OVERVIEW OF CHANGES TO CWS CCG LOW PRIORITY PROCEDURES, PROCEDURES WITH RESTRICTIONS AND NICE INTERVENTIONAL PROCEDURES SEPTEMBER 2018

To be read in conjunction with 'Combined CEC Clinical Policy v2- 23 May 2018. Key highlights include:

- **Emphasis on shared decision making process not simply a presumed discussion**
- **Oxford scores replaced by healthwise resources**
- **DLQI test under Removal of Benign Skin Lesions**

New Policies

Asymptomatic Gallstones Surgery	**New Policy:** The CCG will not routinely fund surgery for asymptomatic gallstones. **The CCG will only support the funding of cholecystectomy in asymptomatic gallstones if one or more of the following criteria are met:** • High risk of gallbladder cancer, e.g. gallbladder polyps ≥1cm, porcelain gallbladder, strong family history (parent, child or sibling with gallbladder cancer), • Transplant recipient (pre or post-transplant), • Diagnosis of chronic haemolytic uraemic syndrome by a secondary care specialist, • Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones larger than 2cm or smaller than 3mm with a patent cystic duct, presence of multiple stones, • Confirmed episode of gallstone induced pancreatitis or obstructive jaundice. **The CCG will not normally support the funding of cholecystectomy for patients in the following scenarios:** • Asymptomatic gallstones in patients undergoing bariatric surgery, unless intra-operatively the gallbladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy • All patients with asymptomatic gallstones who do not meet any of the above criteria.
Bariatric Surgery	**Interim New Policy:** **Bariatric Surgery will be funded where all of the following criteria are fulfilled:** • The patient has a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (e.g. Type 2 diabetes or high blood pressure) that could be improved if they lost weight. For people of Asian family origin who have recent-onset 1 type 2 diabetes, the BMI threshold will be reduced by 2.5 points i.e. 32.5 kg/m2 and 37.5 kg/m2 • All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss. • The individual has recently received and complied with a local specialist weight management programme (tier 3) for a duration considered appropriate by the multi-disciplinary team (MDT) which is a minimum of 6 months. • The person is generally fit for anaesthesia and surgery as determined by the MDT in T4 services. • The person commits to the need for long term follow up.(written /signed consent). • A formalised MDT led process for the screening of co-morbidities and the detection of other significant diseases has been completed. The decision making process should include identification, diagnosis, severity/complexity assessment, risk stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway. The decision making process includes the following: • the specialist hospital bariatric MDT agrees surgery is indicated; • for each patient a risk benefit evaluation should favour bariatric surgery In addition the bariatric surgery team must satisfy themselves that there are no contraindications for surgery, risks have been minimised and the patient is likely to engage in the follow up programme that

	is required after any bariatric surgical procedure.
Bariatric Surgery-Revision	**Interim New Policy:** **Revision of bariatric surgery will be funded as per NHS England Clinical Guidance on revision surgery for complex obesity (2016).** A) Revision surgery will be routinely funded for patients presenting with a clinical history, symptoms and/or signs that suggest acute / acute on chronic / worsening medical and/or surgical complications related to their primary obesity operation. This will include patients with adverse anatomical complications of the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/or the gastro-jejunal junction. B) Revision surgery will not be routinely funded for patients who have failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight (unless criterion a is met). C) Revision surgery will not be routinely funded for patients who have comorbidities which have persisted or re-emerged following primary obesity surgery (unless criterion A is met). D) Where patients have had their primary obesity surgery outside of NHS contracts but subsequently present at NHS facilities as clinical emergencies, the NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment.
Excision of Haemorrhoid	**New Policy:** **Surgery commissioned for symptomatic:** 1. Grade III and IV haemorrhoids. 2. Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:- • Diet modification to relieve constipation, • Topical applications, • Stool softeners and laxatives, • Rubber band ligation, • Sclerosant injections, • Infrared coagulation. **Surgical treatment options include**: • Surgical excision (haemorrhoidectomy), • Stapled haemorrhoidopexy, • Haemorrhoidal artery ligation. **Removal of skin tags is not routinely commissioned.** Removal of haemorrhoids as part of other surgeries or before other anal surgeries is permitted. The grading system described by Goligher, (Goligher JC. ADVANCES IN PROCTOLOGY. Practitioner 1964;193:526-32.) is the most commonly used and is based on objective findings and history: • Grade I: No prolapse, vascular cushions in the anal canal visualized by endoscopy. • Grade II: Prolapse during defecation, but spontaneous reduction. • Grade III: Prolapse during defecation, which need manual reduction. • Grade IV: Persistent prolapse irrespective of attempts to reduce the prolapse.
Exogen Ultrasound Bone Healing System	**New Policy – Secondary Care:** **Not routinely funded unless criteria met in line NICE MTG12 – 'EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing'** Medical technologies guidance [MTG12] Published date: January 2013 *'NICE has said that EXOGEN can be used to treat non-union fractures of long bones (such as the tibia or femur, long bones in the leg). Non-union means that the fracture hasn't healed after 9 months. Healthcare teams may want to use the EXOGEN ultrasound bone healing system because the evidence shows high rates of fracture healing when it is used and it can save money, by avoiding surgery, compared with current treatment for non-union fractures.'* https://www.nice.org.uk/guidance/mtg12

Foetal Alcohol Spectrum Disorder	**New Policy & Pathway:** Referrals should be directed/managed through joint commissioning process (children's commissioning team/mental health team as appropriate). **This procedure is not routinely funded by the CCGs**. **Referrals to the National Foetal Alcohol Spectrum Disorder Clinic for specialist assessment will not be routinely funded.** Assessment for and diagnosis of Foetal Alcohol Spectrum Disorder should be undertaken by local specialists. Please contact the relevant CCG for information on referral pathways/local arrangements.
Hydrotherapy	**New Policy:** **Hydrotherapy unless part of an established care package is not routinely funded.**
Minimal Access Surgery for Uterine Fibroids	**New Policy:** **This procedure is not routinely funded by the CCGs**. This treatment will only be funded when following criteria are met in full: 1. Symptomatic fibroids where: • The fibroid is greater than 3 cm in diameter; **OR**, • Women with symptomatic fibroids for whom appropriate conservative management has been unsuccessful (conservative management revolves around control of symptoms such as heavy menstrual bleeding and pain); 2. Women who are unsuitable for or do not wish to undergo open surgery For those patients diagnosed with a fibroid through subfertility investigations – referrals into secondary care for a fibroid will only be accepted if patient has been seen and reviewed by subfertility specialist first.
Sleep Apnoea	**New Policy:** As defined by British Snoring & Sleep Apnoea Association – using the Epworth Sleepiness Scale found at: http://www.britishsnoring.co.uk/sleep_apnoea/epworth_sleepiness_scale.php#topLink Sleep apnoea is graded into:- - 0 - 10 - considered normal - 11-14 - considered as mild day time sleepiness - 15-18 - considered as moderate day time sleepiness - 19-24 - considered as severe day time sleepiness **Mild sleep apnoea (score of 11-14)**: • Behavioural interventions offered, • Patient information leaflets to help manage their condition (Appendix 2 Sample patient information leaflet), • **NOT** normally be referred to secondary care. *In those circumstances where patients are referred to secondary care then:* • CPAP provision funding – **ONLY** in exceptional individual case basis if the patient has symptoms that seriously affects their quality of life and ability to go about their daily activities AND if lifestyle advice and any other relevant treatment options have been considered and deemed inappropriate or unsuccessful. • IOD/MAD may be provided if deemed clinically appropriate. **Moderate sleep apnoea (score of 15-18)**: • Patients should also be offered behavioural interventions, • Patient information leaflets, • Are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician, • CPAP and IOD/MAD are appropriate treatment options for patients with moderate OSA. **Severe sleep apnoea(score of 19-24)**: • Patients should also be offered behavioural interventions, • Patient information leaflets, • Are eligible for NHS funding of an appropriate management option as determined by the treating respiratory physician, • In the first instance, this should involve use of a CPAP machine, • IOD/MAS is an appropriate treatment option for patients with severe OSA who are unable to tolerate CPAP.

	Surgery: The CCG does not routinely commission surgical treatment for Sleep Apnoea Tonsillectomy for sleep apnoea will be funded by CCG if the following are met: • Severe sleep apnoea **AND** • large tonsils **AND** • patient and physician consider it to be appropriate **AND** • decision needs to be made in consultation with an ENT physician.
Amended Policies	
Arthroscopic Knee Surgery	**Knee Arthroscopy for chronic osteoarthritis is not routinely funded.** Funding **will NOT** be approved for: • Arthroscopic lavage and debridement as part of treatment for osteoarthritis (as per NICE interventional procedure guidance 230). • Use as a primary diagnostic tool **Policy does not cover arthroscopy recommended by an orthopaedic specialist in those under 18 years of age or in adults following:** • acute injury with suspected internal joint derangement; • septic arthritis; • suspected malignancy
Carpal Tunnel Decompression	**One of the following**: • Acute, severe symptoms, that interfere with daily life due to pain or sensory loss which persist after conservative therapy, having tried a local corticosteroid injection by a trained, competent practitioner, and nocturnal splinting for 8 weeks for acute severe symptoms, **OR**, • Mild to moderate symptoms including pain or sensory loss, which persist for at least 3 months after conservative therapy having tried local corticosteroid injection (if appropriate) and nocturnal splinting (used for at least 8 weeks), **OR**, • Positive diagnostic nerve conduction study ,**OR**, • Presence of muscle wasting **AND** Shared decision making is adopted and the patient wants surgery
Circumcision	**Additional criteria includes**: •Congenital urological abnormalities when skin is required for grafting • Symptomatic cases of paraphimosis • Symptomatic cases of minor hypospadias • Recurrent balanoposthitis resistant to antibiotic treatment • The nature of the phimosis severely interferes with sexual function • Traumatic (e.g. zipper injury referred from secondary care).
Female Genital Prolapse	**Asymptomatic patients should not be referred to secondary care. Surgery is not routinely funded for asymptomatic patients or those with mild symptoms.** **CCGs will fund surgery for Female Genital / Pelvic Organ Prolapse for patients who meet the following criteria**: • Symptomatic pelvic organ prolapse (e.g. overactive bladder, incomplete emptying of bladder, feel lump/see lump, dragging sensation, sexual dysfunction'), **AND**: The patient has undergone a minimum of 6 months supervised lifestyle and specialist management which could include: • A programme of supervised physiotherapy and pelvic floor exercises / muscle training (PFMT) • Weight loss if the woman's body mass index is 30 kg/m2 or greater • Managing chronic cough • Received smoking **cessation** advice • Avoiding constipation • Avoiding heavy lifting and high-impact exercise Recurrent prolapse is out of scope of this policy
Ganglia Surgery	**Policy covers both wrist and foot.** Includes the sentence - Policy is related to ganglions and excludes mucoid cysts, and highlights the need for shared decision making.

Hallux Valgus/ Surgical Treatment of Bunions	**Criteria expanded to include:** • 6 months conservative measures instead of 3 months and has detailed information about conservative measures. • Also explicit about patient understanding that they will be out of work for a number of weeks post-surgery. *The CCGs will not fund surgery for cosmetic reasons for asymptomatic Hallux Valgus*
Hernias	**This policy is for age 18 and above only. Recurrent hernia is not in scope.** **Amendments include:** **Inguinal Hernia/ Umbilical Hernia Repair:** • Pain/ symptoms interfering with activities of daily living, • Pain during strenuous activity, • Significantly increasing in size (assessed by GP follow up or reported history). **Incisional Hernia:** • Pain/ symptoms interfering with activities of daily living AND conservative management (e.g. weight loss, has been tried first where appropriate), • Threatened strangulation, • Hernia repair using Strattice Mesh will not be funded
Hysterectomy for Heavy Menstrual Bleeding	**The CCG will not routinely fund laparoscopic hysterectomy or open hysterectomy for dysfunctional uterine bleeding**. Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated, or have been declined by the patient.
Primary Hip Replacement(no more Oxford Scores)	**Oxford scores replaced by healthwise resources**.- **Arthritis – Should I have hip replacement surgery?** https://public.coastalwestsussexccg.nhs.uk/hip-decision-tool Highlights the need for shared decision making process not simply a presumed discussion. There is also more detailed information on conservative management.
Primary Knee Replacement (no more Oxford Scores)	**Oxford scores replaced by healthwise resources- Arthritis Should I have knee replacement surgery?** https://public.coastalwestsussexccg.nhs.uk/knee-decision-tool Highlights the need for shared decision making process not simply a presumed discussion. There is also more detailed information on conservative management.
Reduction Mammoplasty	**No longer IFR but procedure with restriction. Must fulfil all the following criteria:** • Documented on-going physical symptoms of back, neck and/or shoulder pain due to large breasts (plus documented evidence for treatment of pain). • Requires more than 500g tissue to be removed from each breast (to be assessed by the surgeon). • BMI<26kg/m2 • Non-smoker. • Breast development is complete (documented for at least 18 months). **Secondary care pathway** *This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer.*
Removal of Benign Skin Lesions	Highlights the need for DLQI test and includes tools and instructions. This policy also applies to Primary Care LCS
Rhinoplasty/ Septorhinoplasty	**Criteria expanded to include:** • Correction of nasal deformity causing severe nasal blockage, OR, • Correction of nasal deformity associated with recognised facial congenital disorders, unless this is the commissioning responsibility of NHS England. *''severe nasal blockage - severe symptoms significantly impacting on daily life"* ***AND/OR*** *50% reduction in bilateral flow*

Tonsillectomy	**Additional criteria includes:** • Obstructive sleep disordered breathing in people aged under 16 demonstrated by accepted method of diagnosis including sleep study, which impacts on development, behaviour and quality of life • Obstructive sleep - disordered breathing in people aged 16 and over • Description of instances where it will be funded for sleep apnoea *And also highlights that Shared decision making tools should be used in discussions between patients and their healthcare professionals about management options before referral to surgery and in Acute care before deciding to have surgery.*
Trigger Finger	**Criteria expanded to include:** • The patient is suffering from significant functional impairment.***Patients with Trigger Finger AND Inflammatory Arthritis:** The CCG will agree to fund surgical intervention for trigger finger where the: • Patient has been diagnosed with inflammatory arthritis, AND, • There is a joint agreement by the patient's Rheumatoid Arthritis Consultant and Hand Surgeon that their trigger finger is unlikely to be corrected by conservative treatment. This needs to be documented in the patient's medical record through relevant clinic letters.
Varicose Veins	**Trial of compression stockings not included in the criteria** Interventional treatments for varicose veins will only be funded for patients who have ANY one of the following: • Bleeding varicose veins; OR • Significant Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency; OR • Superficial vein thrombosis (characterized by the appearance of hard, painful veins) and suspected venous incompetence; OR • A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks); OR • A healed venous leg ulcer
(To be reworded/amended or reviewed as part of Tranche 3) Policies	
Arthroscopy of the Hip	Moved to Tranche 3
Assisted Conception & Fertility Preservation	Falls under Tranche 3
Bariatric Surgery & Revision of Bariatric Surgery	CWS's policy is interim, final policy will fall into Tranche 3 policy set
Blepharoplasty	Moved to Tranche 3
Botulinum Toxin injections	CWS amending to include Cervical Dystonia
Brow Ptosis	Moved to Tranche 3
Cataract	Moved to Tranche 3
Dupuytren's Surgery	Moved to Tranche 3
Female Sterilisation	CWS rewording
Lumbar Epidurals	Moved to Tranche 3