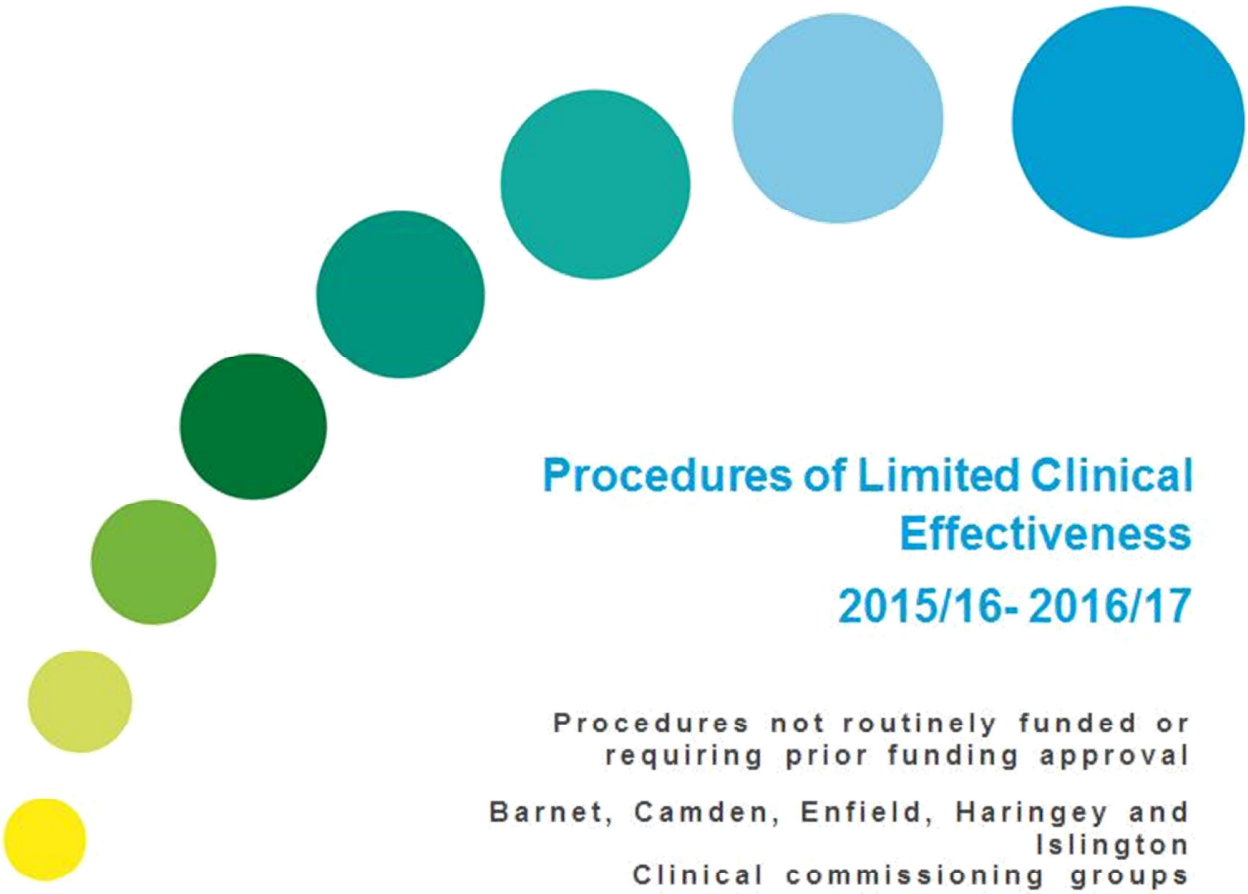

Procedures of Limited Clinical Effectiveness

2015/16- 2016/17

Procedures not routinely funded or requiring prior funding approval

Barnet, Camden, Enfield, Haringey and Islington
Clinical commissioning groups

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1. Introduction

1.1 The North Central London (NCL) Procedures of Limited Clinical Effectiveness (PoLCE) is a revised policy (previously known as Low Priority Treatments).

1.2 This document sets out the services

1.3 which fall under the PoLCE definition, including the criteria that the patient must meet for treatment to be approved (see Appendix 1); and

1.4 the process for obtaining prior approval and the role of GPs and Providers in ensuring implementation.

1.5 The revised policy focuses on those procedures which have evidence for limited clinical effectiveness and that are appropriate only for a patient to undergo if a certain set of medical criteria are met. Only when patients meet these criteria, or where exceptional and evidenced circumstances exist, will funding be granted.

1.6 The policy aims to ensure that patients are provided with the best in clinical care and does not aim to stop a patient from having a procedure of limited clinical effectiveness if they meet the clinical criteria set out in this policy.

1.7 This document is valid from 1st September 2015. It will be kept under regular review to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.

2. What is a 'Procedure of Limited Clinical Effectiveness'?

2.1 A PoLCE is a procedure where the clinical effectiveness of that procedure is either absent or evidence shows weak efficacy and long term benefits reached

2.2 A PoLCE could be a procedure which is clinically effective but only under certain conditions, such as when a person meets certain criteria, otherwise more conservative alternatives should be tried first

2.3 A PoLCE is a treatment of a condition where not funding the treatment will not result in a significantly adverse effect on the patient's physical or mental health

2.4 A policy on Procedures of Limited Clinical Effectiveness is needed in order to:

2.5 improve quality of clinical care; there is considerable national and international evidence that the areas covered by PoLCE guidance demonstrate poor clinical

effectiveness, or that current practice does not comply with best clinical practice and significant variation exists.

3. Purpose of the policy

3.1 The purpose of the policy is to:

3.1.1 clarify the threshold and criteria under which PoLCE applications can be made and the process for seeking prior approval;

3.1.2 clarify the assessment process and the timescales on receipt of PoLCE referrals to when a decision is made to either approve or not approve the original PoLCE referral;

3.1.3 clarify in which circumstances the PoLCE prior approval requirement will not apply, i.e. suspected malignancy cases (see exclusions policy in section 5 below);

3.1.4 ensure there is standardisation in the application of the PoLCE policy and processes across NHS North Central London (NCL)

4. What does the PoLCE policy mean for Providers?

4.1 Under current healthcare commissioning arrangements, a majority of services are undertaken without requiring prior approval from the commissioning body. However, for services that fall under PoLCE, treatment should only be provided when the patient meets certain specific criteria, hence prior approval is required and must be obtained.

4.2 Providers should note the following:

4.2.1 In order to avoid challenge PoLCE treatments will NOT be funded unless prior approval for that treatment is sought and received in advance from either the patients GP or the relevant PoLCE Approval Service or Referral Management

Service (RMS). (This applies to all providers unless a process of self-regulation has been agreed between the CCG and The Provider).

4.2.2 The relevant pro-forma/ approval level must be completed and attached to the referral.

4.3 Providers **MUST** no longer accept direct referrals for PoLCE procedures without first receiving evidence that the patient has been granted approval to receive the PoLCE treatment. Evidence will be in the form of an approval letter.

4.4 Direct referrals to Providers without "Prior Approval" agreed **MUST** be returned to the patient's GP so that an appropriate approval request can be completed. The GP will be required to seek prior approval in line with the PoLCE application and approval process.

4.5 Providers should note that the 18 week clock does not stop whilst an application is being assessed by the PoLCE Approval Service/RMS. The clock starts ticking on the date the GP makes the PoLCE referral.

5. Exclusions to this Policy

5.1 PoLCE does not apply to the following:

5.1.1 Suspected cancer: diagnoses should be dealt with via a two week wait referral and **NOT** via a PoLCE application.

5.1.2 Emergency or urgent care.

5.2 In relation to the above exclusions the provider should be able to demonstrate the clinical need as part of the payment verification process.

6. Application process for obtaining Prior Approval

6.1 For GP PoLCE Prior Approval referrals GPs should follow the application process for obtaining Prior Approval. Applications for approval should be from a GP or healthcare care professional. It is expected that GPs and hospital clinicians will be familiar with the policy and check patients' eligibility for treatment against the criteria.

6.2 Prior approval is also required for GP assessment only referrals, i.e. diagnostics, and should be made via the PoLCE Approval Service/RMS as per the process.

6.3 The approval application form should be sent to the relevant PoLCE Approval Service/RMS.

6.4 Applications should be sent by email and should be accompanied by copies of all relevant evidence to demonstrate how the application meets the PoLCE criteria. To comply with data protection and confidentiality requirements, all forms and patient

identifiable information sent to the Cluster should be through a secured NHS mail account.

6.5 An assessment is carried out once the referral is received by the PoLCE Approval Service/RMS.

6.6 Once the assessment has been completed by the PoLCE Approval Service/RMS and the decision has been made, the referring clinician will usually be notified of the decision within 5 working days of receipt of the application. If approved, an approval letter will be sent to the GP, with a copy sent to the patient and the Trust (if applicable); if not approved the rejection letter will be sent to the GP, and a copy sent to the Trust (if applicable).

6.7 If approved, the approval letter should be attached with the referral letter and the referral should be progressed the normal way (i.e. using Choose and Book via a RMS).

7. Provider POLCE Prior Approval referrals – Interim Process

7.1 It has been identified that NCL's systems for processing prior approval applications from providers are not consistent across all Boroughs/CCGs which poses a significant challenge for Providers. While this issue is resolved, the following process should be adopted by providers who do not have access to a suitable Referral Management Service to process prior approval applications:

7.1.1 A system of self-regulation has been adopted, and will be in place until further notice or until the audits have been assessed.

7.1.2 It is expected that providers will put into place a system to ensure that the PoLCE Policy is being applied and a record of patients treated that meet the criteria within the policy maintained.

7.1.3 The provider is required to provide Commissioners with a data set each month which can then be validated against the Trust's SUS data.

7.1.4 NCL will challenge any PoLCE procedures that are contained within the SUS data but are not covered by the data set provided by the Trust.

7.1.5 NCL will develop a clinical audit process to confirm the provider's system is suitable. This will include reviewing individual forms and patient notes.

7.1.6 There are some procedures that are not routinely funded by the NHS at all. Therefore, all applications for these treatments should go through an Individual Funding Request (IFR) process if appropriate.

8. Adding additional Procedures of Limited Clinical Effectiveness to the list

8.1 To add further procedures to the list of procedures of limited clinical effective (PoLCE) policy the application process for additional procedures will be followed. Additions will be undertaken on a quarterly basis to coincide with contract reviews and allow time for clinical engagement

9. Performance monitoring arrangements

9.1 Performance measures and audits will be introduced to monitor PoLCE activity across all sectors within the NCL cluster.

9.2 The provider is required to provide Commissioners with a data set each month which can then be validated against the Trust's SUS data

9.3 All providers will be asked to clarify any activity or procedure code that fail to comply with those set out within the PoLCE policy. These will be brought to the attention of the relevant commissioners for NCL and any procedure not in line with this policy will be investigated and, where appropriate, challenged for non-payment.

9.4 NCL will challenge any PoLCE procedures that are contained within the SUS data but are not covered by the data set provided by the Trust.

9.5 NCL will develop a clinical audit process to confirm the provider's system is suitable. This will include reviewing individual forms and patient notes on a quarterly basis for nominated specialities.

9.6 The PoLCE Approval Service/RMS routinely provide data which will be used to:

- reconcile activity with SUS; and
- assess the effectiveness of the policy and assist in targeted support work with GPs and Providers to improve practice where required.

10. Who this Policy applies to

10.1 This section specifies the stakeholders to whom this policy applies:

Referral Management Services:	North Central London -Referral Management Services (Primary Care)
	Barnet - Referral Management Service
	Camden - Referral Management Service (CCAS)

	Enfield - Referral Management Service (ERS)
	Haringey – Bounds Green Group Practice
	Islington - Individual Funding Request Team
North Central London Boroughs:	Barnet CCG
	Camden CCG
	Enfield CCG
	Haringey CCG
	Islington CCG
North Central London Primary Care Stakeholders:	Clinical Cabinet
	Clinical Commissioning Groups (CCG)
	Local Medical Committee (LMC)
	Local Dental Committee (LDC)
	North Central London - GP Practices
	North Central London - Dental Practices
North Central London Hospital Sites (Acute Providers):	Barnet and Chase Farm Hospital
	Great Ormond Street Hospital
	Moorfields Eye Hospital
	North Middlesex University Hospital
	Royal Free Hospital
	Royal National Throat, Nose and Ear Hospital
	Whittington Health Hospital
	University College London Hospital
All out of sector Acute Providers who see NCL patients	
Private and Independent Providers of NHS Healthcare services.	

11. APPENDIX 1 – PROCEDURE & DIAGNOSIS CODES COVERED BY THIS POLICY

Procedures of Limited Clinical Effectiveness Policy June 2015

Musculoskeletal / Pain Management

Treatment	Criteria
BACK PAIN - Spinal Cord Stimulation (SCS) for Neuropathic Pain	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** NCL CCGs will fund SCS for neuropathic pain for failed back surgery syndrome or chronic regional pain syndrome if the patient has: 1. Experienced chronic pain (measuring at least 50mm on a 0-100mm visual analogue scale) for at least six months despite appropriate conventional medical management **AND** 2. Completed a successful trial of stimulation as part of an assessment by an experienced multi-disciplinary chronic pain management team. Spinal cord stimulation is not recommended as a treatment option for adults with chronic pain of ischaemic origin except in the context of research as part of a clinical trial. Such research should be designed to generate robust evidence about the benefits of spinal cord stimulation (including pain relief, functional outcomes and quality of life) compared with standard care. NCL CCGs will not routinely fund health care interventions that NICE has not recommended they 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. **NICE Guidance** http://www.nice.org.uk/guidance/ta159/resources/guidance-spinal-cord-stimulation-for-chronic-pain-of-neuropathic-or-ischaemic-origin-pdf
BACK SURGERY – Interlaminar, Transforaminal and Caudal Epidural	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. NCL CCGs will fund interlaminar, transforaminal and caudal epidural injections for patients with radicular pain due to herniated disc (where

Injections for Patients with Radicular Pain	progressive neurological changes and/or impending caudaequina syndrome have been excluded) when the following criteria have been met. **Criteria for eligibility** 1. The patient is 16 years or above **AND** 2. 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 **OR** 3. There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise–positive up to 45° or positive femoral tension sign) **AND** 4. Symptoms persist for at least six weeks despite non-operative treatments (e.g. analgesia, advice and reassurance and manual therapy e.g. physiotherapy) **OR** 5. Uncontrolled pain resistant to normal analgesia regimes. Epidural injections beyond the first three injections are provided as part of a comprehensive pain management programme provided there has been >50% reduction in symptoms for six weeks. Patients may receive up to six injections six months apart provided there has been >50% reduction in symptoms for six weeks from each injection. **NICE Guidance** http://www.nice.org.uk/guidance/cg88/resources/guidance-low-back-pain-pdf
BACK SURGERY – Therapeutic Facet Joint Injections	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. NCL CCGs will fund medial branch blocks for the management of cervical, thoracic and lumbar back pain as specified below. **Criteria for eligibility** NCL CCGs will fund medial branch blocks when all the following criteria are met: 1. The pain has lasted for more than one year **AND** 2. The pain has resulted in moderate to significant impact on daily functioning

	AND 3. All conservative management options (advice and reassurance, analgesia and manual therapy e.g. physiotherapy) have been tried and failed. **Clinical practice** Please provide documented evidence relating to: • In the diagnostic phase the patient may receive up to one injection, in the therapeutic phase, up to two injections six months apart provided there has been >50% reduction in symptoms for six weeks. • Medial branch blocks beyond the first three injections should be provided as part of a comprehensive pain management programme. Intra-articular facet joint injections will not normally be funded unless it forms part of a pre-operative workup, including imaging. **NICE Guidance** http://www.nice.org.uk/guidance/cg88/resources/guidance-low-back-pain-pdf
BACK SURGERY – Thermal Radiofrequency Denervation (LUMBAR and CERVICAL FACET JOINTS)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** NCL 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: 1. Patients aged over 16 **AND** 2. Non-radicular lumbar (all levels) or cervical (C3-4 and below) facet joint pain **AND** 3. All conservative management options (advice and reassurance, analgesia and manual therapy e.g. physiotherapy) have been tried and failed **AND** 4. Radiological imaging to rule out any correctable structural lesion e.g. MRI **AND** 5. At least two anaesthetic diagnostic blocks one of which must be of the medial branch of the dorsal ramus innervating the target facet joint with at least 50% 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 **AND** 6. All procedures must be performed under fluoroscopy (x-ray guidance). Thermal radiofrequency denervation is provided as part of a comprehensive pain management programme. • NCL CCGs will not fund cryoneurolysis or laser denervation. • NCL CCGs will fund up to three facet denervations on one occasion. • NCL CCGs will not fund re-treatment at the same location unless at least six months have elapsed since prior treatment. **NICE Guidance** http://www.nice.org.uk/guidance/cg88/resources/guidance-low-back-pain- pdf

Cosmetic procedures

Treatment	Criteria
COSMETIC – Surgery (Aesthetic)	**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 that 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 NCL CCGs. All applications need to be approved via an Individual Funding Request where exceptional circumstances are clearly demonstrated. **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 table below describes the indicative criteria/guidelines for Aesthetic procedures.

Criteria for eligibility - general principles

- 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.
- Patients who are current smokers should be referred or re-directed to a smoking cessation service prior to surgical intervention,as smoking impairs successful wound healing after surgery.
- Patients should be counselled about the complications of surgery and the potential risk of scarring, infection and potential recurrence.
- This policy does not apply to any lesions where cancer is suspected – these should be investigated/ treated through the appropriate pathway.

NCL CCGs will not generally fund cosmetic procedures solely to improve appearance in the absence of the following:

- Significant obstruction of orifice or vision
  OR
- Facial lesions with a diameter greater than 1cm that cause significant disfigurement
  OR
- Where lesion is causing pain, active inflammation, or recurrent infection unresolved by standard medical treatments (more than two episodes of inflammation in twelve months requiring antibiotics for each episode)
  OR
- The lesion is located in an anatomic area subject to recurrent trauma, causing bleeding and pain
  OR
- Congenital deformity (this does not include normal variation)
  OR
- Significantly impaired ability to perform activities of daily living, which has been formally assessed.

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

- Psychological distress may be considered as a reason for cosmetic surgery only in rare exceptional circumstances in which severe and enduring psychological dysfunction can be demonstrated, and for which all alternative psychotherapeutic interventions have been tried.

Breast procedures	
Bilateral Breast Augmentation (Breast Enlargement)	NCL CCGs will not routinely fund bilateral breast augmentation. In rare situations and with prior approval, funding for breast augmentation may be considered if the criteria below is met and evidenced: 1. Congential amastia – developmental failure resulting in bilateral absence of breast tissue. 2. Bilateral loss of breast tissue due to treatment for breast cancer or as the result of burns or trauma.
Breast Asymmetry	Procedures to correct breast asymmetry will not be routinely funded. Reduction of the larger breast should be regarded as the first line treatment for patients seeking to correct breast asymmetry. Procedures to correct breast asymmetry will only be considered for funding in the following circumstances. • Developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia). **OR** • Breast asymmetry ≥ 2 cup sizes due to mastectomy, excision breast surgery for cancer/lumpectomy, prophylactic mastectomy for cancer prevention in high risk cases. **OR** • For breast asymmetry ≥ 2 cup sizes due to trauma or burns, or endocrine abnormalities. **OR** • Patients with gross asymmetry (defined as a difference greater than 2 standard cup sizes*) to the extent that they cannot get a bra to fit. **NICE guidance** http://www.nice.org.uk/guidance/ipg417/resources/guidance-breast-reconstruction-using-lipomodelling-after-breast-cancer-treatment-pdf
Gynaecomastia ** (Male breast reduction for gynaecomastia) (Liposuction may form	This cosmetic procedure is not routinely funded by the NCL CCGs. NCL CCGs will consider funding this procedure if all the criteria are met as outlined below.

part of the treatment plan for this condition)	The patient should meet the following criteria: 1. The patient should be 25 or over at the time of application **AND** 2. Have Grade III gynaecomastia where resection would be >100gm (avoids purely minor cosmetic requests) **AND** 3. BMI must be <25 (avoids pseudo-gynaecomastia requests) **AND** 4. Have been screened for endocrinological causes **AND** 5. Have been screened for drug related causes **AND** 6. Other non-surgical treatments have been considered, tried or have been unsuccessfully **OR** 7. For specific un-correctable aetiological factor identified such as androgen therapy, or caused by a side effect of treatment of another condition such as a side effect of treatment for prostate cancer. BMI should be <30 in these cases. Documented additional information should be provided where circumstances include: • Pain • Gross asymmetry • The gynaecomastia is iatrogenic.
Mastopexy ** (Breast Lift)	This cosmetic procedure is not routinely funded by the NCL CCGs. **NB:** For asymmetry; please see section relating to **Breast Augmentation.** For back pain as a result of breast size: please see section relating to **Breast Reduction**.
Reduction Mammoplasty ** (Female breast reduction)	This cosmetic procedure is not routinely funded by the NCL CCGs. All patients should meet the following criteria: 1.BMI equal to or below 27 for at least two years (documented)and for at least two years post bariatric surgery 2. The patient should be 18 or over at the time of application. 3. The patient's breast size is cup H or larger. **AND**

	4. Evidence to be submitted to demonstrate patient is symptomatic – with at least TWO of the following for at least one year (documented evidence of GP visits for these problems): • Pain in the neck • Pain in the upper back • Pain in the shoulders • Painful kyphosis documented by X-rays • Pain / discomfort / ulceration from bra straps cutting into shoulders. **AND** 5. Evidence to be submitted to demonstrate pain symptoms persist as documented by the physician despite a six month trial of therapeutic measures including all of the following: • Supportive devices (e.g., proper 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. **AND** 6. Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless the entire above are met and the patient has failed to respond to six months of conservative treatment. **OR** 7. Patients with virginal hyperplasia/hypertrophy.
Revision of Breast Augmentation **	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced: **The patient should be 18 or over at the time of application.** Removal of implants (including implants carried out in the private sector) will be considered, **but not replacement,** if at least ONE of the following criteria is met: • Rupture of silicone-filled gel. • 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 purposes. Documented evidence is required to demonstrate this. If augmentation is approved please see the Augmentation/Mammoplasty ** (Breast enlargement) section in the PoLCE policy.
**Surgical Correction of Nipple Inversion ** **	This cosmetic procedure is not routinely by the NCL CCGs.
Ear procedures	
Pinnaplasty/Otoplasty	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. Initial referrals should be for assessment only. • The patient must be under the age of 19 years at the time of referral. • Patients seeking pinnaplasty should be seen by a plastic surgeon or appropriate ENT surgeon and following assessment, if there is any concern, assessed by a psychologist. • Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist. • Requests for patients over 19 years old will be considered as an IFR application
Repair of External Ear Lobes (Lobules)	This procedure is not routinely funded by NCL CCGs.
Facial procedures	
Blepharoplasty (Surgery on the lower or upper eyelid	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced: • Impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically. Supporting evidence in the form of an appropriate visual field test result will be required.

	• Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow. • Significant ectropion or entropion that requires correction. For the removal of lesions of the eyelid skin or lid margin. Other demonstrated complications, e.g. disruptions of the tear film, evidence of chronic compensation of ptosis through elevation of the brow.
Brow Lift	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. After assessment by a specialist; evidence must be provided demonstrating the severity and clinical need for surgery in these instances: • Impairment of vision. • To correct impairment of the visual field.
Injection of Botulinum Toxin	This cosmetic procedure is not routinely funded by the NCL CCGs. **NB:** For Hyperhidrosis: Please see section relating to **Hyperhidrosis**.
Rhinoplasty (Surgery to reshape the nose)	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **The patient should be 18 or over at the time of application.** 1. Prior ENT consultation should take place for patients with isolated airway problems (in the absence of visible nasal deformity) **OR** 2. Nasal airway obstruction causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing) **OR** 3. Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy **OR** 4. Correction of complex congenital conditions unless covered by specialised commissioning arrangements.
Rhytidectomy Face Lift	This cosmetic procedure is not routinely funded by the NCL CCGs.

Cosmetic Genital Surgery	Labiaplasty is not routinely funded by the NCL CCGs. IFR applications for labiaplasty should be made by a gynaecologist and describe the clinical circumstances which necessitate surgery.
Gender Reassignment Surgery	This procedure is not routinely funded by the NCL CCGs. For this treatment to be considered patients must be on a recognised programme of care and the NCL should check the specialised commissioning arrangements in their area. Note: Patients should be referred to a recognised NHS programme of care for management of these cases. Treatment is covered by specialised commissioning arrangements. Any treatments not covered by specialised commissioning arrangements are to be considered under the relevant section of the aesthetic surgery guidelines, e.g. breast augmentation and hair removal.
Correction of Hair Loss (including male pattern baldness) (Alopecia)	This cosmetic procedure is not routinely funded by the NCL CCGs.
Hair Epilation (hair removal by electrolysis and/or laser)	This cosmetic procedure is not routinely funded by NCL CCGs. Funding for hair epilation may be approved by the IFR Panel for patients who: 1. Have undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck or upper chest (areas not covered by normal clothing) **OR** 2. Are undergoing treatment for pilonidal sinuses to reduce recurrence.
Skin procedures	
Apronectomy or Abdominoplasty ** (Tummy Tuck)	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced:

	• The patient should be 18 or over at the time of application.
	• If following bariatric surgery, patient is at least 18 months post bariatric surgery
	AND
	• At the time of the application patients 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 18 months.
	For patients who have had very significant weight loss post bariatric surgery who have lost at least 50% of their original excess weight at the time of the application the patient should have a BMI equal or less than 35 kg/m2 and maintained this weight for at least six 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. walking, dressing and ambulatory restrictions) which has been formally assessed.
	  • Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.
	  • Poorly-fitting stoma bags.
	  • Surgery is required as part of an abdominal hernia correction or other abdominal wall surgery.

Body Contouring ** (other skin excision for contour e.g. buttock lift, thigh lift, arm lift **(Brachioplasty)** Not including breast procedures. Please see the relevant section.	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced: 1. The patient should be 18 or over at the time of application. 2. If following bariatric surgery, patient is at least 18 months post bariatric surgery **AND** 3. At the time of the application patients 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 18 months. For patients who have had very significant weight loss post bariatric surgery who have lost at least 50% of their original excess weight at the time of the application the patient should have a BMI equal or less than 35 kg/m2 and maintained this weight for at least six months, be stable at this weight and be at least 18 months post-surgery **AND** 4. Have severe functional problems which must include:

	• Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions) which has been formally assessed, and/or • Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.
Keloidectomy	NCL CCGs will not routinely fund procedures to refashion keloid scars for cosmetic purposes. All patients seeking treatment should be advised of the risk of scar recurrence. Patients should only be referred for surgical treatment once conservative approaches have been exhausted, and if the following criteria below are met and evidenced. If the keloid: • Results in significant functional impairment; **OR** • Causes significant pain requiring chronic analgesic medication; **OR** • Bleeding; **OR** • Obstruction of orifice or vision; **OR** • Is a facial lesion causing disfigurement.
Liposuction	This cosmetic procedure is not routinely funded by the NCL CCGs.
Skin Resurfacing and other Surgical Interventions for Scarring (including laser, dermabrasion and chemical peels)	This cosmetic procedure is not routinely funded by the NCL CCGs.
Tattoo Removal	This cosmetic procedure is not routinely funded by the NCL CCGs.
Treatment of Skin Hyper-pigmentation (including	This cosmetic procedure is not routinely funded by the NCL CCGs.

laser therapy, chemical peels etc)	
Treatment of Vascular Lesions (Port wine stains on the head and neck) **(Vascular Lesions)**	This cosmetic procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced: • (Facial haemangiomas), capillary malformations e.g. port wine stains, venous malformations. • Capillary malformations e.g. port wine stains, venous malformations. • Large congenital haemangiomas. Small, benign, acquired, vascular lesions such as thread veins and spider naevi would not normally be treated.
COSMETIC – Minor Skin Lesions (Treatment of)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. Minor skin lesions include pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment. For all other benign skin lesions the NCL CCGs will only routinely fund surgery in patients meeting the following criteria: • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this. **AND** • This results in infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year **OR** • The lesion is obstructing an orifice or impairing field vision **OR** • The lesion significantly impacts on function e.g. restricts joint movement **OR** • Greater than 1cm facial lesions that cause significant disfigurement

	OR • Congenital deformity (this does not include normal variation). Applications should clearly evidence the size and site of the lesion, and the impact on the patient. e.g. a lesion of 1.5cm diameter, on the chin, which bleeds every time the patient shaves. e.g. a lipoma measuring 20cm x 25cm raised by 2cm lying across the left shoulder which restricts full joint movement. e.g. a sebaceous cyst measuring 1cm x 1cm on the right ear which regularly becomes infected and has twice required antibiotic treatment in the previous 12 months **NICE Guidance** http://www.nice.org.uk/guidance/csgstim/evidence/skin-tumours- including-melanoma-evidence-update2 http://www.nice.org.uk/guidance/cg27/resources/guidance-referral- guidelines-for-suspected-cancer-pdf
COSMETIC – Varicose Veins **This policy to be reviewed 2015**	This procedure is not routinely funded by the NHS NCL and will only be considered for funding if the criteria below are met and evidenced. This guidance applies to each leg individually. The techniques that are normally approved are open surgery (ligation and stripping) and the endovenous techniques endovenous laser ablation (EVLA) and radiofrequency ablation (RFA) using VNUS Closure system. Sclerotherapy will not normally be funded. Factors to be taken into account when selecting the most appropriate treatment include local equipment, clinical assessment (including vein tortuosity and anatomy) and patient preference. **Criteria for eligibility**

	NCL will normally fund surgical or endovenous intervention for varicose veins if they are accompanied by one or more of the following complications: • Intractable ulceration secondary to venous stasis. **OR** • Healed venous ulcerations in patients that cannot tolerate compression stockings for clinical reasons. **OR** • Significant haemorrhage from a ruptured superficial varicosity (serious enough to warrant transfusion or admission **ALTERNATIVELY** After an unsuccessful **six month trial** of conservative management (compression stockings **AND** exercise **AND** daily elevation several times a day) when varicosities result in either: • recurrent documented thrombophlebitis (two or more episodes) **OR** • persistent skin changes (eczema, pigmentation or lipodermatosclerosis) **OR** • persistent aching, heaviness, itching or swelling severely affecting the patient's quality of life (for example the patient is unable to stand throughout the day for their job or they are woken regularly at night by severe discomfort

Dental procedures

Treatment	Criteria
Temporo-Mandibular Joint (TMJ) Surgery	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. TMJ surgery referred to in this document excludes arthroscopy as it may be performed for diagnostic reason. Temporo-mandibular joint disorder (TMD), or TMJ syndrome, is an umbrella term covering acute or chronic inflammation of the temporo-mandibular joint, which connects the mandible to the skull. This disorder transcends the boundaries between several health-care disciplines in particular Dentistry and Neurology. **Criteria for eligibility** It is suggested that before any dentist or surgeon commences any plan or approach involving surgery, a thorough search for inciting para-functional jaw habits have been performed with the correction of any discrepancies from normal as the primary goal. Application for approval must evidence the following treatments: 1. Jaw rest **AND** 2. Medications: non-steroidal Anti-inflammatory medications such as aspirin, ibuprofen to control inflammation. Muscle relaxants, such as diazepam may decrease muscle spasms **AND** 3. Physiotherapy **AND** 4. Local anaesthetic **AND** 5. Occlusal therapy: a custom made acrylic appliance which fits over the teeth prescribed for night and day to balance the bite, reduce and eliminate teeth grinding or clenching (bruxism) **AND** 6. Botulinum toxin injections. Surgery is only indicated and approved after these medical therapies have failed and is done as a last resort. TMJ ligament tightening, joint restructuring, and joint replacement are only considered in the most severe cases of joint damage or deterioration. **Absolute contraindications to surgery are:** • Active or chronic infection; • Insufficient quantity or quality of bone to support the components; • Systemic disease with increased susceptibility to infection; • Patients with extensive perforations in the mandibular fossa and/or bony deficiencies in

	• the articular eminence or zygomatic arch that would severely comprise support for the • artificial fossa component; • Partial TMJ joint reconstruction; • Known allergic reaction to any materials used in the components; • Patients with mental or neurological conditions who are unwilling or unable to follow • post-operative care instructions; • Skeletally immature patients • Patients with severe hyper-functional habits (e.g. clenching, grinding etc.) **NICE Guidance** http://www.nice.org.uk/guidance/ipg500/resources/guidance-total-prosthetic- replacement-of-the-temporomandibular-joint-pdf

ENT – Ears, Nose & Throat procedures

Treatment	Criteria
(Adenoidectomy) Tonsillectomy	Tonsillectomy is a clinically effective and cost-effective procedure when performed for appropriate indications. It should be approved for funding if the criteria below are met and evidenced. These criteria refer to tonsillectomies with or without adenoidectomies. Adenoidectomies alone, for clinical reasons, are routinely funded. **Criteria for eligibility** **Recurrent acute tonsillitis:** 1. FIVE or more episodes in the last year **OR** 2. FOUR or more episodes in each of the last two successive years **OR** 3. THREE or more episodes in each of the last three years **AND** 4. With significant impact on quality of life indicated by absence from school, work or playgroup or failure to thrive. **OR** **Obstructive sleep apnoea in children:**

	The diagnosis may be based on a clear parental history of snoring, obstructed, laboured breathing, apnoeas and disturbed sleep, together with anatomical evidence of upper airway obstruction. N.B. Daytime neurobehavioural abnormalities or sleepiness are not always present in children with significant OSA. A lower threshold for considering surgery if the patient has habitual snoring with laboured breathing and falls into one of the following complex high risk categories for sleep apnoea: • Down's syndrome • Cerebral palsy • Craniofacial disorders • Chronic lung disease • Sickle cell disease • Neuromuscular disorders • Genetic/metabolic/storage disease • Central hyperventilation syndromes **OR** 1. ONE quinsy or ONE or more episodes of tonsillitis requiring admission to hospital where there has been a previous history of recurrent tonsillitis **OR** 2. One year or more of chronic tonsillitis with tonsoliths causing halitosis and significant social embarrassment **OR** 3. Tonsillitis exacerbating existing disease such as febrile convulsions, guttate psoriasis, glomerulonephritis or rheumatic fever. **NB. Suspected tonsil neoplasms are not to be considered by this process.**
Surgery for Sleep Related Breathing Disorder (SRDB)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the following three criteria stages are met and evidenced: Before consideration for surgery patient has had: 1. Trial of lifestyle measures which have failed to have included: • Weight loss (details of management and duration to be provided). • Reduction of alcohol intake. • Failed medical treatment for nasal symptoms (details of treatment and duration to be provided) **AND**

	2. Sleep study test: AHI should be greater than FIVE and in patients with upper airways resistance syndrome the AHI may be less than FIVE but the flow limitation index should be greater than 15 and Epworth sleepiness score should be greater than 12 **AND** 3. Sleep nasendoscopy (SNE) demonstrating significant anatomical problem: • Nasal, oropharyngeal or hypopharyngeal. One of the following clinical indications for consideration of surgical management must apply: 4. Severe symptoms of sleep disordered breathing for whom CPAP is not appropriate, for example: • Obvious obstructive upper airways pathology making CPAP use difficult. • Claustrophobia (details of methods and duration of trials to be included) **OR** 5. Patient with OSA who has failed a trial of CPAP: • CPAP trail should be for a minimum of three months (documented evidence to be provided). • All patients who use CPAP should be reassessed in a CPAP clinic where a smart card can give information on various parameters such as reduction of AHI, mask leak and pressure requirements, allowing for analysis of efficacy and compliance of CPAP therapy **OR** 6. Patient with OSA who has failed, or is unable to tolerate, treatment with a Mandibular Advancement Device: • All patients who OSA and try a mandibular advancement device will undergo a further sleep study with the device in situ and if the AHI is still high then this is deemed a failure. Also if they begin to encounter dental problems or TMJ dysfunction then they have failed this treatment modality and should be considered for surgery. ONE of the following indications for surgery must apply: 7. Patient has a high “Flow Limitation Index” **OR** 8. The aim of surgery is to: • Partially improve upper airway to facilitate CPAP use. • Completely resolve upper airway obstruction.

Surgical Treatment of Chronic Rhinosinusitis	This procedure is not routinely funded by the NCL CCGs. **Criteria for eligibility** ENT referral may be appropriate if there is: 1. Recurrent or chronic sinusitis of uncertain cause **OR** 2. Unremitting or progressive facial pain **OR** 3. A trial of intranasal corticosteroids for three months has been ineffective **OR** 4. A significant anatomical abnormality. Suspected complications of rhinosinusitis and suspected sinonasal tumours should be referred to ENT on an emergency or urgent basis. **Criteria to meet for consideration of surgical management**: 1. Symptoms/signs warranting urgent treatment **OR** 2. Failure of medical treatment **OR** 3. On-going facial pain with evidence of rhinosinusitis **OR** 4. Recurrent/chronic rhinosinusitis of uncertain cause **OR** 5. Significant anatomical abnormality.

Genitourinary Medicine

Treatment	Criteria
Circumcision	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. Circumcision is an effective operative procedure with a range of medical indications. This statement refers to circumcision (the surgical removal of the penile foreskin) in males only. Female circumcision is prohibited by law (The Prohibition of Female Circumcision Act 1995). Circumcisions for social, religious or cultural reasons will not be funded by the NHS.

	Criteria for eligibility NCL CCGs will fund circumcisions for the following indications: 1. Traumatic foreskin injury where it cannot be salvaged. Other indications: 2. Phimosis seriously interfering with urine flow and/or associated with significant recurrent infections **OR** 3. Balanitis xerotica obliterans **OR** 4. Adult phimosis or phimosis in children with spraying, ballooning and/or recurrent infection **OR** 5. Congenital urological abnormalities when skin is required for grafting **OR** 6. Interference with normal sexual activity in adult males **OR** 7. Symptomatic cases of paraphimosis **OR** 8. Symptomatic cases of minor hypospadias.
Reversal of Sterilisation	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** • Death of only existing child. • Remarriage following death of spouse.
Varicocoele	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** • Documented evidence of persistent discomfort or pain despite adequate conservative management.

Gynaecology

Treatment	Criteria
Treatment for Bartholin's Cysts	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility**

	1. A Bartholin cyst that is large and painful with significant infection **OR** 2. Rapidly growing Bartholin cyst causing significant pain that is unresolved by non-surgical treatments. The procedure carried out should follow the following treatments: 3. Draining the cyst and letting it heal by keep the cyst from closing and filling up again which it is held open for a few weeks. Importantly with a small piece of gauze which keeps the cyst from closing **AND** 4. Stitches to prevent the cyst wall from reforming a closed sac as bartholin gland cysts only come back in about 5 to 10 out of 100 women after this procedure **AND** 5. If an abscess is present antibiotics may be prescribed after the procedure.
Dilatation and Curettage for Heavy Menstrual Bleeding (in women aged under 40 years only)	This procedure is not routinely funded by the NCL CCGs. There is no evidence that this procedure has any therapeutic value. For women with dysfunctional uterine bleeding, a range of medical intervention is available (e.g. mefenamic acid with norethisterone etc). Exceptional individual circumstances may be referred to the Individual Funding Request Panel for consideration. **Recommendations** The use of Dilatation and Curettage in the non-pregnant uterus will not be routinely funded. Dilatation and Curettage will not be funded in any, and including the following indications. • Investigation and/or treatment of menorrhagia (HMB) – NICE CG no.44. • Investigation of dysfunctional uterine bleeding (DUB) or post-menopausal bleeding (PMB). • Treatment of irregular periods. • Treatment of endometrial hyperplasia. • Removing unwanted tissue, endometrial polyps or benign tumours from the womb. Hysteroscopy and biopsy when indicated are now the procedures of choice. **NICE Guidance** http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf

Hysterectomy for Heavy Menstrual Bleeding (HMB)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. Hysterectomy should not be used as a first-line treatment solely for HMB. **Criteria for eligibility** NCL will fund hysterectomy for heavy menstrual bleeding only when: 1. There has been an unsuccessful trial (of at least six cycles) with a levonorgestrel intrauterine system (e.g Mirena®) unless medically contraindicated (1st line drug treatment) **AND** 2. A second drug treatment (unless contraindicated) has been tried and has also failed. These drug treatments include: • Tranexamic acid (2nd line drug treatment) • Non-steroidal anti-inflammatory drugs (NSAIDs) (2nd line drug treatment) • Combined oral contraceptives (2nd line drug treatment) • Oral progesterone (3rd line drug treatment) • Injected progesterone (3rd line drug treatment) **AND** 3. Endometrial ablation has been tried (unless the patient has fibroids >3cm, an abnormal uterus or other contraindications) Note: endometrial ablation is suitable for women who do not want to conceive in the future and should only be offered after full discussion of risks and benefits and other treatment options **AND** 4. Documented evidence is provided to demonstrate: • Other drug, surgical and radiological treatment options have failed, are contraindicated or are declined by the woman. • There is severe impact on quality of life. • Fibroids (if present) are >3cm in diameter. • There is structural/histological abnormality of the uterus. • The woman no longer wishes to retain her uterus and fertility. **NICE Guidance** http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual- bleeding-pdf

JOINT PROCEDURES

Treatment	Criteria
Autologous Chondrocyte Implantation (ACI) **)**	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. NICE has produced technical guidance on the use of autologous chondrocyte implantation (ACI). **Criteria for eligibility** • ACI is NOT recommended for the treatment of articular cartilage defects except in the context of on-going or new clinical studies that are designed to generate robust and relevant outcome data. • NCL CCGs will not routinely fund health care interventions that NICE has not recommended they 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. **NICE Guidance** http://www.nice.org.uk/guidance/ta89/resources/guidance-the-use-of-autologous-chondrocyte-implantation-for-the-treatment-of-cartilage-defects-in-the-knee-joints-pdf
Carpal Tunnel Syndrome (Surgical treatment of)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. All referrals should be through an agreed pathway to optimise access to conservative treatment. **Absolute criteria** The NCL CCGs will fund carpal tunnel surgery where: 1. Patient has acute, severe symptoms that persist for more than three months after conservative therapy with either local corticosteroid injection and/or nocturnal splinting **OR** 2. Mild to moderate symptoms persist for at least four months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least eight weeks) **OR** 3. There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction

	AND 4. Severe symptoms significantly interfering with daily activities and sleep which have been assessed.
Ganglion (Excision of Ganglia)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** *(This protocol is adapted from the Derby Ganglion Referral pro forma).* The NCL CCGs will fund the surgical removal of the ganglia in the following cases: 1. The ganglion is painful seed ganglia and diagnostic uncertainty **OR** 2. In patients presenting a significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts **OR** 3. The ganglia are mucoid cysts arising at the distal interphalangeal joint and disturbing nail growth or discharging **OR** 4. The ganglion is causing significant functional impairment and/or pain unrelieved by aspiration or injection. The degree of functional impairment as a result of the condition should be considered. Patients should be made aware that most ganglia resolve spontaneously with the passage of time. Patients should be made aware of the complications of ganglion excision. If aspiration has not been attempted, referrals may be redirected to a local 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.
Dupuytren's Contracture (Fasciotomy/Fasciectomy (Surgical Treatment)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** NCL will fund surgical treatment for Dupuytren's contracture if the following conservative treatments have been applied: **Conservative and "Non-operative" Treatment**

	1. Direct injection of clostridial collagenase into nodules and cords has been shown to cause lysis and rupture of digital cords, releasing contractures (Badalamente 2000) Percutaneous needle fasciotomy (PNF) is used to relieve contracture in the elderly or frail or as a temporising measure. PNF may be performed on an outpatient basis by an appropriately trained specialist. In 2004, the NICE published guidance stating that percutaneous fasciotomy was safe and effective (www.nice.org.uk/ip177overview) **AND** 2. Patient has loss of extension in ONE or more joints exceeding 25 degrees **OR** 3. Patient has at least 10 degrees loss of extension in TWO or more joints. **Indicative criteria** NCL CCGs will also consider funding surgical treatment for any degrees of proximal inter phalangeal joint contracture. **NICE Guidance** https://www.nice.org.uk/guidance/ipg43/resources/guidance-needle- fasciotomy-for-dupuytrens-contracture-pdf
Knee Washout (in patients with knee osteoarthritis)	This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. **Criteria for eligibility** NCL 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/resources/guidance-arthroscopic-knee-washout-with-or-without-debridement-for-the- treatment-of-osteoarthritis-pdf

Trigger Finger	Surgical treatment for trigger finger will be funded if the following apply: 1. Patient has failed to respond to a single hydrocortisone injection **OR** 2. Patient has fixed deformity that cannot be corrected.

OTHER PROCEDURES

Treatment	Criteria
MASSAGE – Manual Lymphatic Drainage (MLD)	NCL CCGs will not routinely fund Manual lymphatic drainage (MLD) as part of the Decongestive Lymphoedema Treatment (DLT) or on its own. In all applications please include the patient's full diagnosis, the duration of treatment, the expected outcomes and cost of the treatment. Applications must come from the secondary care vascular team after a full and appropriate assessment and be part of a wider programme to address the patients' symptoms.
ME/CFS – Myalgic Encephalopathy/Chronic Fatigue Syndrome (Treatment of) **(Outside NHS service level agreements)**	This procedure is not routinely funded by the NCL CCGs outside of NHS Service Level Agreements. **Referral** To a specialist service may be considered if: • There is doubt about the diagnosis • Symptoms severe • Children and young people should be referred to a paediatrician or adolescent medicine specialist for assessment within 6 weeks of presentation • After 3 months if moderate • After 6 months if mild CFS/ME **NICE Guidance** http://www.nice.org.uk/guidance/cg53/resources/guidance-chronic-fatigue-syndromemyalgic-encephalomyelitis-or-encephalopathy-pdf

SKIN – Hyperhidrosis This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced. Hyperhidrosis is a condition that causes excessive sweating. Where treatment options two or three are requested, evidence of the previous options having failed is required.	There are two types of hyperhidrosis: • Focal hyperhidrosis, where only certain parts of the body are affected, such as the armpits, hands, feet or face, and • Generalised hyperhidrosis, where the entire body is affected. Hyperhidrosis can also be either: • Primary idiopathic hyperhydrosis, where there is a no apparent cause for the excessive sweating **AND** • Secondary hyperhidrosis, where the excessive sweating is the result of an underlying health condition, such as an overactive thyroid gland. **Criteria for eligibility** Criteria of presentation (must have these): <u>Diagnose primary focal hyperhidrosis when focal, visible, excessive sweating:</u> • Occurs in at least ONE of the following sites: axillae, palms, soles, or craniofacial region **AND** • Has lasted at least six months **AND** • Has no apparent cause **AND** • Hyperhydrosis Disease Severity Score (HDSS) Score of 3 of 4 <u>Has at least TWO of the following characteristics:</u> • Bilateral and relatively symmetrical. • Impairs daily activities. • Frequency of at least one episode per week. • Onset before 25 years of age. • Positive family history. • Cessation of local sweating during sleep **AND**

	Conservative Management (done this): <u>Focal hyperhidrosis</u> • Advice about lifestyle measures and sources of information and support should be given • Aluminium salts should be given under primary care supervision (to ensure compliance) for at least two months • Intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone • Consider treating any underlying anxiety, which may be an exacerbating factor: Cognitive behavioural therapy may be preferable to antidepressants or propranolol, which can cause or worsen hyperhidrosis. <u>Generalised hyperhidrosis</u> • Treatment of the underlying conditions • Referral to a dermatologist should be made if the above measures are inadequate or unacceptable. **Treatment options requiring approval:** • The treatment options must be undertaken in the order as set out below. • Documentary evidence must be provided of the unsuccessful trial and/or why the treatment is contra-indicated before commencing the next option. <u>Severe axillary hyperhidrosis</u> **Option 1:** Iontophoresis. **Option 2:** Botulinum Toxin injections will only be considered where all other treatments have failed or are contra-indicated. **Option 3:** Local surgery (axillary; resection of sweat glands) will only be considered where all other treatments have failed or are contra-indicated. <u>Plantar or palmar hyperhydrosis</u> **Option 1:** Iontophoresis.

	Option 2: Botulinum Toxin injections will only be considered via the Individual Funding Request where all other treatments have failed or are contra-indicated. **Option 3:** For **PALMER ONLY** endoscopic thoracic sympathectomy (ETS) will only be considered where all other treatments have failed or are contra-indicated. <u>Craniofacial hyperhydrosis</u> **Option 1:** Oral anti-cholinergic medications. **Option 2:** Botulinum Toxin injections will only be considered via the Individual Funding Request where all other treatments have failed or are contra-indicated. **Option 3:** Endoscopic thoracic sympathectomy (ETS) will only be considered where all other treatments have failed or are contra-indicated **Option 4:** Generalised hyperhidrosis: Oral anti-cholinergic medications. **NICE Guidance** http://www.nice.org.uk/advice/esuom16/resources/non-guidance- hyperhidrosis-oral-glycopyrronium-bromide-pdf

Open MRI/ Bariatric MRI	NCL CCGs will not routinely fund open MRIs. Open MRI scans provide lower quality images than those from a conventional scanner. As there is no NHS provision in north London they can also lead to significant inconvenience to patients. For these reasons NCL CCGs will only fund open MRIs by prior approval under the following conditions: **Claustrophobic patients** Most patients with claustrophobia can be successfully scanned using a conventional MRI scanner. Applications for open MRI will only be accepted if the patient has failed to tolerate a conventional scan using feet first and oral sedation approaches as appropriate. Applications for open MRI should confirm that the patient has not tolerated a conventional scan with or without oral sedation as appropriate and, given the poorer image quality from an open MRI scan, confirm that no other diagnostic tests are suitable. **Obese patients** Patients who are too large to fit within a conventional MRI scanner should be referred by a secondary care clinician to the bariatric MRI service at Bartshealth

Complementary and alternative therapies	There is some evidence that some forms of complementary treatments can be effective in certain conditions. • The CCG agrees to fund ONLY applications for the treatments listed below where there are NICE recommendations. Please include the reference and supporting section of the NICE Guidance in the application. • In **all** applications please include the patient's diagnosis, the treatment for which you are applying for, the duration of treatment, the expected outcomes and cost of the treatment. NHS NCL will fund the following complementary and alternative therapies because of some evidence of clinical benefit in selected conditions **Acupuncture** • For non-surgical management of joint pain as part of pathway which may lead to joint replacement • In non-acute lumbar pain not warranting surgical referral • In chronic pain conditions (and only when therapy is accompanied by continued symptomatic improvement i.e. not maintenance) • In selected patients with migraine headache • In selected cases of nausea of pregnancy • In some cases with postoperative and chemotherapy-induced nausea and vomiting • In selected cases of postoperative dental pain • Temporomandibular disorders (TMD) • Sub-acute and chronic low back pain of more than six weeks duration **Osteopathy**

	• Children with spastic cerebral palsy • In the treatment of paediatric dysfunctional voiding • Adults with Lumber or Cervical pain not warranting surgical referral being treated as part of an integrated MSK Package. • Some adults with large joint pain as part of a care pathway that may lead to joint replacement **Bio-Feedback** Chronic constipation (biofeedback is the primary treatment option for patients with dyssynergic defecation) • Irritable bowel syndrome • Levator ani syndrome. • Migraine and tension headaches (muscle, thermal or skin biofeedback); • Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (policy does not cover neuromuscular electrical stimulators) • Raynaud's disease • Refractory severe subjective tinnitus • Temporomandibular joint (TMJ) syndrome • Urinary incontinence **Electrical stimulation** • As an adjunct or as an alternative to the use of drugs either in the treatment of acute postoperative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including, as appropriate, physical

	therapy and pharmacotherapy. • A physician evaluated trial lasting between 1 and 2 months should determine if treatment is to continue. **Selected use in palliative care** • Mistletoe in cervical cancer • Meditation and Tai Chi in selected elderly patients with optimally treated heart failure – evidence of reduction in sympathetic activity (SIGN 95) **Hypnotherapy** • Severe chronic insomnia • Irritable Bowel Syndrome **Manipulation and Stretching** • Selected cases of osteoarthritis of the hip as an adjunct to core treatment • Sub-acute and chronic low back pain of more than six weeks duration • Acute low back pain of less than six weeks • Mobilisation of the neck

The CCG will NOT routinely fund the following therapies because of lack of sufficient evidence of effectiveness (*Adapted from the AETNA Complementary and Alternative Medicine Policy)*

Active release technique	Hypnosis
Acupressure	Hyperoxygen therapy
Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries) technique	Immunoaugmentive therapy
Alexander technique	Infratronic Qi-Gong machine
AMMA therapy	Insulin potentiation therapy
Antineoplastons -- see CPB 240 – Antineoplaston Therapy and Sodium Phenylbutyrate	Inversion therapy
Apitherapy	Iridology
Applied kinesiology	Iscador
Aromatherapy	Juvent platform for dynamic motion therapy
Art therapy	Kelley/Gonzales therapy
Aura healing	Laetrile
Autogenous lymphocytic factor	Live blood cell analysis
Auto urine therapy	Macrobiotic diet
Bioenergetic therapy	Magnet therapy
Biofield Cancell (Entelev) cancer therapy	MEDEK therapy
Bioidentical hormones	Meditation/transcendental meditation
Brain integration therapy	Megavitamin therapy (also known as orthomolecular medicine)
Carbon dioxide therapy	Meridian therapy
Cellular therapy	Mesotherapy
Chakra healing	Moxibustion (except for fetal breech presentation) - see CPB 135 - Acupuncture
Chelation therapy for Atherosclerosis -- see CPB 234 - Chelation Therapy	MTH-68 vaccine
Chung Moo Doe therapy	Music therapy
Coley's toxin	Myotherapy
Colonic irrigation	Neural therapy
Colour therapy	NUCCA procedure

Conceptual mind-body techniques	Ozone therapy
Craniosacral therapy	Pfrimmer deep muscle therapy
Crystal healing	Polarity therapy
Cupping	(Poon's) Chinese blood cleaning
Dance/Movement therapy	Primal therapy
Digital myography	Psychodrama
Ear Candling	Purging
Egoscue method	Qigong longevity exercises
Electrodermal stress analysis	Ream's testing
Electrodiagnosis according to Voll (EAV)	Reflexology (zone therapy)
Equestrian therapy -- see CPB 151 - Hippotherapy	Reflex Therapy
Essential Metabolics Analysis (EMA)	Reiki
Essiac	Remedial massage
Feldenkrais method of exercise therapy (also known as	Revici's guided chemotherapy
Flower essence	Rife therapy/Rife machine
Fresh cell therapy	Rolfing (structural integration)
Functional intracellular analysis*	Rubenfeld synergy method (RSM)
Gemstone therapy	714-X (for cancer)
Gerson therapy	Sarapin injections
Glyconutrients	Shark cartilage products
Graston technique	Telomere testing
Greek cancer cure	Therapeutic Eurythmy-movement therapy
Guided imagery	Therapeutic touch
Hair analysis - see CPB 300 - Hair Analysis	Thought field therapy (TFT) (Callahan Techniques Training)
Hako-Med machine (electromedical horizontal therapy)	Trager approach
Hellerwork	Traumeel preparation
Hoxsey method	Vascular endothelial cells (VECs) therapy
Human placental tissue	Vibrational essences

Hydrolysate injections	Visceral manipulation therapy
Humor therapy	Whitcomb technique
Hydrazine sulfate	Wurn technique/clear passage therapy
Hydrogen peroxide therapy	Yoga

Complementary therapies are seen by an increasing number of people (with increasing requests for treatment) as a more holistic and 'natural' approach to dealing with a variety of complaints. Attractions include the comparably longer interaction time with the practitioner and the belief that such therapies will work, affecting a complex mix of factors impacting on health.

However there is much uncertainty about benefit/effectiveness, evidence of complications for some therapies and considerable grounds to suspect other adverse effects may occur. Since conventional medicine also aspires to a holistic approach, this means that some alternative therapies should be considered where evidence exists.

The types of complimentary therapies covered under this policy include Homoeopathy, Acupuncture, Osteopathy, Biofeedback, Hypnotherapy, Chiropractic Therapy, Massage, Reflexology, Clinical Ecology, Aromatherapy, Herbal Remedies, Chinese medicines, Psychotherapy and Meditation. This list is not exhaustive and other treatments not listed here but that are considered 'alternative' or 'complimentary' therapies will be considered in the same way.

Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are usually through charitable services and not part of commissioned services. Some patients may also be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned, although exceptionality would need to be demonstrated.

Evidence

The House of Commons Science and Technology Committee enquiry into the provision of homeopathic services within the NHS in 2009 recommended that homeopathic treatments should not be routinely available within the NHS (ref 1). The committee report included a robust review of the evidence base for a variety of homeopathic treatments but found no evidence of effectiveness for any condition from published RCTs and systematic reviews. A previous report commissioned by the Association of Directors of Public Health in 2007 (ref 2) and more recent reviews by AETNA (ref 3) are all consistent in confirming the lack of sufficient evidence of effectiveness of homeopathic treatments despite many years of

research and hundreds of studies.

There is some evidence of clinical benefit for some complimentary therapies such as acupuncture, osteopathy, biofeedback and hypnotherapy for certain conditions. For example, NICE recommends

Acupuncture for up to ten sessions for the treatment of sub-acute and chronic low back pain of more than six weeks duration. NICE also suggests that manipulation and stretching should be considered as an adjunct to core treatment for osteoarthritis of the hip, sub-acute and chronic low back pain of more than six weeks duration, acute low back pain of less than six weeks duration and mobilisation of the neck (ref 4 to 7).

Acupuncture, osteopathy and chiropractic may already be routinely provided within the NHS as part of an integrated pathway within musculoskeletal or chronic pain services as an adjunct to other treatments.

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