



Commissioning Policy covering procedures of limited clinical value

Version D (March 2011)

Although Primary Care Trusts (PCTs) and East Midlands Specialised Commissioning Group (EMSCG) were abolished at the end of March 2013 with the formation of 5 Nottinghamshire County wide clinical Commissioning Groups (CCGs) policies that were in place prior to 1 April 2013 remain in place to ensure a consistent approach.

The NHS Nottingham North & East Clinical Commissioning Group have adopted this policy, in its existing form, at a meeting of its Governing Body on 20 August 2013.

This policy sets the overall parameters within which care will be delivered.



Nottinghamshire County



Nottingham City

**NHS Nottinghamshire County
& NHS Nottingham City**

**Commissioning Policy covering procedures of limited
clinical value**

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Version control

Version B	July 2010	<p>Hernias: criteria removed</p> <p>MRI criteria – harmonised with criteria for discectomy</p> <p>Apnoea: Embed Epworth Sleepiness Scale</p> <p>IBS: clarify that criteria relates to adults; link to NICE Guidelines for IBS</p> <p>Reference to APC position statement on Homeopathy</p> <p>Formatting changes</p>
Version C	September 2010	<p>Annotated to clarify meaning of “restricted”</p> <p>Added Chinese Medicine to list of alternative therapies</p> <p>Tonsillectomy: added that episodes must be appropriately treated</p> <p>Xray/MRI: prompt to City GPs to Direct Access</p> <p>Guidelines for investigating spinal disc lesions</p> <p>IBS: further highlight that this applies only to adults</p>
Version D	January 2011	<p>Introduction: reword for consistency, and set out what is meant by low value</p> <p>Cataract: amended criteria</p> <p>Inguinal hernia: added criteria</p> <p>Glucosamine: removed; belongs in prescribing policy</p> <p>Shoulder arthroplasty: removed criteria – general restriction regarding IPG applies</p> <p>Ganglion: clarified existing criteria</p> <p>Aim & implications of policy: added text to explain policy to patients and summary list of procedures for GPs/patients</p>

Patient guide to the policy & why your doctor has to observe it

NHS funds

- NHS Nottinghamshire County and NHS Nottingham City buy healthcare on behalf of the local population. The money for this comes from a fixed budget. By law, we are required to keep within this budget.
- Demand for healthcare is greater than can be funded from this fixed budget. Unfortunately, this means that some healthcare which patients might wish to receive and which professionals might wish to offer cannot be funded.
- This has always been the situation since the start of the NHS.

Assessing what the overall population most needs

- Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed.
- This assessment of need is made across the whole population and, wherever possible, on the basis of best evidence about what works. We also aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services.
- This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations.
- One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which don't work well enough to justify any use within the local NHS. A similar list has been drawn up for medications, to ensure that the local NHS gets the greatest possible value for the local population. We aim to review these lists to ensure that they reflect the best available evidence and are affordable and fair.

Implications for you

- This may mean that your doctor is not able to offer you a certain treatment because it would not be funded by the local NHS.
- Although most doctors recognise the need for some kind of policy like this, she/he may be uncomfortable because of its implications for you as an individual.
- Even so, your doctor has to observe the policy because it is the policy of the local NHS, and is the best way to ensure that local NHS funds are spent on the things that will bring greatest overall benefit to local people in a way that is affordable and fair.

Please turn page for a brief summary of what is included in this policy and in the related policy covering cosmetic treatments.

Examples of treatments which are not funded by the local NHS

The following list contains examples of some of the treatments that are not funded or are restricted, and are most relevant to patients in a primary care setting

- [Dental implants](#) for cosmetic purposes
- Surgical treatment of **varicose veins** – strict criteria apply
- Surgical or laser treatment for a range of benign skin lesions except in specific circumstances set out in the Cosmetics policy, e.g.
 - **viral warts, seborrhoeic warts, molluscum contagiosum, spider veins, cherry angioma, skin tags, papillomas, naevi, haemangiomas, xanthelasma, epidermoid cysts**
- [Complementary therapies including acupuncture](#) (except acupuncture for low back pain up to 12 months duration)
- [Grommets, tonsillectomy, adenoidectomy, surgery for sleep apnoea](#) – strict criteria apply
- [Surgery for snoring](#)
- [Hysterectomy for heavy menstrual bleeding](#) – strict criteria apply
- [Caesarean section \(elective\)](#) – criteria apply
- [Cataracts](#) – criteria apply
- [Labial reduction](#) – except for dyspareunia
- [Circumcision](#) – except for medical reasons
- [Haemorrhoidectomy](#) – strict criteria apply
- [Inguinal hernia repair](#) – strict criteria apply
- Tests for confirming diagnosis of [Irritable Bowel Syndrome](#) in adults
- [Reversal of sterilisation](#)
- [Back surgery and injections](#) – strict criteria apply
- Surgery for [Dupuytren's, Ganglion, and Joint injections](#) – strict criteria apply
- **Cosmetic treatments** except in the very specific circumstances set out in the Cosmetics policy. List of treatments not funded includes (but not limited to):
 - **Excision of excessive skin from thigh/ leg/ hip/ buttock/ arm/ forearm, facelifts, fat grafts, liposuction, phalloplasty, chin implant, cheek implants, collagen implant, cranial banding for positional plagiocephaly, earlobe repair, botulinum for wrinkles/ frown lines/ aging neck, resurfacing by laser for skin conditions causing scarring, correction of nipple inversion, breast uplift, hair depilation, electrolysis**

For a full list of all treatments and applicable exclusions and criteria, please refer to Commissioning policy covering procedures of limited clinical value (this document) and the East Midlands Cosmetics Policy.

1.1 Introduction

The purpose of this policy is to ensure that NHS Nottinghamshire County, NHS Nottingham City and their successor organisations fund treatment only for clinically effective interventions delivered to the right patients. It sets out the treatments deemed to be of insufficient priority to justify funding from the available fixed budget.

Approved prescribing of medicines falls outside the scope of this document and is covered in the guidelines and protocols produced by the Nottinghamshire Area Prescribing. Further information can be obtained from the Pharmacy/Medicines Management Department or via www.nottsapc.nhs.uk.

1.2 Definitions

Procedures of limited clinical value (PLCV) are those which deliver a relatively poor output/outcome to the population. Low value procedures are those which:

1. Have clear evidence that they are ineffective or do more harm than good.
2. Have no evidence of effectiveness and are not being delivered in a context that would allow the gathering of an evidence base to judge effectiveness, i.e. through ethically approved research.
3. Have evidence of effectiveness but are being offered to patients whose characteristics are different from the characteristics of the patients in the research studies which produced the evidence for effectiveness
4. Use resources that would produce more value, namely a better balance of benefit to harm, if invested in some other service for the same group of patients.

In this policy, the term PLCV is extended to include procedures which may be effective but where there may be significant differences in value depending on the setting in which the procedure is delivered (usually due to large differences in pricing between providers).

Within this document the terms “low priority procedure” and “procedure of limited clinical value” are used synonymously.

1.3 Scope

This policy sets out PLCV that are not normally commissioned and those that are only commissioned when certain criteria are met.

1.4 Principles

PCT commissioning decisions are made in accordance with the commissioning principles set out in the PCT Individual Funding Request Policy. These principles include the need for evidence of clinical effectiveness, cost effectiveness, affordability of equitable provision, and best value for money.

1.5 Exceptionality

The PCT commissions according to the policy criteria. Requests for individual funding will not normally be considered, unless the circumstances strictly fulfil the criteria for exceptionality as defined within the PCT's current policy for determining Individual Funding Requests, in which case they may be submitted for consideration with the framework and process outlined in the IFR policy.

1.6 Implementation

The policy will be implemented across providers in primary and secondary care. It will be formally incorporated into contracts and will be subject to routine monitoring for compliance.

1.6.1 The schedule of procedures of limited clinical value

The schedule is set out below and can be incorporated into contractual and service level agreements. The PCT will require all providers in primary and secondary care to embrace and abide by the policy, advising patients accordingly.

This policy should be read in conjunction with other policies published by the PCT, its successor organisations, and East Midlands Specialised Commissioning, e.g. Commissioning Policy for Cosmetic Procedures

2 Schedule

Procedure	Criteria	Basis / Evidence
DENTAL / MAXILLOFACIAL		
Dental Implants – RESTRICTED	<p>Dental implants will only be undertaken under the direction of a Consultant in Restorative Dentistry. Funding will be based on the case meeting the agreed PCT criteria or in exceptional circumstances if approved through the individual case review process.</p> <p>The following conditions will be considered for dental implant treatment:</p> <ul style="list-style-type: none"> • Major tissue loss, hard or soft, as a result of trauma or cancer surgery. • Congenital abnormalities including Cleft Lip and Palate and Hypodontia/Anodontia, where the abnormality or the care correcting it are adverse indications for other prostheses. • Significant neuromuscular disorders or other conditions, e.g. Parkinson’s Disease, Bell’s Palsy, where the patient cannot functionally manage conventional denture prostheses. • Oral mucosal conditions affecting the function of conventional dentures. 	
Third molar extraction NOT FUNDED	Asymptomatic	<p>NICE Technology Appraisal TA 1. Guidance on the Removal of Wisdom Teeth, March 2000</p> <p>‘Management of Unerupted and Impacted Third Molar Teeth’, SIGN Publication No. 43, March 2000</p>
Third molar extraction RESTRICTED	<p>Symptomatic</p> <p>Funding for surgical removal of impacted third molars is limited to patients with evidence of pathology. Such pathology includes unrestorable caries, non-treatable pulpal and/or periapical pathology, cellulitis, abscess and osteomyelitis, internal/external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst/tumour, tooth/teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection.</p> <p>Plaque formation is a risk factor but is not in itself an indication for surgery.</p>	<p>NICE Technology Appraisal TA 1. Guidance on the Removal of Wisdom Teeth, March 2000</p> <p>‘Management of Unerupted and Impacted Third Molar Teeth’, SIGN Publication No. 43, March 2000</p>

	<p>The evidence suggests that a first episode of pericoronitis, unless particularly severe, should not be considered an indication for surgery. Second or subsequent episodes should be considered the appropriate indication for surgery.</p> <p>N.B.</p> <ol style="list-style-type: none"> 1. Indications for third molar extraction in primary care are as shown below. 2. It is the duty of all Providers with a dental mandatory services contract to ensure that they have Dental Performers who are competently able to undertake third molar extraction (and others listed in Minor Oral Surgery Criteria, NHS Nottinghamshire County). 3. Only patients with more complex conditions should be referred to secondary care. Funding for secondary care treatment is restricted to patients with more complex conditions. <p>Indications for lower third molar extraction in a Primary Care Location</p> <ul style="list-style-type: none"> • Within NICE Guidelines • Partially erupted • Vertical impaction with <5mm bone removal • Mesio-angular impaction with <5mm bone removal without decoronation • Disto-angular impaction with <5mm bone removal • Horizontal impaction, provided surgeon competent to decoronate • No associated pathology • No ID Canal involvement • Other considerations – complex medical history, age of patient 	
<p style="text-align: center;">ENT</p>		
<p>Grommets RESTRICTED</p>	<p>The PCT will fund treatment with grommets for children with otitis media with effusion (OME) where:</p> <ul style="list-style-type: none"> • There has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT; AND • The child is placed on a waiting list for the procedure at the end of this period; AND • OME persists after three months AND the child (who must be over three years of age) suffers from at least one of the following: <ul style="list-style-type: none"> At least 5 recurrences of acute otitis media in a year. Evidence of delay in speech development. 	<p>NICE Clinical Guideline on surgical management of otitis media with effusion CG60</p> <p>SIGN Guideline 66 (2003) <i>Diagnosis and management of childhood Otitis Media in Primary Care</i></p>

	<p>Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss). A significant second disability such as Downs syndrome.</p>	
<p>Tonsillectomy and/or adenoidectomy RESTRICTED</p>	<p>Unequivocal indications for tonsillectomy:</p> <ul style="list-style-type: none"> • Suspected malignancy • Peri-tonsillar abscess (Quinsy) • Acute upper airways obstruction • Recurrent sore throat where the following applies: <p style="padding-left: 40px;">7 or more episodes in the last year, OR 5 or more episodes in each of the last two years, OR 3 or more episodes in each of the last 3 years; AND</p> <p style="padding-left: 40px;">There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work; AND/OR Failure to thrive.</p> <p>Each of the episodes must be documented in the patient's notes, appropriately treated and characterised by at least one of the following:</p> <ol style="list-style-type: none"> a. Oral temperature of at least 38.3 C b. Tender anterior cervical lymph nodes c. Tonsillar exudates d. Positive culture of group A beta haemolytic streptococci e. The episodes are disabling and prevent normal functioning (school / work) f. Tonsillar enlargement giving rise to symptoms of obstruction <p>(Recurrent attacks are a succession of definite episodes, as opposed to chronic tonsillitis)</p> <p>The PCT will consider funding for tonsillectomy in sleep apnoea syndrome in children when one or more of the following apply:</p> <ul style="list-style-type: none"> A positive sleep study. A significant impact on quality of life demonstrated. A strong clinical history suggestive of sleep apnoea. <p>Note: The case is much more likely to be approved where there is supporting evidence such as sleep studies, growth charts, letters from GPs and letters from employer and school.</p>	<p>Royal College of Paediatrics and Child Health. Guidelines for good practice. Management of acute and recurring sore throat and indications for tonsillectomy. London: RCPCH; 2000</p> <p>Scottish Intercollegiate Guidance Network. Management of sore throat and indications for tonsillectomy. Edinburgh: SIGN guidance 34 (1999, reviewed 2005).</p>

<p>Surgery/Treatment for snoring</p> <p>NOT FUNDED</p>	<p>None</p> <p>Other procedures which fall into this policy also include:</p> <p>correction of deviated septums</p> <p>surgical reduction of the tongue</p> <p>removal of tonsils</p>	<p>PCT considers surgical treatment to be a low priority where snoring is the sole problem</p>
<p>Surgical treatment for sleep apnoea</p> <p>RESTRICTED</p>	<p>The PCT will fund surgical treatment of sleep apnoea in the following circumstances:</p> <p>Patient has moderate to severe symptoms (measured for example by the Epworth Sleepiness Score: 15-18= moderate, >18 = severe; see bottom of this section for copy of Epworth tool);</p> <p>OR</p> <p>Patient is sleepy in dangerous situations such as driving (regardless of Epworth Sleepiness Score);</p> <p>AND</p> <p>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);</p> <p>AND</p> <p>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;</p> <p>AND</p> <p>A specialist believes the individual patient will benefit (according to available literature the subgroups in which surgical intervention may be effective are not currently known);</p> <p>AND</p> <p>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.</p> <p>AND</p> <p>Evidence of compliance to advice about weight loss and alcohol intake</p> <p>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 IFR/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.</p>	

	Copy of Epworth Sleepiness Tool http://epworthsleepinessscale.com/epworth-sleepiness-scale.pdf	
OBSTETRICS, GYNAECOLOGY & FERTILITY		
Caesarean Section RESTRICTED	<p>A planned CS should be offered to women with:</p> <ul style="list-style-type: none"> A term singleton non-cephalic (if external cephalic version is contraindicated or has failed) A twin pregnancy with non-cephalic first twin HIV Both HIV and hepatitis C Primary genital herpes in the third trimester Grade 3 and 4 placenta praevia <p>A planned CS should not be routinely offered to women with:</p> <ul style="list-style-type: none"> Twin pregnancy (first twin is cephalic at term) Preterm birth A 'small for gestational age' baby Hepatitis B virus Hepatitis C virus Recurrent genital herpes at term <p>Caesarean Section for non-clinical reasons will not be funded. Maternal request is not on its own an indication for Caesarean Section.</p>	NICE CG13 Caesarean section.
D&C for menorrhagia RESTRICTED	<p>The PCT will not fund D&C as a diagnostic tool or as a therapeutic treatment for menorrhagia.</p> <p>D&C will be funded in the following circumstances:</p> <ul style="list-style-type: none"> • as an investigation for structural and histological abnormalities where hysteroscopy and ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive, • post-dilatation, pre-procedure when undertaking endometrial ablation 	NICE Clinical Guideline on heavy menstrual bleeding CG44

<p>Hysterectomy for menorrhagia</p> <p>RESTRICTED</p>	<p>The PCT will only fund hysterectomy for heavy menstrual bleeding when each of the following conditions are satisfied:</p> <ol style="list-style-type: none"> 1. after an unsuccessful trial with a levonorgestrel intrauterine system (e.g Mirena®) for at least 6 months and it has failed to relieve symptoms (or where it is medically inappropriate or contraindicated <p>AND</p> <ol style="list-style-type: none"> 2. at least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence (NICE) guidelines: <ol style="list-style-type: none"> a. Non-steroidal anti-inflammatory agents. b. Tranexamic acid c. Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) <p>AND</p> <ol style="list-style-type: none"> 3. A surgical treatment such as endometrial ablation, uterine artery embolisation or myomectomy has been offered and has failed to relieve symptoms (or are not appropriate or are contra-indicated). <p>In addition, the PCT will fund hysterectomy for heavy menstrual bleeding due to fibroids greater than 3 cm when the following criteria are satisfied:</p> <ol style="list-style-type: none"> 1. Other symptoms (e.g. pressure symptoms) are present 2. There is evidence of severe impact on quality of life. 3. Other pharmaceutical options have failed. 4. Patient has been offered myomectomy and/or uterine artery embolisation (unless medically contraindicated). 	<p>NICE CG44 Heavy menstrual bleeding: investigation and treatment – Jan 2007</p> <p>Royal College of Obstetricians and Gynaecologists (1999). <i>Management of Menorrhagia in Secondary Care</i></p>
<p>Labial reduction for reasons other than dyspareunia</p> <p>NOT FUNDED</p>	<p>(Covered by the East Midlands Commissioning Policy for Cosmetic Procedures) Only funded for dyspareunia</p>	<p>See East Midlands Cosmetics Policy</p>
<p>Mirena Coils</p> <p>RESTRICTED</p>	<p>To be fitted by primary care and not secondary care unless specific medical issue which prevents fitting by primary care or fitted as part of contraception provided in conjunction with Termination of Pregnancy.</p>	<p>Price in primary care is lower</p>
<p>Reversal of female sterilisation</p>	<p>Not funded</p>	

NOT FUNDED		
Reversal of male sterilisation NOT FUNDED	Not funded	
OPHTHALMOLOGY		
Cataract Surgery RESTRICTED	<p>The PCT will fund Cataract Surgery where there is a visual acuity of 6/12 (corrected) in the worst eye, or for:</p> <ol style="list-style-type: none"> 1. Patients for whom it is vital to have good visual acuity in the worse eye for the purpose of fulfilling essential occupational responsibilities (e.g. watchmaker). 2. Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions 3. Driving: the legal requirement for driving falls between 6/9 and 6/12 (strictly speaking it is based on the number plate test). It is anticipated that the threshold will not render the majority of people unable to drive as it applies to the worst eye only. Exceptions to this include: <ul style="list-style-type: none"> * Patients who need to drive who experience significant glare which affects driving; * Patients for whom it is vital to drive at night for the purpose of fulfilling essential domestic, carer or occupational responsibilities, and who experience glare that is related to cataract; * Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field. 4. Patients with glaucoma who require cataract surgery to control intra ocular pressure 5. Patient with diabetes who require clear views of their retina to look for retinopathy <p>Cataract Second Eye</p> <ol style="list-style-type: none"> 1. Where the cataract procedure on the first eye has achieved a VA of 6/9 or better, and the VA for the second eye is 6/24 or better, then the patient should be discharged, unless receiving treatment for any other eye condition. The patient should be advised to attend an optometrist for a sight test annually or earlier if they notice any deterioration of vision. 2. If the first eye does not achieve a VA of 6/9 or better, then the second eye should be dealt with on clinical merit, taking into account any directly related essential responsibilities (i.e. the requirement for night driving). 3. There are circumstances, where despite good acuities, there may still be a clinical need to operate on the second eye fairly speedily e.g. where there is resultant anisometropia (a large refractive difference between the two eyes) which would result in poor binocular vision 	<p>Department of Health. Commissioning Toolkit for Community Based Eyecare Services (DH 2007)</p> <p>NHS Executive. Action on Cataracts: Good practice guidance (Jan 2003)</p>

	or even diplopia. In these circumstances, the notes should clearly record this so that it can be identified during any future clinical audit.	
Laser treatment of myopia NOT FUNDED	Not funded	
Surgery for correction of short sight NOT FUNDED	Not funded	
GENERAL SURGERY		
Anal/rectal skin tags NOT FUNDED	Not funded	
Cholecystectomy for asymptomatic gallstones	<p>Not funded for asymptomatic gallstones.</p> <p>Only funded for patients at risk of developing gallbladder carcinoma or gallstone complications.</p> <p>Where there are no symptoms, cholecystectomy confers no benefit to patients with asymptomatic gallstones, even in patients with one attack of uncomplicated gallstone pain.</p>	<p>WGO Practice Guideline: Asymptomatic Gallstone Disease. Available at: guidelines@worldgastroenterology.org</p>
Circumcision RESTRICTED	Not normally funded in either adults or children unless there are medical indications.	<p>“Statement on Male Circumcision”. Statement from the British Association of Paediatric Surgeons, The Royal College of Nursing, The Royal College of Paediatrics and Child Health, The Royal College of Surgeons of England and The Royal College of Anaesthetists. 6 March 2001.</p> <p>“The law and ethics of male</p>

		circumcision - guidance for doctors" BMA, June 2006
Gastroplasty RESTRICTED	Falls within scope of the EMSCG Commissioning Policy for Bariatric Surgery , which contains restrictive criteria including (amongst others) the requirement to which includes the requirements for potential candidates for surgery to have adequately tried all appropriate and available non-surgical measures for a period of a least 6 months (but ideally 12 to 18 months) without maintaining significant weight loss (i.e. ≥10%).	See East Midlands policy
Haemorrhoidectomy RESTRICTED	Only funded for recurrent and persistent bleeding that fails to respond to conservative treatment; haemorrhoids that cannot be reduced.	
Inguinal hernia in adults – elective repair RESTRICTED	<p>This procedure is not routinely funded for asymptomatic or minimally symptomatic inguinal hernias in adults.</p> <p>Patients should be referred for surgical assessment if they meet one or more of the following criteria:</p> <ol style="list-style-type: none"> 1. A history of incarceration of, or real difficulty reducing, the hernia. 2. An inguino-scrotal hernia. 3. Increase in size month to month. 4. Pain or discomfort significantly interfering with activities of daily living. 5. Work related issues e.g. of work/missed work/unable to work/on light duties due to hernia 6. Comorbidity which does not render the patient unfit for elective surgery currently, but which is likely to significantly increase the risks associated with future surgery <p>Patients with femoral hernias should be referred for consultation.</p>	<p>European Hernia Society Guidelines Hernia (2009) 13:343–403</p> <p>Fitzgibbons RJ Jr, Giobbie-Hurder A, Gibbs JO, et al. Watchful waiting vs repair of inguinal hernia in minimally symptomatic men: a randomized clinical trial. JAMA. 2006;295:285-292.</p>
Hyperbaric oxygen therapy for wound healing NOT FUNDED	Not funded pending East Midlands policy	East Midlands policy pending
Irritable Bowel Syndrome (Adults) – tests for confirming diagnosis	In the absence of red flag symptoms of malignancy, the following tests will not be funded for confirmation of diagnosis in adults who meet the IBS diagnostic criteria:	For context, please refer to NICE CG61 Diagnosis and management of IBS in primary care: http://guidance.nice.org.uk/CG61/Q

RESTRICTED	ultrasound rigid/flexible sigmoidoscopy colonoscopy; barium enema thyroid function test faecal ova and parasite test faecal occult blood hydrogen breath test (for lactose intolerance and bacterial overgrowth).	uickRefGuide/pdf/English
Varicose Veins – surgical treatment RESTRICTED	Falls within scope of East Midlands Commissioning Policy for Cosmetic Procedures Surgical treatment is funded only when one, or more, of the following clinical criteria are met : <ul style="list-style-type: none"> • Varicose eczema • Lipodermatosclerosis or a varicose ulcer • At least two episodes of documented superficial thrombophlebitis • A major episode of bleeding from the varicosity 	
MSK		
Autologous Chondrocyte Implantation NOT FUNDED	None	NICE TA89
Back pain Discectomy for lumbar disc prolapsed RESTRICTED	Absolute Criteria: The patient is 18 years or older; AND 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; AND The patient has a corresponding neurologic deficit (asymmetrical depressed reflex, decreased sensation in a dermatomal distribution, or weakness in a myotomal distribution, altered bowel or bladder function); OR The patient has radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement;	

	<p>OR 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); AND Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, bed rest etc).</p>	
<p>Back pain Spinal fusion RESTRICTED</p>	<p>PCT will fund for unequivocal root compression; spinal stenosis; instability; failure of adequate conservative trial of >6 months duration</p>	
<p>Back pain Spinal epidural injections RESTRICTED</p>	<p>Spinal epidural injections For low back pain - single injection for pts who might have undergone discectomy sciatica - where patient responded previously. Not funded for patients who have non-specific low back pain up to 12 months duration</p>	<p>NICE Clinical Guidance CG 88 (published May 2009)</p>
<p>Back pain Facet joint injections</p>	<p>Only funded as diagnostic/screening tool prior to radiofrequency denervation or surgery in order to show probability of benefit; as treatment where co-morbidities that preclude other interventions PCT does not fund facet joint injection for patients who have non-specific low back pain</p>	
<p>Carpal Tunnel</p>	<p>Criteria for this are in development – thresholds to be advised in due course (N.B. PCTs in Derbyshire have adopted the following threshold for this procedure: Patients with a score of 5 or more on the modified CTS questionnaire (modified version of the Levine self assessment questionnaire) with any of the following to be referred without delay to secondary care: evidence of thenar wasting permanent numbness symptoms are severe/frequent/functionally impairing the condition makes work impossible and threatens employment. Patients who score 3 or 4 – refer to OT service for 2 week trial of neutral wrist splinting (or provide in house). Patients who score 3 or 4 and receive no relief from neutral wrist splinting, to be referred by GP to hand surgeon / neurologist.)</p>	

Dupuytren's Contracture	Patient has loss of extension in one or more joints exceeding 25 degrees; pt under 45 with >10 degree loss extension in 2 or more joints; evidence of proximal interphalangeal joint contracture.	NICE Guidance CG34 (February 2004)
RESTRICTED		
Ganglion Cysts	Referral to orthopaedics for symptomatic ganglia only: <ol style="list-style-type: none"> 1. Ganglion on wrist – with evidence of neurovascular compromise or functional disability 2. Seed ganglia at base of digits – with significant pain 3. Mucoid cysts at DIP joint – nail growth disrupted, cysts tend to discharge <p>No referrals for cosmetic surgery for ganglion cysts</p> <p>Excision of ganglion cyst is funded only for patients meeting one or more of these criteria.</p>	Many ganglia resolve spontaneously. Up to 88% recurrence after single aspiration. Surgical treatment for symptomatic ganglia remains controversial.
RESTRICTED		British Society for Surgery of Hand http://www.bssh.ac.uk/education/referralguidelines/ganglion.pdf
Hip Arthroscopy	None	
Hip and Knee and other joint revisions	The PCT will fund revisions using standard prosthesis.	
Hip replacement (primary)	The PCT will fund prostheses which meet the guidelines set out in NICE Technology Appraisal Guidance 2.	
	Other criteria for this are in development – thresholds to be advised in due course	
	(N.B. PCTs in Derbyshire have adopted the following threshold for this procedure: Evidence that conservative means have failed to alleviate pain and disability Salisbury score =14 Oxford score >36/60)	
Hip resurfacing	Those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements	
RESTRICTED		
Joint Injections	Restricted if patient candidate for joint replacement in 6-12 months.	
RESTRICTED	As diagnostic tool prior to joint replacement to confirm joint as source of symptoms or for patients unfit or unsuitable for surgery. (NB there will be a maximum tariff price which reflects carrying out in an aseptic theatre and not a sterile theatre).	
Knee – diagnostic arthroscopy	None	

NOT FUNDED		
Knee – washouts & debridement RESTRICTED	Patient has mechanical features of locking (not gelling, ‘giving way’ or x-ray evidence of loose bodies).	NICE IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. Aug 2007 NICE CG59 The care and management of osteoarthritis in adults. Feb 2008
Knee replacement (primary)	The PCT will fund prostheses which are standard. Other criteria for this are in development – thresholds to be advised in due course. (N.B. PCTs in Derbyshire have adopted the following threshold for this procedure: Evidence that conservative means have failed to alleviate pain and disability Salisbury score =14 Oxford score >36/60)	
Other joint prosthetics RESTRICTED	Joint replacement for people who: experience joint symptoms (pain, stiffness and reduced function) AND have a substantial impact on their quality of life AND are refractory to non-surgical treatment. Referral should be made before there is prolonged and established functional limitation and severe pain	
Therapeutic use of ultrasound in Hip and knee osteoarthritis NOT FUNDED	None	
Trigger Finger RESTRICTED	Failure to respond to conservative measures; fixed deformity non-correctable.	
MRI of back for low		NICE – Early management of non-

<p>back pain</p> <p>RESTRICTED</p>	<p>MRI of lumbar spine for low back pain in the following circumstances:</p> <ol style="list-style-type: none"> 1) Red flag symptoms: <ol style="list-style-type: none"> a) Spinal malignancy b) Infection c) Fracture d) Cauda equina syndrome e) Ankylosing spondylitis or another inflammatory disorder f) Suspected osteoporotic fracture. 2) In the context of a referral for an opinion on spinal fusion 3) In the context of Discectomy for lumbar disc prolapsed (as specified elsewhere in this policy). <p>Nottingham City GPs – please refer to Direct Access Guidelines for investigating spinal disc lesions</p>	<p>specific low back pain 2010. http://guidance.nice.org.uk/CG88</p>
<p>X-ray (plain) of back for low back pain</p> <p>NOT FUNDED</p>	<p>X-ray of lumbar spine for non-specific low back pain – Not funded (Funding is only provided for the investigation of specific pathology)</p>	<p>NICE – Early management of non-specific low back pain 2010. http://guidance.nice.org.uk/CG88</p>
<p>Osteopathy and chiropractic</p> <p>NOT FUNDED</p>	<p>Not funded unless an agreed care pathway is already in place.</p>	
<p>PAIN MANAGEMENT (OTHER)</p>		
<p>Spinal Cord Stimulation for Chronic Pain</p>	<p>Criteria for this are in development – thresholds to be advised in due course</p>	<p>NICE - Pain (chronic neuropathic or ischaemic) - spinal cord stimulation. Issue date October 2008. http://guidance.nice.org.uk/TA159</p> <p>NICE Technology Appraisal TA159 - Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin. Issue date October 2008. http://www.nice.org.uk/nicemedia/li</p>

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Pain management programmes using cognitive behavioural approach	Criteria for this are in development – thresholds to be advised in due course	
Residential pain management programmes	Not funded	
Acupuncture for non-specific low back pain of up to 1 yr duration RESTRICTED	<p>The PCT will fund up to 6 sessions of acupuncture in an 8 week period for recurrent or persistent non-specific low back pain of more than 6 weeks duration, where:</p> <ol style="list-style-type: none"> 1. the patient is receiving and has positively engaged with a package of care that is consistent with NICE CG88 pathway including information and support to promote self-management, and the offer of appropriate drug treatments to help the patient keep active, AND 2. a baseline assessment of pain and function using the Brief Pain Inventory is documented in the patient notes prior to the first session of acupuncture <p>The PCT will fund up to an additional 4 sessions (i.e. up to an absolute maximum of 10 sessions for any given patient), where:</p> <ol style="list-style-type: none"> 1. an assessment of pain and function using the Brief Pain Inventory made six weeks after the sixth session and prior to the seventh session demonstrates that there has been an improvement of at least 50% since the baseline assessment, AND 2. the patient continues to positively engage with a package of care that includes information and support to promote self-management, and the offer of appropriate drug treatments to help the patient keep active, AND 3. the patient acknowledges that the number of sessions of acupuncture funded for any given patient is limited to an absolute maximum of 10 <p>For the purposes of this policy, number of sessions includes all sessions of acupuncture received regardless of the provider</p>	<p>NICE – Early management of non-specific low back pain 2010. http://guidance.nice.org.uk/CG88</p>

UROLOGY		
Penile Implants RESTRICTED	Not funded except in patients with impotence of organic cause, or for those who have failed to respond to, or are unable to continue with, medical treatment or external devices	
COMPLEMENTARY THERAPY		
Acupuncture for purposes other than as part of treatment plan for low back pain, Alexander Technique, Applied Kinesiology, Aromatherapy, Autogenic Training, Ayurveda, Chinese Medicine, Chiropractic, Environmental Medicine, Osteopathy, Healing, Herbal Medicine, Hypnosis, Homeopathy*, Massage, Meditation, Naturopathy, Nutritional Therapy, Reflexology, Reiki, Shiatsu, Other alternative therapies	<p>Complementary medicine/alternative therapies are generally not funded on the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be funded either as part of the PBR tariff or explicitly agreed in the SLA.</p> <p>On existing available evidence the PCT would not support referral outside the NHS for these services.</p> <p>Prior Approval is required on a case by case basis by the PCT IFR Panel for any requests outside the above criteria. The panel will require proven evidence of effectiveness of the therapy, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners.</p> <p>Homeopathy Not funded. *For definitive statement of policy on this please refer to the Nottinghamshire Area Prescribing Committee's position statement (March 2010).</p> <p>Hypnotherapy Not commissioned. Insufficient research evidence to demonstrate effectiveness (e.g. IBS)</p>	Various including Cochrane reviews

BEHAVIOURAL/ PSYCHOLOGICAL (IF NOT COVERED ELSEWHERE)		
Therapeutic community method for treatment for borderline personality disorder	Not funded	
Out of Area or referrals to the independent sector for Children with suspected Autism	Referrals to the independent sector or out of area will only be considered where the child's care has been assessed by CAMHS or paediatric services and where there is a recommendation by either or both agencies that such a referral is necessary.	
MISCELLANEOUS		
Out of area treatment for chronic Fatigue Syndrome/ME	Not funded. Local pathway in place.	
Assisted conception	Not addressed by this policy	See East Midlands policy
Gender reassignment	Not addressed by this policy	See East Midlands policy