confirmed by controlled diagnostic local anaesthetic block.

In the diagnostic phase the patient may receive 1 course of injections.

In the therapeutic phase, one further course of injections within a 12 month period. In the therapeutic phase, up to 6 injections 2-3 months apart provided that there has been a >50% reduction in symptoms for six weeks. Medial branch blocks beyond the first 3 injections should be provided as part of a comprehensive pain

**Evidence**

**Medial Branch Blocks**

Injection of a local anaesthetic, steroid or other agents around the primary nerve innervating the facet joint (the medial branch of the posterior primary ramus) is termed a medial branch block. It can be used as a diagnostic procedure intended to establish whether pain originates from the facet joint, and it may also be used as a therapeutic procedure.

Manchikanti et al. \(^2\) identified four randomized trials that assessed medial branch block using an active control design, demonstrating strong evidence of both short and long term pain relief in the cervical, thoracic and lumbar spine. However Chou et al. \(^1\) found no randomized control trials that compared efficacy of therapeutic medial branch block versus sham or placebo injection, and concluded that there is insufficient evidence to reach reliable conclusions regarding the effectiveness of therapeutic median nerve block.

**Intra-articular facet joint injections**

Intra-articular facet joint injections will not normally be funded as there is good evidence from randomised control trials that facet joint injections are not effective \(^1, 2\).

The UK RCGP guidelines found that facet joint injection do not produce pain relief or global improvement, with neither the type of agent injected nor the site of injection making a significant difference to outcomes \(^3\). This is supported by American Pain Society Guidelines \(^1\) and other evidence reviews\(^2\).

NICE guidance\(^4\), relating only to treatment of back pain of less than 1 year's duration states: “Do not offer injections of therapeutic substances into the back for non-specific back pain.”

**Diagnostic facet joint blocks**

Diagnostic facet joint blocks have a specificity of 8% and sensitivity varying from 27- 63% for cervical spine, 42-58% thoracic spine and 17-50% in the lumbar spine. The positive predictive value has been estimated at 31% and the diagnostic effect may be confounded by leakage into the peri-articular tissues.

The European COST guidelines recommend against facet joint blocks for the diagnosis of facet joint pain\(^3\).

**Complications**

The most common complications are related to needle placement and drug administration e.g. dural puncture, spinal cord trauma, infection, intra-arterial and intravenous injection, spinal anaesthesia, chemical meningitis etc.
References:


15.13 Thermal radiofrequency denervation of lumbar & cervical facet joints

These criteria do not relate to cancer related pain.

Criteria

CCGs will fund thermal radiofrequency controlled denervation of the medial branch of the dorsal rami of the lumbar and cervical facet joints (medial branch neurotomy) in the following circumstances:

- The patient must be aged over 18 or above.
- Non-radicular lumbar (all levels) or cervical (C3-4 and below) facet joint pain.
- Failure of one year of non-invasive therapy, such as medication and physiotherapy and bed rest.
- Radiological imaging to rule out any correctable structural lesion e.g. MRI.
- At least 2 anaesthetic diagnostic blocks, one of which must be of the medial branch of the dorsal ramus innervating the target facet joint with at least 80% reduction in pain following each block during the activities that normally generate pain. The pain relief must be consistent with the expected duration of the anaesthetic block.
- All procedures must be performed under fluoroscopy (x-ray guidance).

Thermal radiofrequency denervation is provided as part of a comprehensive pain management programme.

CCGs will not fund cryoneurolysis or laser denervation.

CCGs will fund up to three facet denervations on one occasion.

CCGs will not fund re-treatment at the same location unless at least six months have elapsed since prior treatment.

Evidence of the effectiveness of the treatment of facet joint pain associated with a neurological deficit, radiculopathy or overt disc herniation, metastatic diseases, patients awaiting back surgery or patients with multiple, focal or chronic pain syndromes is limited.

Background

Facet or zygapophysial joints are innervated by the medial branches of the dorsal rami. Facet joint pain is responsible for spinal pain in 15-45% of patients with low back pain, 36-67% of people with neck pain and 34-48% of people with thoracic pain.
The procedure

Radiofrequency denervation is the destruction of nerves using heat generated by a radiofrequency current. It involves the placement of a catheter or electrode near or in the target nerve. Once the position of the catheter is confirmed by fluoroscopy, a radiofrequency current is applied in order to heat and coagulate adjacent tissues, including the target nerve.

Complications

The most common complications are related to the placement of the catheter or electrode near to or in the target nerve.

Evidence

- Chou et al.\(^1\) found insufficient evidence from nine randomized trials to reach reliable conclusions regarding the use of radiofrequency denervation for chronic back pain, due to conflicting results from the RCTs.
- Manchikanti et al.\(^2\) identified nine randomised control trials, but only considered two of sufficient quality. On this basis they concluded that there is evidence of short term effectiveness at the lumbar level, and short and long- term effectiveness at the cervical level.
- NICE guidance\(^3\), relating only to treatment of back pain of less than 1 year's duration recommends not referring people for radiofrequency facet joint denervation.
- The European COST guidelines found insufficient evidence to recommend radiofrequency denervation of dorsal root ganglion for chronic low back pain\(^4\).

References:


15.14 Trigger Finger

Criteria for surgical treatment

<table>
<thead>
<tr>
<th>Initial conservative treatment (e.g. activity modification, non-steroidal anti-inflammatory drugs for pain control, joint immobilisation (splinting)) has been unsuccessful; AND The patient has failed to respond or experiences recurrence of triggering following one corticosteroid injection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR The patient has a fixed contracture.</td>
</tr>
</tbody>
</table>

Rationale

- Spontaneous recovery has been reported in up to 29% of cases.
- Initial treatment should be conservative involving activity modification, non-steroidal anti-inflammatory drugs for pain control, joint immobilisation (splinting) and corticosteroid injection.
- Splinting has been shown to have a 55 - 73% success rate.
- An RCT comparing corticosteroid injection with surgical interventions indicated success rates following a single corticosteroid injection are 57%. Success rates as high as 97% have been reported for patients with mild trigger finger.
- Corticosteroid injection is associated with low morbidity and is a less painful method of treating trigger finger than surgery.
- Some patient groups are less likely to benefit from corticosteroid injections; these include diabetic patients, those with multiple digit involvement and those with symptom duration ≥6 months. However corticosteroid injection should still form the first line of treatment for these patients as it still offers the opportunity for the avoidance of surgery.

References:

1. Local clinical consensus developed via email, April 2012
16. Vascular

16.1 Manual lymphatic drainage (MLD)

CCGs will not routinely fund MLD as part of the Decongestive Lymphoedema Treatment (DLT)\(^1\) or on its own. It can only be considered through the prior approval route. Applications for funding can be made in the form of an individual application (such as an Individual Funding Request (IFR)).

The panels may consider referral criteria, staging (at appendix H) and guidelines contained in the Best Practice for the management of Lymphoedema (Lymphoedema Framework 2006) to determine exceptionality. In all circumstances, MLD should not be funded on its own but in combination with DLT.

Rationale

- The components of DLT are:
  
  - **Manual lymphatic drainage (MLD)** - a specialised massage technique designed to stimulate the flow of fluid and reduce swelling,
  
  - **Multilayer lymphoedema bandaging (MLLB)** - MLLB uses elastic compression bandages and compression garments to support muscles to encourage the movement of fluid out of the affected limb.
  
  - **Remedial exercises** - designed to strengthen the muscle in the limb in order to improve lymph circulation, and **skin care** - required to prevent infection.

- There is good evidence that other components of DLT work well except for MLD\(^1,2,3,4\).

- A crossover study of MLD followed by self administered massage versus no treatment concluded that improvements in both groups were attributable to the use of compression sleeves and that MLD provided no extra benefit\(^1\).

- The Cochrane review concluded that more research is needed in order to evaluate the effectiveness of massage in the treatment of lymphoedema\(^1\).

- Multilayer bandaging as an initial phase of treatment for lymphedema patients followed by hosiery achieves greater and more sustained limb volume reduction than hosiery alone\(^2\).

- International consensus guidelines acknowledge the limited amount of research data to conclusively support the use of MLD. The guidelines state that “although there is a wealth of clinical opinion advocating the benefits of MLD, there are little research data to conclusively support its use. The most appropriate techniques, optimal frequency and indications for MLD, as well as the benefits of treatment, all remain to be clarified\(^3\).

- There is moderate evidence that compression bandages decreased lymphoedema but pneumatic pumps had no effect on lymphoedema. No conclusions could be drawn regarding other interventions, such as manual lymphatic drainage due to poor quality of studies\(^4\).

- High level evidence indicates that the addition of MLD to compression and exercise therapy for the treatment of secondary lymphoedema is unlikely to produce a significant reduction in the volume. Although individual studies reported advantages associated with MLD\(^11\). Therefore, the referral criteria and guidelines included in the Best Practice for the management of Lymphoedema 2006 guidelines should be considered.
Evidence

- There are two systematic reviews (one of very poor quality), several low quality RCTs, some case series and prospective trials available that have reviewed MLD along with other conservative treatments\(^1\), 2,3,4,5,6,7,8,9,10. They concluded that there was a need of large scale clinical trial in this area. The Cochrane review carried out in 2008 agreed with these findings.

- Cochrane review (carried out in 2008) concluded that more research is needed in order to evaluate the effectiveness of massage in the treatment of lymphoedema. The review aimed to assess the effect of physical treatment programmes on the volume, shape, condition and long term control of oedema in lymphoedematous limbs. Three RCTs were included involving 150 patients were included. Only one considered MLD. This crossover study of MLD followed by self administered massage versus no treatment concluded that improvements in both groups were attributable to the use of compression sleeves and that MLD provided no extra benefit\(^1\).

References


16.2 Varicose veins

Symptomatic primary or symptomatic recurrent varicose vein procedures are commissioned if one or more of the following apply:

1. Patients experiencing spontaneous bleeding (not including spontaneous bruising) should be referred urgently

2. A documented history of superficial vein thrombosis and suspected venous incompetence

3. Trophic skin changes

4. Lipodermatosclerosis, healed leg ulceration

5. Varicose eczema associated with varicose veins (Varicose Eczema is common in patients with varicose veins and not usually an indication on its own for surgical intervention)

6. Venous leg ulceration with evidence of varicose veins

7. Skin changes indicative of ulceration

Varicose vein procedures are not otherwise commissioned.

Patients not suitable for NHS vascular surgical treatment
A. Patients with no symptoms or skin changes associated with venous disease
B. Patients whose concerns are cosmetic including telangiectasia and reticular veins
C. Patients with mild symptoms including itch, ache, mild swelling, minor changes of skin eczema and haemosiderosis
D. Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out other than in exceptional circumstances. Compression hosiery should be considered for symptom relief of leg swelling associated with varicose veins during pregnancy

Rationale
This policy has been reviewed in the light of the revised NICE guidance CG168 published July 2013
17. Podiatry

17.1 Hallux Valgus Surgery

Surgery for patients with asymptomatic bunions is not normally funded, regardless of the cosmetic appearance.

The removal of bunions that are causing symptoms will only be funded where:

1. All appropriate conservative measures have been tried for a minimum of 3 months and have failed.\(^1\) Conservative measures include: avoiding high heels shoes, wearing roomier footwear with soft leather uppers, the use of oral analgesia for pain management, the use of bunion pads or ice packs, the use of customised footwear; orthoses for appropriate patients, treatments for ulceration, use of bunion splints for pain (these can be obtained online or on advice from a Podiatrist/GP/MSK physio/orthotist/Orthopaedic clinic)

AND

The patient suffers from:

2. Severe deformity
   - (with or without lesser toe deformity) that causes significant functional impairment that prevents the patient from properly fulfilling work, domestic or carer activities, or educational responsibilities,
   - despite optimised footwear renders the patient at risk of ulceration.

OR

3. Severe pain that causes significant functional impairment that prevents the patient from properly fulfilling work, domestic or carer activities, or educational responsibilities. Pain may include transferred pain to second metatarsal or the ball of the foot.

Prior to referral, patients should be counseled to understand the outcomes of surgery and made aware of the potential complications which include, pain, stiffness to the big toe, infection, swelling, non-union, recurrence and Deep Vein Thrombosis(DVT) / Pulmonary Embolism (PE). There is no guarantee that the foot will be perfectly straight or pain-free after surgery. Patients should be informed that they are unable to drive for 6 weeks after surgery and full recovery can take an average of four to six months.

Patients may still have to alter their footwear post surgery; transfer hyperkeratotic lesions may develop after surgery which may require attention.

References:

1. NICE CG 177: Osteoarthritis: Care and management in adults (February 2014)
2. NICE IPG 332: Surgical Correction of hallux valgus using minimal access techniques (February 2012)
3. NICE IPG 140: Metatarsophalangeal joint replacement of the hallux (November 2005)
Appendix A: Croydon CCG Prior Approval Process and Individual Funding Process

*Any Procedures undertaken under the Choosing Wisely Policy has to follow the Prior Approval Process detailed in the diagram below.

**N.B.** Please note that any activity that is undertaken without Prior Approval will NOT be funded for by the CCG.

![Diagram of the Prior Approval Process]

**CHOOSING WISELY THRESHOLDS (60)**

- **PRIOR APPROVAL (40)**  
  Appendix 1.2

- **TICKBOX FORM COMPLETED**

- **SUBMITTED TO THE ADMIN TRIAGE**

- **AUTOMATED TRAFFIC LIGHT CHECKING SYSTEM (24)**

- **REQUIRE CLINICAL REVIEW (16)**

- **GREEN**
  - BLUETEQ ADMIN TEAM PROCESS

- **AMBER**
  - BLUETEQ ADMIN TEAM PROCESS

- **RED**
  - OUTCOME Communicated to the BLUETEQ ADMIN TEAM within 72 HOURS

- **IFR EXCEPTIONAL CIRCUMSTANCES (20)**  
  (17 Procedures (Croydon CCG has refreshed 5 Policies) + 3 Not Funded) Appendix 1.1

- **COMPLETE AN IFR APPLICATION FORM**

- **IFR PANEL CONSIDERS APPLICATION AND APPLICANT OR PATIENT’S CLINICIAN ADVISED OF DECISION**

- **PATIENT INFORMED OF DECISION**

**N.B.:** Please see next page list of Categories for Prior Approval and IFR
IFR Team contact details:

<table>
<thead>
<tr>
<th>South West London IFR Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>South London CSU</td>
</tr>
<tr>
<td>120 The Broadway</td>
</tr>
<tr>
<td>Wimbledon</td>
</tr>
<tr>
<td>London</td>
</tr>
<tr>
<td>SW19 1RH</td>
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Email: slcsu.IFRswlondon@nhs.net
Phone: 020 3668 1222
IFR (INDIVIDUAL FUNDING REQUESTS)

- Blepharoplasty (surgery on the upper & lower lid)
- Brow lift
- Facial skin procedures
- Hair depilation
- Hair replacement techniques to correct hair loss
- Injection of facial botulinum toxin for cosmetic indications
- Keloidectomy
- Liposuction
- Manual lymphatic drainage (MLD)
- Minor Skin Lesions (Treatment of)
- Nasal Surgery (including Rhinoplasty, Septoplasty and Septorhinoplasty)
- Pinnaplasty
- Repair of external ear lobes
- Rhinoplasty
- Scar Revision Surgery & Resurfacing
- Treatment of vascular lesions
- Uterine fibroids (minimally invasive surgery for)

PRIOR APPROVAL REQUESTS

- (Adeno)Tonsillectomy
- Acupuncture for Non-Specific Low Back Pain (LBP)
- Apronection or Abdominoplasty
- Augmentation/ Mammaplasty
- Autologous chondrocyte implantation
- Body contouring
- Carpal tunnel syndrome (surgical treatment of)
- Cataract surgery
- Circumcision
- Cosmetic genital surgery
- Dilatation & curettage (D&C)
- Discectomy for lumbar disc prolapse (elective)
- Dupuytren’s contracture (fasciectomy/fasciectomy)
- Epidural injections for lumbar back pain
- Female genital prolapse/stress incontinence (assessment of)
- Ganglia (Excision of ganglia)
- Grommets in children under 12 (ventilation tubes) (Insertion of)
- Grommets in older children (12 and above) and adults (ventilation tubes) (Insertion of)
- Gynaecomastia
- Hallux Valgus Surgery
- Hip replacement surgery (primary)
- Hysterectomy for heavy menstrual bleeding
- Knee arthroscopy
- Knee replacement surgery (primary)
- Knee washout (in patients with knee osteoarthritis)
- Mastopexy
- Obstructive sleep apnoea in adults
- Open magnetic resonance imaging (MRI)
- Reduction mammoplasty
- Revision of breast augmentation
- Rhytidectomy
- Surgical correction of nipple inversion
- Tattoo removal
- Therapeutic facet joint injections/medial branch blocks
- Thermal radiofrequency denervation of lumbar & cervical facet joints
- Treatment of skin hyperpigmentation
- Trigger Finger
- Varicose veins
- Wireless capsule endoscopy and double balloon enteroscopy in obscure gastrointestinal bleeding
- Wireless capsule endoscopy and double balloon enteroscopy in Crohn’s disease

PROCEDURES NOT FUNDED

- Asymptomatic gallstones
- IVF/ISCI Treatment
- Homeopathic/Complementary therapies

NOT FUNDED SURGERY

- Aesthetic or cosmetic surgery
APPENDIX B: INDIVIDUAL FUNDING REQUEST (IFR) APPLICATION FORM

Please tick or select the corresponding CCG that the patient is registered to:

- Croydon CCG
- Kingston CCG
- Merton CCG
- Sutton CCG
- Richmond CCG
- Wandsworth CCG
- Bexley CCG
- Greenwich CCG
- Lambeth CCG
- Lewisham CCG
- Southwark CCG

All forms must be typed and all fields must be completed (or n/a stated where field is not applicable). Incomplete mandatory fields and hand-written forms will result in the form being returned and may cause delays to consideration for funding.

Anonymity – Please ensure that in order to protect patient’s identity, apart from Section A, the patient is not referred to by name or initials within the application form.

* Mandatory field for all requests
** Mandatory field for drug requests
*** Mandatory fields for non-drug requests

SECTION A: CONTACT INFORMATION

3. Applicant Details
   The applicant should have clinical responsibility for this intervention for this patient for this specific clinical indication. Please ensure the declaration is signed and dated (Section H)

   Name: *
   Designation: *
   Tel: *
   nhs.net address - No other email accepted *

4. Patient Details

   Initials: *
   NHS Number: *
   Hospital ID number:
   DoB: *
   Patient Address: *
   Registered Consultant:
   Registered GP name: *
## SECTION B: INTERVENTION REQUESTED
(NB: Intervention refers to requested treatment, investigation, etc)

### 5. Patient Diagnosis or condition (for which intervention is requested) *

### 6. Do you consider this condition to be rare? If so please state UK prevalence and quote the source/reference *

- **Yes** ☐  **No** ☐
- **UK prevalence:**
- **Ref:**

### 7. Other relevant diagnosis or co-morbidities

### 8. Details of intervention (for which funding is requested).

- **Name** of intervention: *
- **Type of Intervention:** *
  - Drug ☐  Procedure ☐  Device ☐  Other ☐
- **Planned duration of intervention:** (please do not use abbreviations)
- **Dose and frequency of drug:**
- **Route of administration of drug:**

### 9. Anticipated start date

**Clinical Urgency**
The decision to treat in the event of immediate or life-threatening circumstances must be made in accordance with NHS Approved Provider (Trust) governance mechanisms.

- **Your request will be acknowledged within 5 working days of receipt. A funding decision usually takes the CSU up to 4 weeks from the date of receipt of a full & accurately completed application with copies of supporting clinical papers and completion of section I.**
- **Is the case more urgent than this?** *
  - **Yes** ☐  **No** ☐
  - **If ‘Yes’ please state why**

### 10. Is requested intervention part of a clinical trial?

- **Yes** ☐  **No** ☐

If **Yes**, then STOP HERE. This funding route is not appropriate. Please speak to your Trust Chief Pharmacist for drug trials. There is no need to complete the rest of this proforma.

### 11. NHS Approved Provider

- **Name**

### 12. Address

### 13. Does the intervention requested fall under a TAP or ECI procedure?

- **Yes** ☐  **No** ☐

If yes and this application is being submitted by a GP, please check whether your CCG provides a referral management/clinical assessment service which processes TAP and ECI requests before submitting this to the IFR Team.
14. If yes, has this request already been declined by a referral management/clinical assessment centre?  

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<tr>
<td>Yes</td>
<td>No</td>
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**SECTION C: COMPARISON WITH STANDARD COMMISSIONED INTERVENTION**

15. (a) What would be the standard intervention / management at this stage?  

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(b) What would be the expected outcome from the standard intervention?  

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(c) What are the patient specific reasons that make the standard intervention inappropriate for this patient?  

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**SECTION D: CURRENT STATUS OF PATIENT**

16. For all conditions  

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Please summarise the current status of the patient in terms of quality of life, symptoms etc including any recognised condition-specific QoL / status scores.  

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What is the patient’s current clinical severity?  

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Please use standard scoring systems e.g. WHO, DAS28, 6MW, cardiac index or those applicable to the patient’s clinical diagnosis. Please include interpretation of the score  

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**SECTION E: PREVIOUS TREATMENT/INTERVENTIONS**

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

* Reasons for stopping may include:
  - Course completed
  - No or poor response
  - Disease progression
  - Adverse effects/poorly tolerated (please detail nature of adverse effect/intolerance)  

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<tbody>
<tr>
<td>Start Date:</td>
<td>Stop Date:</td>
<td>Name of Intervention (for drugs include name, dose and frequency of use)</td>
<td>Reason for stopping* / Response achieved or indicate if still continuing</td>
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18. Has a previous application been submitted on behalf of this patient?  

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<tr>
<td>Yes</td>
<td>No</td>
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**SECTION F: EVIDENCE FOR EFFECTIVENESS OF INTERVENTION REQUESTED**

19. Is the requested intervention licensed for the requested indication in the UK?  

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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
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</table>
20. Governance
Has the Approved NHS Provider approved the requested intervention for use through its recognised clinical governance arrangements?

<table>
<thead>
<tr>
<th>Drugs- Has the trust Drugs and Therapeutics Committee (DTC) or equivalent approved the requested intervention for use? **</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No, then STOP HERE. The application requires DTC approval</td>
<td></td>
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<tr>
<td>Evidence MUST be supplied e.g. DTC minutes, a letter from the DTC Chairman, if Chairman’s action has been taken</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Medical devices &amp; interventions- has the device/ intervention been approved in accordance with Approved NHS Provider clinical governance arrangements***</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No, then STOP HERE. The application requires approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence MUST be supplied e.g. meeting minutes where approval was given</td>
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</table>

21. Evidence
It is the applicant’s responsibility to provide robust*, relevant and valid evidence to support the use of the intervention in this patient.

| All relevant evidence should be provided. Give details of national or local guidelines/ recommendations (e.g. NICE, Scottish Medicines Consortium, London (Cancer) New Drugs Group etc) and/or full published papers (rather than abstracts) supporting the use of the requested intervention for this condition, unless the application relates to the use of an intervention in a rare disease. Please include any available data on the use of this treatment by your unit including audits Copies of key references MUST be provided |

*Hierarchy of Evidence (Taken from NPC ‘Supporting rational local decision-making about medicines (and treatments) Feb 2009)
1. Well-conducted meta-analysis of several, similar, large, well-designed RCTs
2. Large well-designed RCT
3. Meta-analysis of smaller RCTs
4. Case-control and cohort studies
5. Case reports and case series
6. Consensus from expert panels
7. Individual opinion

22. Outcomes *

(a) What would you consider to be a successful outcome for this intervention in this patient? – include details of the parameters you intend to measure

(b) How will you monitor this and how frequently will you monitor this?

(c) What is the minimum timeframe/course of treatment at which a clinical response can be assessed?

(d) What stopping criteria will be used to decide when the intervention is no longer effective?

(e) Detail the current status of the patient according to these measures.

23. What are the anticipated adverse effects and potential risks of the intervention for this patient? *

24. How do the benefits outweigh
### SECTION G: STATEMENT OF EXCEPTIONALITY OR RARITY

<table>
<thead>
<tr>
<th>25. On which basis are you making this request?</th>
<th></th>
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<tbody>
<tr>
<td>☐ Exceptional clinical circumstances</td>
<td></td>
</tr>
<tr>
<td>☐ Rarity of condition or presentation</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>26. If exceptionality, please describe why the patient’s clinical circumstances are exceptional *</th>
</tr>
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<tbody>
<tr>
<td>Give specific information to indicate how this patient is significantly different from the cohort of other patients with the same clinical condition</td>
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<tr>
<th>27. If rarity, please describe why this patient’s condition or clinical presentation is so unusual that there is no relevant commissioning arrangement in place</th>
</tr>
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</table>

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<tr>
<th>28. How many patients with the same condition or presentation as this patient do you expect to see in the next 12 months? *</th>
</tr>
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</table>

### SECTION H: COSTS and REVIEW

If the application is for a drug, the completed form must be sent to the Trust Chief Pharmacist, for completion of Part A. If the application is for a medical device or other intervention, the completed form must be sent to the Trust Service Manager (or equivalent) for completion of Part B. Part C needs to be completed for both drug and non-drug applications by the service manager.

**PART A – DRUG INTERVENTIONS** (to be completed by approved NHS provider Chief Pharmacist)**

<table>
<thead>
<tr>
<th>29. Total Acquisition cost (inc VAT) for duration of treatment being applied for (or annual cost if treatment for longer than one year),</th>
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<tr>
<th>30. State the value of any offset costs</th>
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<tr>
<th>31. Please benchmark these costs against London Procurement Prices</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>32. Application reviewed by Chief Pharmacist or nominated authorised deputy</th>
</tr>
</thead>
</table>

Name:  
Signature or email confirmation:

**PART B - NON-DRUG INTERVENTIONS** (to be completed by approved NHS provider service manager)***

<table>
<thead>
<tr>
<th>33. Total Acquisition cost (inc VAT) for duration of treatment being applied for (or annual cost if treatment for longer than one year),</th>
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<table>
<thead>
<tr>
<th>34. State the value of any offset costs</th>
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<table>
<thead>
<tr>
<th>35. Please benchmark these costs against London Procurement Prices</th>
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</table>

**PART C- ALL INTERVENTIONS** (to be completed by approved NHS provider service manager )

<table>
<thead>
<tr>
<th>36. Application reviewed by Service Manager or nominated authorised deputy</th>
</tr>
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</table>

Name:  
Signature or email confirmation:

### SECTION I: APPLICANT’S DECLARATION

Date Approved: January 2017  
Review Date: December 2018  
Version Final 1.0
29. Declaration *
I declare that this application is complete and accurate and that all necessary supporting information and evidence has been provided on this form (& attachments).

Yes ☐  No ☐

30. Patient Consent *
I confirm that this IFR has been discussed in full with the patient, including an appraisal of the benefits/risks of the intervention and they have consented to the proposed treatment. I confirm the patient has consented to CCG & CSU staff involved in the preparation, consideration and funding of their case to access confidential clinical information about them (including their NHS no.) to enable full consideration of this request and payment of invoices. In the case of a minor or vulnerable adult I confirm I have complied with the relevant legislation guidance including the Children Act 2004 and Mental Capacity Act 2005.

Yes ☐  No ☐

Patient Signature (Optional):

28. Correspondence and Contact *
The IFR team will copy the patient into correspondence concerning progress and outcome of their application. If you do not want the patient to be contacted or to receive correspondence please indicate this.

Please copy the patient into correspondence. *
Yes ☐  No ☐

Responsible Clinician Name: *
Signature or email confirmation: *
Date: *
DD/MM/YY

Forward application to the IFR team (via Trust Service Agreements Department or equivalent, if applicable).

For SW London CCGs: Croydon, Kingston, Merton, Sutton, Richmond and Wandsworth Forms should be submitted to slcsu.ifrswlondon@nhs.net  Tel. enquiries: 020 3668 1222

For SE London CCGs: Lewisham, Bexley, Greenwich, Southwark and Lambeth Forms should be submitted to: slcsu.sellfr@nhs.net Tel. enquiries: 020 3049 4154
Patient Equality Monitoring Data
This section is for data monitoring purposes only and will be removed from the application prior to consideration by the IFR Panel.

Information unavailable □
Prefer not to disclose □

<table>
<thead>
<tr>
<th>1 Ethnic Origin</th>
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<tbody>
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<td>White</td>
<td>British</td>
<td>Irish</td>
<td>Any other White background</td>
</tr>
<tr>
<td>Mixed</td>
<td>White and Black Caribbean</td>
<td>White and Black African</td>
<td>White and Asian</td>
</tr>
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<td>Asian or Asian British</td>
<td>Indian</td>
<td>Pakistani</td>
<td>Bangladeshi</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>Caribbean</td>
<td>African</td>
<td>Any other Black background</td>
</tr>
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<td>Other Ethnic Groups</td>
<td>Chinese</td>
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<td></td>
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<table>
<thead>
<tr>
<th>2 Gender</th>
<th></th>
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<tbody>
<tr>
<td>Male</td>
<td></td>
<td>Female</td>
<td>Transgender</td>
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<table>
<thead>
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<th>3 Sexuality</th>
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</thead>
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<tr>
<td>Heterosexual</td>
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<td>Bisexual</td>
<td>Gay</td>
</tr>
<tr>
<td>Not disclosed</td>
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</table>

<table>
<thead>
<tr>
<th>4 Age Group</th>
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</thead>
<tbody>
<tr>
<td>16-25</td>
<td></td>
<td>26-35</td>
<td>36-45</td>
</tr>
<tr>
<td>56-65</td>
<td>66+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 5 Do you consider yourself to have a disability? |       |       |
|-------------------------------------------------|-------|
| Registered disabled | Unregistered disabled | Not disabled |

<table>
<thead>
<tr>
<th>Nature of disability</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing impairment</td>
<td></td>
<td>Speech impairment</td>
<td>Mobility Impairment</td>
<td>Age related impairment</td>
</tr>
<tr>
<td>Visual impairment</td>
<td></td>
<td>Learning disability</td>
<td>Mental health</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6 Religion</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No religion</td>
<td></td>
<td>Christian</td>
<td>Buddhist</td>
</tr>
<tr>
<td>Hindu</td>
<td></td>
<td>Jewish</td>
<td>Muslim</td>
</tr>
</tbody>
</table>
Appendix C: Policy on alternative/homeopathic/complementary therapies

The literature on the effectiveness of alternative (complementary) therapies is notable by the lack of good quality studies. That much more rigorous evidence is demanded for complementary therapies compared to other areas of medical practice is an argument often advanced but this is not true. All new developments/innovations are to be backed up by evidence of effectiveness. South West London CCGs have accepted the effectiveness agenda and attempting to introduce unevaluated therapies would be a departure from this, more so since alternative therapies are not without side effects and complications, and this is especially so for spinal manipulation.

There is absolute lack of well-conducted systematic reviews that permits any basic analyses of these therapies. The only procedure that seems to have any effect is acupressure on pre- and postoperative nausea and vomiting, as explained below.

For the rest of the procedures:

**Homeopathy:** There is very little, if any, evidence of effectiveness of homeopathy and, even when it is claimed to exist (such as for asthma), it is inconclusive and based on poorly designed studies. Although some CCGs have a clear policy denying the commissioning of homeopathy, the present system for dealing with homeopathic referrals allows again the patient’s GP to justify the referral. This justification is hardly ever based on scientific grounds but on social need, failure of traditional methods or pressure on the part of the patient. It is, therefore, recommended that funding homeopathy for any procedure should cease completely in any form or through any possible referral route, be it from Primary Care or be it through consultant to consultant referral. This policy should also be extended to palliative patients, as there is no evidence whatsoever that homeopathy benefits in any way to these patients.

**Acupuncture:** Acupuncture appears to be effective for chemotherapy-related and postoperative and nausea and vomiting in adults and that related mainly to acupressure. It is also effective for low back pain for a cohort of patients who fulfil the criteria for Low Back Pain included in this document. It should not be funded for any other indications (like obesity or smoking cessation, etc), other than the mentioned above.

**Osteopathy and Spinal Manipulation:** The present state of evidence is such that the effectiveness of spinal manipulation has been shown only for acute low back pain. Spinal manipulation is of different types (osteopathy, chiropractor, physiotherapy) and it is not clear which of these are effective. There is no data on cost-effectiveness. In view of this, SWL CCGs should not commission osteopathy services.

**Clinical Ecology:** Multiple Chemical Sensibilities and all the treatments attached to this, including rotation diet, avoidance, antifungal treatment for candidiasis, and provocation-neutralisation procedure, lack of sound scientific evidence to support their use. EPD and other forms of allergy immunotherapy it should be considered investigational.

**Other Alternative Therapies:** No sound evidence of the effectiveness of aromatherapy, Chinese medicines, chiropractice therapy, herbal remedies, hydrotherapy, hypnotherapy, massage or reflexology has been found.
Appendix D – Eligibility for NHS funded wigs

Any patient recommended by a dermatologist for wigs may have to be paid for in part by the patient.

Patients can get free wigs and fabric supports if they:*

- are under 16
- are aged 16, 17 or 18 in full-time education
- are a hospital in-patient
- are a war pensioner and the wig or fabric support is for them accepted
- disablement and they have a valid war pension exemption certificate
- are getting or their partner gets:
  - Income Support
  - Income-based Jobseeker’s Allowance (Incapacity Benefit or Disability Living Allowance do not count as they are not income related.)
- Pension Credit Guarantee Credit
- are entitled to, or named on, a valid NHS tax credit exemption certificate
- are named on a valid HC2 certificate.

Partial help: if they are named on a valid HC3 certificate they might get some help.

Appendix E: Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading.</td>
<td></td>
</tr>
<tr>
<td>Watching TV.</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g a theatre or a meeting).</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break.</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit.</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone.</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol.</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic.</td>
<td></td>
</tr>
</tbody>
</table>

USER GUIDE

As a guide, a total score of 11 or more may mean a sleeping disorder such as obstructive sleep apnoea. A very high score such as 17 or more may indicate narcolepsy.

Normal Epworth Sleepiness Scale (ESS) Scores (4)

Data from Australia show that “normal” adults (N = 72) who do not have evidence of a chronic sleep disorder (including snoring) have a mean Epworth Sleepiness Scale (ESS) score of 4.6 (confidence intervals 3.9 - 5.3) with a standard deviation of 2.8 and a range from zero to 10. The normal range defined by the 2.5 and 97.5 percentiles is also zero to 10 (2). This is different from the results first published in 1991, in which the normal range was reported as 2-10 (3). It is not yet clear whether the Epworth Sleepiness Scale (ESS) scores of normal subjects in other cultures are the same. Epworth Sleepiness Scale (ESS) scores do not differ significantly between normal men and women (1), nor do they change much with age.

References

## Appendix F: Classification of Pain Levels and Functional Limitations Table for Primary Hip Replacement and Oxford Hip Score

<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 at regular doses, paracetamol.</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 at regular doses, paracetamol.</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>
</tbody>
</table>

### Previous non-surgical treatments

| Correctly Done                  | NSAIDs, paracetamol, aspirin or narcotic analgesics at regular doses during 6 months with no pain relief; weight control treatment if overweight, physical therapies done. |
| Incorrectly Done                | 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. |

### 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>
</tr>
</thead>
<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>
</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>
# OXFORD HIP SCORE(1) TO BE COMPLETED BY THE PATIENT DURING THE LAST 4 WEEKS:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1 (scoring 4-0) | How would you describe the pain you usually have from your hip?  
None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ |
| 2 (scoring 4-0) | Have you had any trouble with washing and drying yourself (all over) because of your hip?  
No trouble at all ◯ Very little trouble ◯ Moderate trouble ◯ Extreme difficulty ◯ Impossible to do ◯ |
| 3 (scoring 4-0) | Have you had any trouble getting in and out of a car or using public transport because of your hip?  
No trouble at all ◯ Very little trouble ◯ Moderate trouble ◯ Extreme difficulty ◯ Impossible to do ◯ |
| 4 (scoring 4-0) | Have you been able to put on a pair of socks, stocking or tights?  
Yes, easily ◯ With little difficulty ◯ With moderate difficulty ◯ With extreme difficulty ◯ Impossible to do ◯ |
| 5 (scoring 4-0) | Could you do the household shopping on your own?  
Yes, easily ◯ With little difficulty ◯ With moderate difficulty ◯ With extreme difficulty ◯ All of the time ◯ |
| 6 (scoring 4-0) | For how long have you been able to walk before pain from your knee becomes severe? (with or without a stick)  
No pain/more than 30 minutes ◯ 16-30 minutes ◯ 5 to 15 minutes ◯ Around the house only ◯ Not at all-pain severe when walking ◯ |
| 7 (scoring 4-0) | Have you been able to climb a flight of stairs?  
Yes, easily ◯ With little difficulty ◯ With moderate difficulty ◯ With extreme difficulty ◯ All of the time ◯ |
| 8 (scoring 4-0) | After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?  
Not at all painful ◯ Slightly painful ◯ Moderately painful ◯ Very painful ◯ Unbearable ◯ |
| 9 (scoring 4-0) | Have you been limping when walking because of your hip?  
Rarely/Never ◯ Sometimes, or just at first ◯ Often, not just at first ◯ Most of the time ◯ All of the time ◯ |
| 10 (scoring 4-0) | Have you had any sudden, severe pain - 'shooting', 'stabbing' or 'spasms' from the affected hip?  
No days ◯ Only 1 or 2 days ◯ Some days ◯ Most days ◯ Every day ◯ |
| 11 (scoring 4-0) | How much pain has your hip interfered with your usual work (including housework)?  
Not at all ◯ A little bit ◯ Moderately ◯ Greatly ◯ Totally ◯ |
| 12 (scoring 4-0) | Have you been troubled by pain from your hip in bed at night?  
No nights ◯ Only 1 or 2 nights ◯ Some nights ◯ Most nights ◯ Every night ◯ |

## System of scoring

Each of the 12 questions on the Oxford hip score is scored in the same way with the score decreasing as the reported symptoms increase (i.e. become worse). All questions are laid out similarly with response categories denoting least (or no) symptoms being to the left of the page (scoring 4) and those representing greatest severity lying on the right hand side (scoring 0).

The overall score is reached by simply summing the scores received for individual questions. This results in a continuous score ranging from 0 (most severe symptoms) to 48 (least symptoms). Score each question from 0 to 4 with 4 being the best outcome. This method, when summed, produces overall scores running from 0 to 48 with 48 being the best outcome.

*New scoring system for the Oxford hip score*

When the Oxford knee score was originally devised, the scoring system was designed to be as simple as possible, in order to encourage its use. Thus, in the original publication each question was scored from 1 to 5, with 1 representing best outcome/least symptoms. Scores from each question were added so the overall score was from 12 to 60 with 12 being the best outcome.

Since then, many surgeons have found this scoring unintuitive and have adapted the scoring - leading to considerable confusion. The new scoring system is now recommended.

---

**Date Approved: January 2017**  |  **Review Date: December 2018**  |  **Version Final 1.0**
### Appendix G: Knee Symptomatology, Radiology and Localisation and Oxford Knee Score\(^7\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility and Stability</strong></td>
<td></td>
</tr>
<tr>
<td>Preserved mobility and stable joint</td>
<td>Preserved mobility is equivalent to minimum range of movement from 0° to 90°. Stable or not lax is equivalent to an absence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td>Limited mobility and /or stable joint</td>
<td>Limited mobility is equivalent to a range of movement less than 0° to 90°. Unstable or lax is equivalent to the presence of slackness of more than 5mm in the extended joint.</td>
</tr>
<tr>
<td><strong>Symptomatology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Sporadic pain. Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). Medication: aspirin, paracetamol or NSAID to control pain with no side effects</td>
</tr>
<tr>
<td>Moderate</td>
<td>Occasional pain. Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities. Medication: aspirin, paracetamol or NSAID to control the pain with few or no side effects</td>
</tr>
<tr>
<td>Intense</td>
<td>Pain of almost continuous nature. Pain when walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of NSAIDs for treatment to take effect. Requires the sporadic use of support systems (walking stick, crutches)</td>
</tr>
<tr>
<td>Severe</td>
<td>Continuous pain. Pain when resting. Daily activities significantly limited constantly. Continuous use of analgesics- narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches)</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td></td>
</tr>
<tr>
<td>Slight</td>
<td>Ahlbach grade 1</td>
</tr>
<tr>
<td>Moderate</td>
<td>Ahlbach grade II and III</td>
</tr>
<tr>
<td>Severe</td>
<td>Ahlbach grade IV and V</td>
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<tr>
<td><strong>Localisation</strong></td>
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</tr>
<tr>
<td>Uni-compartmental</td>
<td>Excluded patello-femoral isolated</td>
</tr>
<tr>
<td>Bi-compartmental</td>
<td>Unicompartmental plus patello-femoral</td>
</tr>
<tr>
<td>Tri-compartmental</td>
<td>Disease affecting all three compartments of the knee</td>
</tr>
<tr>
<td>OXFORD KNEE SCORE</td>
<td>TO BE COMPLETED BY THE PATIENT DURING THE PAST 4 WEEKS:</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>1 (scoring 4-0)</td>
<td>How would you describe the pain you usually have from your knee?</td>
</tr>
<tr>
<td></td>
<td>None o Very mild o Mild o Moderate o Severe o</td>
</tr>
<tr>
<td>2 (scoring 4-0)</td>
<td>Have you had any trouble with washing and drying yourself (all over) because of your knee?</td>
</tr>
<tr>
<td></td>
<td>No trouble at all o Very little trouble o Moderate trouble o Extreme difficulty o Impossible to do o</td>
</tr>
<tr>
<td>3 (scoring 4-0)</td>
<td>Have you had any trouble getting in and out of a car or using public transport because of your knee?</td>
</tr>
<tr>
<td></td>
<td>No trouble at all o Very little trouble o Moderate trouble o Extreme difficulty o Impossible to do o</td>
</tr>
<tr>
<td>4 (scoring 4-0)</td>
<td>For how long have you been able to walk before pain from your knee becomes severe? (with or without a stick)</td>
</tr>
<tr>
<td></td>
<td>No pain/more than 30 minutes o 16-30 minutes o 5 to 15 minutes o Around the house only o Not at all-pain severe when walking o</td>
</tr>
<tr>
<td>5 (scoring 4-0)</td>
<td>After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee?</td>
</tr>
<tr>
<td></td>
<td>Not at all painful o Slightly painful o Moderately painful o Very painful o Unbearable o</td>
</tr>
<tr>
<td>6 (scoring 4-0)</td>
<td>Have you been limping when walking because of your knee?</td>
</tr>
<tr>
<td></td>
<td>Rarely/Never o Sometimes, or just at first o Often, not just at first o Most of the time o All of the time o</td>
</tr>
<tr>
<td>7 (scoring 4-0)</td>
<td>Could you kneel down and get up again afterwards?</td>
</tr>
<tr>
<td></td>
<td>Yes, easily o With little difficulty o With moderate difficulty o With extreme difficulty o No, impossible o</td>
</tr>
<tr>
<td>8 (scoring 4-0)</td>
<td>Have you been troubled by pain from your knee in bed at night?</td>
</tr>
<tr>
<td></td>
<td>No nights o Only 1 or 2 nights o Some nights o Most nights o Every night o</td>
</tr>
<tr>
<td>9 (scoring 4-0)</td>
<td>How much has pain from your knee interfered with your usual work (including housework)?</td>
</tr>
<tr>
<td></td>
<td>Not at all o A little bit o Moderately o Greatly o Totally o</td>
</tr>
<tr>
<td>10 (scoring 4-0)</td>
<td>Have you felt your knee might suddenly ‘give way’ or let you down?</td>
</tr>
<tr>
<td></td>
<td>Rarely/Never o Sometimes, or just at first o Often, not just at first o Most of the time o No, impossible o</td>
</tr>
<tr>
<td>11 (scoring 4-0)</td>
<td>Could you do the household shopping on your own?</td>
</tr>
<tr>
<td></td>
<td>Yes, easily o With little difficulty o With moderate difficulty o With extreme difficulty o All of the time o</td>
</tr>
<tr>
<td>12 (scoring 4-0)</td>
<td>Could you walk down one flight of stairs?</td>
</tr>
<tr>
<td></td>
<td>Yes, easily o With little difficulty o With moderate difficulty o With extreme difficulty o All of the time o</td>
</tr>
</tbody>
</table>

**OXFORD KNEE SCORE USER GUIDE**

**System of scoring**

Each of the 12 questions on the Oxford knee score is scored in the same way with the score decreasing as the reported symptoms increase (ie. become worse). All questions are laid out similarly with response categories denoting least (or no) symptoms being to the left of the page (scoring 4) and those representing greatest severity lying on the right hand side (scoring 0).

The overall score is reached by simply summing the scores received for individual questions. This results in a continuous score ranging from 0 (most severe symptoms) to 48 (least symptoms). Score each question from 0 to 4 with 4 being the best outcome. This method, when summed, produces overall scores running from 0 to 48 with 48 being the best outcome.

*New scoring system for the Oxford knee score*

When the Oxford knee score was originally devised, the scoring system was designed to be as simple as possible, in order to encourage its use. Thus, in the original publication (2) each question was scored from 1 to 5, with 1 representing best outcome/least symptoms. Scores from each question were added so the overall score was from 12 to 60 with 12 being the best outcome.

Since then, many surgeons have found this scoring unintuitive and have adapted the scoring - leading to considerable confusion. The new scoring system is now recommended.
Appendix H – Lymphoedema Staging and Referral Criteria

Best Practice for the management of Lymphoedema 2006 guidelines

Referral Criteria

<table>
<thead>
<tr>
<th>BOX 15 Indications for referral to a lymphoedema service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Special groups:</strong></td>
</tr>
<tr>
<td>- swelling of unknown origin</td>
</tr>
<tr>
<td>- midline lymphoedema (head, neck, trunk, breast, genitalia)</td>
</tr>
<tr>
<td>- children with chronic oedema</td>
</tr>
<tr>
<td>- primary lymphoedema</td>
</tr>
<tr>
<td>- lymphoedema in family members</td>
</tr>
<tr>
<td><strong>Factors complicating management:</strong></td>
</tr>
<tr>
<td>- concomitant arterial disease</td>
</tr>
<tr>
<td>- concomitant diabetes mellitus</td>
</tr>
<tr>
<td>- concomitant venous insufficiency with ulceration</td>
</tr>
<tr>
<td>- long-term complications due to surgery or radiotherapy</td>
</tr>
<tr>
<td>- severe papillomatosis, hyperkeratosis or other chronic skin condition</td>
</tr>
<tr>
<td>- severe foot distortion/bulbous toes</td>
</tr>
<tr>
<td>- sudden increase in pain or swelling of lymphoedematous site</td>
</tr>
<tr>
<td>- chylous reflux, eg chyluria, chyle-filled lymphangiectasia</td>
</tr>
<tr>
<td>- neuropathy</td>
</tr>
<tr>
<td>- functional, social or psychological factors</td>
</tr>
<tr>
<td>- obesity</td>
</tr>
<tr>
<td><strong>Management difficulties:</strong></td>
</tr>
<tr>
<td>- compression garment fitting problems</td>
</tr>
<tr>
<td>- failure to respond after three months' standard treatment</td>
</tr>
<tr>
<td>- wound that deteriorates or is unresponsive after three months' treatment</td>
</tr>
<tr>
<td>- recurrent cellulitis/erysipelas</td>
</tr>
</tbody>
</table>

Staging of Lymphoedema

<table>
<thead>
<tr>
<th>BOX 11 International Society of Lymphology (ISL) lymphoedema staging</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ISL stage 0</strong></td>
</tr>
<tr>
<td>A subclinical state where swelling is not evident despite impaired lymph transport. This stage may exist for months or years before oedema becomes evident</td>
</tr>
<tr>
<td><strong>ISL stage I</strong></td>
</tr>
<tr>
<td>This represents early onset of the condition where there is accumulation of tissue fluid that subsides with limb elevation. The oedema may be pitting at this stage</td>
</tr>
<tr>
<td><strong>ISL stage II</strong></td>
</tr>
<tr>
<td>Limb elevation alone rarely reduces swelling and pitting is manifest</td>
</tr>
<tr>
<td><strong>ISL late stage II</strong></td>
</tr>
<tr>
<td>There may or may not be pitting as tissue fibrosis is more evident</td>
</tr>
<tr>
<td><strong>ISL stage III</strong></td>
</tr>
<tr>
<td>The tissue is hard (fibrotic) and pitting is absent. Skin changes such as thickening, hyperpigmentation, increased skin folds, fat deposits and warty overgrowths develop</td>
</tr>
</tbody>
</table>
Croydon CCG will only fund Cataract Surgery Policy, when the following criteria are met:

**Part 1**

<table>
<thead>
<tr>
<th>The CCG will only fund Cataract Surgery when the following criteria are met:</th>
<th>Delete as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The best corrected visual acuity is 6/12 (Snellen) or worse in either the first or second eye; <strong>AND</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>The patient has impairment in lifestyle such as substantial effect on activities of daily living, employment, risk of falls, or extreme glare as evidenced by the Cataract Assessment Form below.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td>Surgery is indicated for management of ocular co-morbidities such as control of glaucoma, view of diabetic retinopathy etc.</td>
<td>Yes</td>
</tr>
<tr>
<td>All eligible patients should wait 7 days to make a decision and wishes to undergo cataract surgery and understands the risks and benefits of this surgery.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer CCCG’s Individual funding request policy for further information.
## Part 2

### Cataract Assessment Form

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Tick as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient HAS been given all the information relating to the procedure and choice</td>
<td>Yes</td>
</tr>
<tr>
<td>The patient has glaucoma</td>
<td>Yes</td>
</tr>
<tr>
<td>The patient has diabetes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Patients need to evidence how cataract is affecting daily activity. A patient needs to score ≥3.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Tick as appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Visual Disability</strong></td>
<td></td>
</tr>
<tr>
<td>Affected by glare</td>
<td>2</td>
</tr>
<tr>
<td>Difficulty with reading</td>
<td>1</td>
</tr>
<tr>
<td>Difficulty watching television</td>
<td>1</td>
</tr>
<tr>
<td>Difficulty performing work or hobbies</td>
<td>1</td>
</tr>
<tr>
<td><strong>2. Social functioning (Tick ONE box only)</strong></td>
<td></td>
</tr>
<tr>
<td>Lives alone</td>
<td>2</td>
</tr>
<tr>
<td>Cares for partner</td>
<td>2</td>
</tr>
<tr>
<td>Lives in sheltered accommodation</td>
<td>1</td>
</tr>
<tr>
<td>Lives with carer</td>
<td>1</td>
</tr>
<tr>
<td>Lives in a residential or nursing home</td>
<td>1</td>
</tr>
<tr>
<td><strong>3. Other</strong></td>
<td></td>
</tr>
<tr>
<td>Drives a car/is in paid employment</td>
<td>1</td>
</tr>
<tr>
<td>Mild/moderate hearing impairment</td>
<td>1</td>
</tr>
<tr>
<td>Severe hearing impairment (Deaf)</td>
<td>2</td>
</tr>
<tr>
<td>Has fallen twice or more in the last 12 months</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total Score:**
**Croydon Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Consultant use only</th>
<th>Optometrist use only</th>
<th>Commissioner's use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please complete the following and file for future compliance audit.</td>
<td>Practice stamp/address</td>
<td>Criteria met as per policy: yes / no</td>
</tr>
<tr>
<td>Referral criteria is met and the patient will benefit from the proposed treatment: yes / no</td>
<td></td>
<td>Compliance with notes: yes / no</td>
</tr>
<tr>
<td>Signature.........................</td>
<td></td>
<td>Audit date:.......................</td>
</tr>
<tr>
<td>Consultant name:.................... Please print</td>
<td>Referring Optometrist:.........</td>
<td>Audited by:.......................</td>
</tr>
<tr>
<td>Hospital: ............Date........</td>
<td>Date: .........................</td>
<td>Please print</td>
</tr>
</tbody>
</table>

(GP/Cons)