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Prior Approval Policy

including

Procedures of Limited Clinical Value (PLCV)

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NHS in Lincolnshire
Prior Approval Policy

Version Control Sheet

Version	Section/Para /Appendix	Version/Description of Amendments	Date	Author/Amended by
1	Document created	Version 1	29 January 2010	Andrew Rix
2	Revised document	Version 2	9 June 2011	Andrew Rix
3	Revised document	Version 3	25 April 2012	Andrew Rix
4		Version 4	1 April 2015	
5		Version 5		
		Version 6	19 Dec 2016	
		Version 7		
7.1	All sections	Reviewed and amended for clarity	October 2017	Sarah Brinkworth
7.2		Removed reference to procedures which fall under the remit of NHS England	January - March 2018	Pat McClenaghan
7.3	Section 1	Amended Abdominoplasty (Appx 1)		
		Added Divarication for Recti (Appx 1a)		
		Amended Gynaecomastia (Appx F)		
	Section 3	Amendment to Blephroplasty criteria		
		Tonsillectomy moved from section 4 to section 3 and amended to include criteria for children with COPD – Require Prior Approval		
		Acupuncture wording revised		
	Section 4	Insert further procedures – Bunions, & Spinal Injection, Shoulder Decompression, Gallstones		
		Moved criteria for Obesity from Section 3 to Section 4		
		Added criteria for Adenoidectomy		
		Moved criteria for Autologous Cartilage Removal to Section 4		
		Added criteria for Therapeutic		

		Knee Arthroscopy		
		Amended criteria for Hernia		
	Section 5	CSS amendment		
	Section 6	New Section added – Procedures not normally commissioned		
		Version 7.1		
	Section 1	Amended Appx G-Sebaceous Cyst	1 Aug 2018	Pat McClenaghan
		Version 8		
	ALL SECTIONS	Revised to reflect NHSE EBI Guidance	March 2019	Pat McClenghan Andrew Rix Kasia Pisarska Kakoli Choudhury
		Reorganised Policy into Specialities to make it easier for Healthcare Professionals to read.		
		Revised CSS Section to reflect NHSE EBI Guidance		
		Other minor changes for clarity		
		Removed reference to procedures which fall under remit of NHSE		

Prior Approval Policy – NHS in Lincolnshire

NHS in Lincolnshire Prior Approval (PA) Policy

Policy Statement

Background

In 1995 the *Low Priority Procedures* policy was introduced to the NHS in Lincolnshire as a first step in ensuring that the NHS only commissioned evidence based and clinically effective services.

Subsequent initiatives, such as the Community Surgery Scheme (CSS) continued the move towards using the allocated budget as effectively as possible by enabling patients to be treated in the least intensive and least costly setting for selected procedures.

Over the years all of the policies that have been developed to serve these aims have been reviewed and refined. NHS England has recently undertaken an evidenced based review of a number of procedures which have been out to Public Consultation and the Policy is re-issued to take note of this National Guidance.

https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

The 4 Clinical Commissioning Groups (CCGs) (Lincolnshire East CCG, Lincolnshire West CCG, South West Lincolnshire CCG and South Lincolnshire CCG) which make up the NHS in Lincolnshire have reviewed their position for 2019/20 with regard to a selected portfolio of procedures it wishes to commission.

This approach is aligned to the national *Right Care* programme. http://www.rightcare.nhs.uk/

Statement

The document sets out to make explicit the position of the NHS in Lincolnshire with regard to which treatments will, or will not be, commissioned from providers and the criteria and thresholds to be applied and should be read in conjunction with the NHS in Lincolnshire 'Commissioning Policy for the Management of Individual Funding Requests'.

It further sets out the process to be followed should a Provider wish to undertake a treatment, or where a clinician wishes to refer to a Provider, which is not commissioned to provide the treatment.

Treatments and services referred to in this Policy should not be undertaken or provided without prior approval being obtained or as indicated. Where prior approval has not been appropriately obtained, then any treatments or services provided will not have been legitimately delivered, and will not be paid for by the responsible Clinical Commissioning Group.

The list is not exhaustive and it should not be assumed if something is not included in this policy that the treatment may be undertaken.

Treatments which fall under the remit of NHS England do not form part of this Policy. The NHS in Lincolnshire reserves the right to challenge activity and require the provider to correct charging. The legal position being GC15 and the NHS Standard Contract.

Where we buy services in collaboration we recognise the substantive PLCV Policy in the coordinating commissioner contract to which the NHS Lincolnshire CCGs are signatories and request that the provider takes regard for the NHS Lincolnshire policy document.

The Commissioners reserve the right to undertake audit of procedures listed to ensure that the criteria are met. This will be by agreed sample size and if audit demonstrates criteria are not met then the activity will not be paid for.

Responsibilities

The strategic responsibility for the implementation, delivery, monitoring and review of the PA Policy is led by South Lincolnshire Clinical Commissioning Group on behalf of all the CCGs which make up the NHS in Lincolnshire.

The Operational responsibility for the management and delivery of the Policy sits with the Individual Funding Request Team, Arden and GEM CSU as designated by the NHS in Lincolnshire.

Dissemination

The policy will be distributed to all providers via the contracting route as it will set out what will and will not be commissioned.

Resource implication

There are no additional resource implications associated with implementation of the policy

EQUALITY STATEMENT

The NHS in Lincolnshire is committed to ensuring equality of access and non-discrimination for all its registered population. People who need help to access NHS services are advised to contact Patient Advice & Liaison Service (PALS), who deliver information, advice, support and advocacy services and aim to support people who face difficult issues and want to make their voice heard. This is a free, independent and confidential service. They can be contacted on 0300 123 9553 (charged at local rate) or email: LHNT.LincsPALS@nhs.net. Calls may also be made by Text Relay.

1. Introduction

The NHS in Lincolnshire exists to serve the needs of all of its patients but also has a statutory duty financially to break even (National Health Service Act 2006). Clinical Commissioning Groups are established under the Health and Social Care Act 2012 ("the 2012 Act"). The 4 Clinical Commissioning Groups (CCGs) are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 ("the 2006 Act"). The duties of the Clinical Commissioning Group to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations under that provision. The Clinical Commissioning Group has a responsibility to provide health benefit for the whole of their population, whilst commissioning appropriate care to meet the clinical needs of individual patients. The CCG receives a fixed budget from the Department of Health and is required to ensure that expenditure does not exceed the aggregate of its allotments for the financial year (See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act). Commissioned services include those provided through primary, secondary and tertiary care NHS providers, the independent sector, voluntary agencies and independent NHS contractors and in house service providers.

The mechanism through which investment and disinvestment decisions are taken is the CCGs Operational Plan in concert with the STP Operational Plan as detailed in the Planning Guidance.

https://www.england.nhs.uk/operational-planning-and-contracting/

The CCG does not expect to make significant decisions outside this process and in particular does not expect to commit significant new resources in year to the introduction of new healthcare technologies (including drugs, surgical procedures, public health programmes) since to do so risks ad hoc decision making and can destabilise previously identified priorities.

The CCGs Operational Plan, and related requirements as referred to above, by its very nature focuses on cohorts of patients with the more common clinical conditions. It cannot meet every healthcare need of all patients in any one clinical group or address the specific needs of patients with less common clinical conditions. The fact that the CCG is not meeting a healthcare need due to resource constraints is an inevitable fact of life in the NHS and does not indicate that the CCGs is breaching its statutory obligations.

Given the longer term financial prospects of the CCG, related to QIPP, and the in funding challenges, it is essential that the CCG seeks to further maximise the number of patients treated within a sustainable financial envelope. This means:

- Only evidence based clinically effective services will be commissioned.
- Patients should be treated in the least intensive and least costly setting.

2. Purpose

The contents of the 'Prior Approval Policy' forms part of the contract between the NHS in Lincolnshire as the Commissioners, and all Providers for the registered population of Lincolnshire as defined in *Who Pays? Determining Responsibility for Payment to Providers.*[1]

The Policy subsumes a number of existing documents into one overarching point of reference. Given this there will be clear signposts to the full documents referred to.

[1] http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

It sets out to make explicit the position of the CCGs with regard to what treatments will, or will not be commissioned from providers and the criteria and thresholds to be applied.

It further sets out the process to be followed should a Provider wish to undertake a treatment, or where a clinician wishes to refer to a Provider who is not commissioned to provide the treatment.

Treatments and services referred to in this Policy should not be undertaken or provided without prior approval being obtained or as indicated. Where prior approval has not been appropriately obtained, then any treatments or services provided will not have been legitimately delivered and will not be paid for by the Commissioner.

3. Contents of This Schedule

This schedule contains the following:

- Principles applied to treatments for which Prior Approval (PA) should be requested Process to be followed:

- Section 1 Policy for Cosmetic Procedures All ages
- Section 2 ENT (Ear, Nose & Throat)
- Section 3 Gastroenterology
- Section 4 General Surgery
- Section 5 Gynaecology & Fertility
- Section 6 Trauma & Orthopaedics
- Section 7 Ophthalmology
- Section 8 Urology
- Section 9 Cardiology
- Section 10 Neurology
- Section 11 Community Surgical Scheme
- Section 12 Treatments not normally commissioned

4. Principles applied to treatments for which Prior Approval should be requested

This policy sets out, as indicated, treatments which should not be provided on one or more of the following grounds:

- Poor or unproven clinical effectiveness
- Poor or unproven cost effectiveness
- Availability of more appropriate treatment alternatives
- Incompatibility with the core purposes and priorities of the NHS
- High cost treatments where only small numbers meeting specific criteria would benefit

It further sets out what treatments can be provided and who is authorised to provide them.

5. Process to be followed

Should an occasion arise when a Provider wishes to provide a treatment for which they are not commissioned or a clinician wishes to refer a patient to such a Provider, then authorisation in the form of Prior Approval should be obtained from the NHS in Lincolnshire. Should the occasion arise where a treatment for which prior approval is required and is undertaken without said prior approval the Commissioner will not retrospectively fund the treatment. Please note the Commissioner reserves the right to audit providers against the criteria set out within this policy and any treatment provided outside of the criteria of the policy will not be funded.

The responsibility to request Prior Approval resides with the clinician who determines or decides which treatment should be provided. As examples:

- Where a GP is seeking treatment included in the list of procedures undertaken by the Community Surgical Scheme (CSS) the GP may refer direct to this service. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP. The GP should then request prior approval for the patient to be treated in secondary care.

- A GP who wishes to have a patient **treated** in secondary care for a procedure on the CSS list should request Prior Approval by setting out a case of need and the reasons why an exception should be made. (i.e. why the patient should be not referred to the CSS).

- A GP who wishes to have a patient treated in secondary care for a procedure contained within the Prior Approval policy should ensure any appropriate criteria has been met, or prior approval obtained before referral to an acute provider.

- A Consultant in Secondary Care receives a referral asking for a review and clinical opinion of a patient. If the Consultant then determines that the patient requires treatment that does not meet criteria listed in the policy or is not a commissioned treatment, then the Consultant should request Prior Approval setting out the case of need and the clinical evidence of effectiveness.

- A Consultant in Secondary Care receives a referral, for which the GP should have requested prior approval before referring; or should have referred to the Community Surgical Scheme, i.e. the referral is not is for clinical opinion. Then the Consultant may reject the referral back to the patient's GP so that the GP may request prior approval or refer into the CSS.

The process to make such a request, on behalf of an individual patient, is detailed in the *CCG's – 'Commissioning Policy for the Management of Individual Funding Requests'.*

The full document can be viewed on the respective CCG web sites:

Lincolnshire East CCG: https://lincolnshireeastccg.nhs.uk/index.php/about-us/policies
Lincolnshire West CCG: http://www.lincolnshirewestccg.nhs.uk/LibraryDocs/prior-approval-policy/
South West Lincolnshire CCG: http://southwestlincolnshireccg.nhs.uk/about-us/policies
South Lincolnshire CCG: https://southlincolnshireccg.nhs.uk/about-us/policies/clinical-governance

Individual Funding Requests must be submitted to the Individual Funding Request Team at Arden and GEMCSU using the IFR Treatment Request Form (Appendix C) or by submission of full details in letter format.

It is the responsibility of the referring clinician to ensure that they obtain the patients' explicit consent to share information with the IFR Team or other Healthcare Professionals for the purpose of processing any submitted request.

If a clinician wishes to discuss whether submission of a Treatment Request Form is appropriate, or would like help with completing the Treatment Request Form, then they should contact the team on 01522 515384 for further advice.

All requests should be submitted via hand, post, or e-mail to

Individual Funding Requests
Arden and GEMCSU
Cross O'Cliff
Bracebridge Heath
Lincoln LN4 2HN
Tel: 01522 515384
agcsu.ifrlincs@nhs.net

Section 1 – COSMETIC PROCEDURES

COMMISSIONING POLICY
FOR COSMETIC PROCEDURES
(ALL AGES)

April 2019

Content Cosmetic Policy

1. Scope

The policy identifies procedures that the CCGs consider to be primarily cosmetic and which have relatively small health benefits compared to other competing priorities for limited NHS resources. It will be applied in conjunction with the Commissioning Policy for Management of Individual Funding Requests (IFRs) and reflects the principles set out in the CCGs' Operational Plan.

The Commissioning Policy for Cosmetic Procedures sets out both cosmetic procedures that are not normally commissioned and those that are only commissioned when certain criteria are met. The criteria have been decided based on clinical evidence and clinical expert opinion.

This section incorporates criteria as detailed in 'Evidence Based Interventions; Guidance for CCGs'

https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

2. Definitions

The term 'cosmetic procedure' covers both 'cosmetic surgery' and 'non-surgical cosmetic treatments'.

The term 'cosmetic surgery' means surgical procedures that revise or change appearance, colour, texture or position to achieve a desire of a patient for bodily features that are perceived to be more desirable.

The term 'non-surgical cosmetic treatments' means other procedures that revise or change appearance, colour, texture or position to achieve a desire of a patient for bodily features that are perceived to be more desirable.

Unless explicitly indicated otherwise, adult means person aged 19 years or over on the date of initial referral. Child/children/young person is defined as person(s) aged 18 years or younger on the date of initial referral.

3. Exceptionality

The NHS in Lincolnshire will consider individual cases for funding outside this commissioning policy in accordance with the CCG's Individual Funding Request Policy which sets out a decision making framework for determining these cases. For an IFR request to be considered, it must first be demonstrated that the patient fulfils the strict criteria for exceptionality. Determination of this focuses on the following issues:

- Are there any clinical features of the patient's case which make the patient significantly different to the general population of patients with the condition in question at the same stage of progression of the condition?
- Would the patient be likely to gain significant more benefit for the requested intervention that might be normally expected for the general population of patients with the condition at the same time of the progression of the condition

4. Cosmetic surgery and non- surgical cosmetic treatments not commissioned (all require Prior Approval)

The following procedures are not commissioned unless the treatment is: post-trauma, part of reconstruction following surgery (e.g. for cancer), part of the management of a congenital abnormality which results in a serious health function deficit, or for an iatrogenic condition arising from treatment previously delivered within the NHS.

- Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm or other areas
- Facelifts - unless part of the treatment of facial nerve palsy/congenital facial abnormalities/ treatment of specific facial skin condition (e.g. cutis laxa, pseudoxanthoma elasticum)
- Fat grafts except in post-trauma cases and/or as part of planned reconstruction surgery (e.g. for cancer)
- Suction assisted lipectomy (liposuction) except as part of planned reconstruction surgery (e.g. for cancer or a congenital syndrome)
- Labiaplasty, vaginoplasty and hymen reconstruction, Phalloplasty
- Chin implant (genioplasty, mentoplasty) / Cheek implants except in post-trauma cases and/or as part of planned reconstruction following surgery (e.g. for cancer)
- Collagen implant except in post-trauma cases and/or as part of planned reconstruction following surgery (e.g. for cancer)
- Cranial banding for positional plagiocephaly
- Earlobe repair, unless there is a complete tear of the lobe as a result of unexpected trauma (not partially split lobes or elongated holes in lobes)
- Botulinum Toxin for the following indications: wrinkles, frown lines, ageing neck
- Resurfacing by laser for skin conditions causing scarring - including post-acne and post-traumatic scarring
- Correction of nipple inversion
- Mastopexy (breast uplift) except where the criteria in Appendix B, C or D are fulfilled
- Procedures related to gender reassignment not included in the original package of care
- Hair depilation (removal) for excessive hair growth (hirsutism)
- Laser treatment for facial hyperpigmentation unless meets the criteria in Appendix F
- Electrolysis treatment for any condition
- Scar reduction unless it meets the criteria in Appendix L
- NB; Any other cosmetic procedure that is not mentioned within this policy is not routinely commissioned by the CCGs.

5. Cosmetic surgery and non-surgical cosmetic treatments that are commissioned when certain criteria are met

The following procedures are only commissioned by the NHS in Lincolnshire when specific criteria are met:

- Appendix A – Abdominoplasty
- Appendix B – Diastases/Divarication of Recti
- Appendix C– Breast Reduction
- Appendix D– Breast Reduction for Asymmetric Breasts
- Appendix E– Breast Surgery for developmental failure
- Appendix F– Breast Implant removal/reinsertion
- Appendix G– Male Breast reduction Surgery for Gynaecomastia
- Appendix H– Surgical Removal of Benign Skin Lesions
- Appendix I– Laser Treatment
- Appendix J– Botulinum Toxin treatment for Axillary Hyperhidrosis
- Appendix K– Septo-Rhinoplasty or Rhinoplasty
- Appendix L– Blepharoplasty/Brow Lift
- Appendix M –Scar Reduction
- Appendix N - Pinnaplasty (“correction” of prominent ears)

5. Eligibility for Specific Procedures

Procedure	Eligibility Criteria	Instructions for Referrer
Appendix A - Abdominoplasty (Apronectomy/ Panniculectomy)	The Commissioner will only fund abdominoplasty (irrespective of the cause of the apron or reason for previous weight loss) when ALL the following criteria are met: 1. Sexual maturation has been reached. (Normally 16 yrs or over and is post pubertal. 2. An abdominoplasty/apronectomy has not already been performed 3. Body Mass Index (BMI) as measured by the NHS is between 18 and ≤27.0 and has been within this range for 1 year as measured and recorded by the NHS. 4. Confirmed non-smoker and/or documented abstinence prior to procedure 5. Photographic evidence 6. Functionally disabling resulting in severe restrictions in activities of daily living[2] Surgical outcomes (e.g. wound healing, complications etc.) can be adversely affected by smoking. To ensure the best outcomes, patients should have stopped smoking prior to surgery. Smoking status may be validated at pre-operative appointment using an appropriate test. Support to stop smoking is available to patients through a range of NHS stop smoking services.	**Requires Prior Approval together with:** • Details of condition • BMI and period maintained • Smoking status • Clinical evidence of functional disablement resulting in severe restrictions in activities of daily living • Clinical photographs.

[2] *For the purposes of this policy, activities for daily living covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food).*

Appendix B - Divarication of Recti/Diastases	The Commissioner considers repair of divarication of recti/diastases as a cosmetic procedure and it is not normally commissioned. Where a Consultant believes there are exceptional circumstances then submission of an Individual Funding Request is required. Any request would be considered in line with the eligibility criteria for abdominoplasty. **Divarication of recti** is a condition where the abdominal muscles become separated in the middle. The condition is relatively common and asymptomatic, although patients may be unhappy with the appearance of their abdomen, it does not lead to any complications that require intervention. This condition does not carry the risks that are associated with actual hernias and repairs are primarily cosmetic. **Rectus Diastases** is repair through the surgical technique of an abdominoplasty, or tummy tuck. The skin is lifted near the pubic hair and elevated to the level of the xipoid. The muscle is tightened in the midline where the tissue has been stretched by pregnancy. Such request is deemed to be the same as abdominoplasty and will be considered in line with the eligibility criteria for abdominoplasty.	**Requires Prior Approval together with:** • Details of condition • BMI and period maintained • Smoking status • Clinical evidence of functionally disabling resulting in severe restrictions in activities of daily living • Clinical photographs

APPENDIX C – BREAST REDUCTION	Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life. The NHS will only provide breast reduction for women if ALL the following criteria are met: • The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. • cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes (Assessment can be supported by a 3D Body Scan - Breast size is =1000cc per breast and Ratio of combined breast volume to adjusted torso volume is equal to or greater than 13% as measured by 3D body scan**) • Body mass index (BMI) is <27 and stable for at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes	**Required Prior Approval together with** **1. Details of Condition** **2. BMI and period maintained** **3. Smoking Status**

	This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment. ** The 3D body scan will be arranged by the IFR Team where all other criteria are met	

Appendix D – Breast Reduction for Asymmetric Breasts	Unilateral breast reduction will only be considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria below. Surgery will not be funded for cosmetic reasons The NHS will only provide/consider unilateral breast reduction for asymmetric breasts women if ALL the following criteria are met: • The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. • cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Unilateral Breast reduction may be approved for a difference of 150 – 200grams. To assist in the assessment the CCG will refer the patient for a 3D body scan. Where asymmetry is greater than 30% difference in volume between the breast the patient may be referred. • Body mass index (BMI) is ≤27 and stable for at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. • Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation. Resection weights, for bilateral or unilateral (both breasts or one breast) breast	**Requires Prior Approval together with** 1. Details of developmental failure/condition 2. Current BMI and length maintained. 3. Smoking Status

	reduction should be recorded for audit purposes This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.	

Appendix E -Breast Surgery for Developmental Failure	The Commissioner will only consider breast augmentation where there is complete developmental failure resulting in Unilateral or bilateral absence of breast tissue OR to correct breast asymmetry due to trauma or as a results of cancer treatment (mastectomy or lumpectomy) that results in a significant deformity	**Required Prior Approval together with** **1. Details of developmental failure**
Appendix F - Breast Implant removal/Reinsertion	The Commissioner will fund the removal of breast implants for any of the following indications in patients who have undergone cosmetic augmentation mammoplasty that was performed either in the NHS or privately: 1. Breast disease 2. Implants complicated by recurrent infections 3. Implants with capsule formation that is associated with severe pain 4. Implants with capsule formation that interferes with mammography 5. Intra or extra capsular rupture of silicone gel-filled implants For women whose breast implants are removed in strict compliance with the criteria above AND whose original surgery was funded by the NHS, the commissioner will also fund insertion of replacement implants. The commissioner will not fund the insertion of replacement implants where the original surgery was funded privately. The commissioner will NOT fund or part fund procedures undertaken in the private sector, irrespective of whether part of that procedure involves removal of a breast implant.	**Requires Prior Approval together with** • Details of Condition • Responsibility for implant operation • Smoking Status

Appendix G - Male Breast reduction Surgery for Gynaecomastia	Gynaecomastia is not routinely funded by the NHS. We do not routinely fund for idiopathic gynaecomastia in men Where gynaecomastia is caused by medical treatment such as prostate cancer an IFR may be considered where BMI is ≤27.0 and there is evidence of functional issues. Suspicious breast lumps should be referred via the 2ww.	**Requires prior approval together with** • Results of endocrine testing/drug related causes • Details of condition • Current BMI and length of time maintained • Smoking Status • Clinical Photographs • Confirmation of non-surgical treatments tried.

Appendix H- Surgical Removal Benign Skin lesions	This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services. Removal of benign skin lesions will not normally be funded by the NHS for cosmetic purposes. Treatment carries a small risk of infection, bleeding or scarring. Surgical removal or cryotherapy of benign skin lesions will only be funded where there is recurrent bleeding, rapid growth or other features suspicious of trauma leading to bleeding. Where there is diagnostic certainty for the following conditions: • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • Dermatofibroma • Milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata **AND where at least ONE of the following criteria are met:** • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain	PATHWAY: CROSS REFERENCE TO THE COMMUNITY SURGICAL SCHEME (CSS) LIST for lesions <1.5cms but <2.5cms Where the procedure is treated in CSS the GP should not make a Direct Referral to Secondary Care and Secondary Care should not accept any referral without Prior Approval having been provided. Lesions is <1.5cm these should be treated under Minor Surgery. Prior Approval is required if the GP wishes to refer to secondary care for lesions <1.5cm and the GP need to provide the following information: • DETAILS OF CONDITION • CLINICAL PHOTOGRAPHS.

	• The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function eg restricts joint movement • The lesion causes pressure symptoms eg on nerve or tissue • If left untreated, more invasive intervention would be require for removal Exclusions: • Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines. • Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care. Epididymal Cysts The following procedures form part of the GP contract and are not commissioned from CSS. • Skin Tags & Papillomas • Viral warts If these criteria are not met then prior approval is required.	

Appendix H – Benign Skin Lesion - LIPOMA	Removal of Lipoma will not normally be funded by the NHS for cosmetic purposes. Treatment carries a small risk of infection, bleeding or scarring. Lipoma <5cm should be observed only using the SIGN Sarcoma Guidelines Surgical removal of lipoma >5cm will only be funded where at least one of the following criteria are met: • The lipoma causes regular pain • The lipoma is obstructing an orifice or impairing field vision • The lipoma significantly impacts on function eg restricts joint movement • The lipoma causes pressure symptoms eg on nerve or tissue • If left untreated, more invasive intervention would be require for removal Lipomas on the body > 5cms, or in a sub-facial position, which have shown rapid growth and/or are painful should be referred to an appropriate Sarcoma clinic.	**Requires prior approval together with:** • Details of condition • Size of lesion • Evidence of functional /trauma. **UNLESS SUSPICION OF MALIGNANCY IN WHICH CASE REFER TO 2WW CLINIC**
Appendix H – BENIGN SKIN LESION - Congenital pigmented lesions on the face (to be read in conjunction with Appendix H – Laser Treatment)	The commissioner will fund treatment of congenital pigmented lesions on the face only if ALL of the following criteria are met: • The patient is aged less than 18 years at the time of referral, and • The child (not just the parent/carer) expresses concern, and • The lesion is located on face, and • The lesion is at least 1cm in size.	**Requires prior approval to include:** Details of condition • Size of lesion • Age.

Appendix I – Laser Treatment	The Commissioner will **only fund** laser treatment for the following conditions where there is evidence of functional problems experienced: *a.* Port wine stains - on the face only (not scalp or neck*) only where the criteria in Appendix G – Congenital pigmented lesion is met.* b. Extensive and severe iatrogenic telangiectasia c. Congenital pigmented lesions on the face d. Rare genodermatosis e.g. Tuberose Sclerosis e. Translocation of hair bearing skin during surgery but NOT for excessive hair growth (hirsutism) f. Intractable and recurrent pilonidal sinus g. Tattoo removal and only if one of the following two criteria is met: i) Result of trauma inflicted against the will of the patient (rape tattoo) where referral for removal has been sought within one year of the tattoo being performed, or -ii) Iatrogenic e.g. radiotherapy tattoo and dirt tattoo.	**Requires prior approval to include:** • Details of condition • Clinical Photographs

Appendix J – Botulinum Toxin Treatment for Axillary Hyperhidrosis	The Commissioner will only commission Botulinum Toxin treatment for axillary hyperhidrosis when ALL of the following criteria are met: 1. The underarm sweating is intolerable and results in severe restrictions in activities of daily living. Documented evidence of medical complications due to hyperhidrosis, ie skin maceration with secondary skin infection. 2. Documented evidence that the patient has regularly applied for a six month trial the following treatments and is either not tolerated, or ineffective in reducing the severity of symptoms to a level where the condition is tolerable and only sometimes interferes with daily activities: A. topical therapy (aluminium chloride 20% or extra strength antiperspirants Driclor, Anhydrol Forte (OTC). B. Second Line: Oxybutynin 2.5 – 5mg twice daily (off label/unlicensed) 3. Gravimetric assessment to quantify axillary sweat production results in 100mg or more per axilla per 5 minutes 4. Further treatment will only be offered in the context of a positive starch iodine test 5. The interval between subsequent treatments will be a minimum of 6 months (Palmar hyperhidrosis may require endoscopic sympathectomy (TECS) if it results in severe restrictions in activities of daily living and topical treatment (Aluminium Chloride 20% - Driclor; Anhydrol Forte) has been regularly applied for four weeks and is either not tolerated, or ineffective in reducing the severity of the symptoms to a level where the condition is tolerable and only sometimes interferes with daily activities).	**Requires prior approval to include:** • Details of condition • Confirmation First line topical therapy has taken place

Appendix K – Septo-Rhinoplasty or Rhinoplasty	The Commissioner will only fund septo-rhinoplasty or rhinoplasty when one, or more, of the following indications are present: 1. Continuous nasal airway obstruction that results in significantly impaired nasal breathing associated with septal or lateral nasal wall deformities or vestibular stenosis. This includes post-traumatic deformity (as demonstrated by pre and post trauma photographic evidence), or significant congenital deformity (such as cleft palate) 2. Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy)In each case the following criteria should be met: • Obstructive symptoms persist despite conservative management for three months or longer, • Where there is an external nasal deformity , preoperative photographs showing the standard 4-way view – base of nose, anterior-posterior, and right and left lateral views • Relevant history of accidental or surgical trauma, congenital defect or disease • Documentation of duration and degree of symptoms related to nasal obstruction. • Documentation of results of conservative management of symptoms.	**Requires prior approval to include:** Details of condition Clinical Photographs.

Appendix L- Blepharoplasty/Brow Lift	Lincolnshire commissioners will commission blepharoplasty or brow lift only if the following criteria are met: 1. Excess tissue or drooping (ptosis) of the brow/ upper eyelid causing functional visual impairment such as difficulty reading or driving due to upper eye lid drooping, looking through the eyelids or seeing the upper eyelid skin AND 2. There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead AND 3. Visual field test shows that eyelid impinges on visual fields – see notes in column **OR** To repair defects predisposing to corneal or conjunctival irritation: a) Entropion or ectropion a) Periorbital sequelae of thyroid disease or nerve palsy or trauma b) Prosthesis problems in an anophthalmia socket c) Painful symptoms of blepharospasm	**Requires prior approval to include:** • Details of condition • Confirmation of the visual field defect, confirming that the eyelid impinges on visual fields reducing field to either 120° laterally and or 40° vertically in the relaxed non-compensatory state. To be assessed in normal position and again with the lid taped up in order to demonstrate that it is the droopy lid causing the field defect • Clinical Photographs

Appendix M – Scar Reduction	The Commissioner will fund repair of or injection/application of topical treatment for keloid scars that result from burns, trauma, keloid formation or surgery when one or more of the following clinical criteria are met: 1. Scar is functionally disabling, OR 2. Scar results in facial disfigurement which causes functional disability. Scar revision will not normally be funded to improve cosmetic appearance.	**Required prior approval together with:** • Details of condition • Evidence of functional disability
Appendix N - Pinnaplasty ("correction" of prominent ears)	The Commissioner will fund surgical "correction" of prominent ear only when all of the following criteria are met: • Referral only for children aged 5 to 18 years at the time of referral, AND • With very significant ear deformity or asymmetry, AND • Where the child (not just the parent/carer) expresses concern. Patients not meeting these criteria should not routinely be referred by the GP for medical opinion.	**Requires prior approval together with:** Details of condition Age Smoking status Clinical photographs

Section 1: Glossary

Word/abbreviation	Meaning
Abdominoplasty/apronectomy	A 'tummy tuck,' which is an operation that is performed to improve the shape of the abdomen. (http://www.bapras.org.uk/guide.asp?id=240).
Acrochordon (Skin Tags)	
Auxiliary hyperhidrosis	Excessive sweating from the armpits. (http://www.medterms.com/script/main/art.asp?articlekey=39657).
Benign heamangiomas	**benign tumours of the vascular epithelium and soft tissues.**
Breast asymmetry	Breast unevenness.
Commissioning	Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. (Taken from www.dh.gov.uk).
Congenital	Condition that is present at birth. (http://www.medicinenet.com/script/main/hp.asp).
Cryotherapy	Treatment by freezing. (http://www.cehjournal.org/0953-6833/10/jceh_10_22_026.html).
Dysplasia	Abnormal development of cells, tissues or structures in the body. (Black's Medical Dictionary, 42nd Edition).
Granuloma	A collection of immune cells known as histiocytes
Facial hyper pigmentation	A change of skin pigmentation.
Functionally disabling	This defines a disability as any long-term limitation in activity resulting from a condition or health problem. This is the World Health Organisation (WHO) definition.
Genodermatosis	A genetic disorder of the skin (http://medical-dictionary.thefreedictionary.com/genodermatosis).
Gynaecomastia	An abnormal increase in size of the male breast. (Black's Medical Dictionary,

Word/abbreviation	Meaning
	42nd Edition).
Individual Funding Request (IFR)	This is the process by which a clinician may request special funding on the grounds that the patient represents a clinical exception (for further definition of the strict criteria applying to this, please refer to the Commissioner's IFR policy.
Labiaplasty (reduction of labia minor).	A surgical procedure to reshape the inner lips of the vagina. (www.bapras.org.uk/page.asp)
Lipodermatosclerosis	This is a skin change of the lower legs that often occurs in patients who have venous insufficiency. It is a type of inflammation of subcutaneous fat. (http://www.dermnetnz.org/vascular/lipodermatosclerosis.html).
Lipoma	A tumour mainly composed of fat. Such tumours occur in almost any part of the body, developing in fibrous tissue – particularly in that beneath the skin. They are benign (non-cancerous) in nature. (Black's Medical Dictionary, 42nd Edition).
Moles (Acquired naevi)	A brown lesion of the skin, sometimes raised which can in certain circumstances become malignant
Molluscum contagiosum	A chronic viral disorder of the skin characterised by groups of small, smooth painless pinkish nodules with a central depression that yield a milky fluid when squeezed.
Otoplasty	Correction of large /protruding ears.
Papillomas	Excess skin to form a tumour. Non-cancerous papillomas are common in the skin and are sometimes viral in origin. (Black's Medical Dictionary, 42nd Edition).
Phalloplasty	Plastic surgery of the penis or scrotum. (http://mw4.merriam-webster.com/medical/phalloplasty).
Positional plageocephaly	This is a disorder that affects a baby's skull, making the back or side of the baby's head appear flattened. (http://www.ich.ucl.ac.uk/gosh_families/information_sheets/plagiocephaly/plagiocephaly_families.html).
Prophylactic mastectomy	Prophylactic mastectomy is surgery to remove one or both breasts to reduce the risk of developing breast cancer. (http://www.breastcancer.org/treatment/surgery/prophylactic_mast.jsp).
Skin Tags/Papilloma	are a small benign tumour that forms primarily in areas where the skin forms creases, such as the neck, armpit and groin. They may also occur on the face, usually on the eyelids. They are harmless and typically painless and do not grow or change over time.

Word/abbreviation	Meaning
Seborrhoeic warts/Keratosis	Non cancerous benign skin growth that originate in keratinocytes – Yellow/brown, greasy or rough grey/black hyperkeratotic papule with stuck on appearance.
Telangiectasia/Spider angiomas (spider veins)	A cluster of minute red blood vessels visible under the skin
Thrombophlebitis	Swelling (inflammation) of a vein caused by a blood clot. (http://www.nlm.nih.gov/medlineplus/ency/article/001108.htm).
Viral warts	small, hard, benign growth on the skin caused by a virus
Xanthelasma	Yellow smooth nodules of lipid laden cells that occur in and around the eyelids. (Black's Medical Dictionary, 42nd Edition).

SECTION 2 – ENT (EAR, NOSE & THROAT)

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Snoring	Snoring (Uvulopalotopharyngoplasty, Laser Assisted Uvuloplastoplasty & Radiofrequency ablation of palate) Treatment of simple snoring (ie in the absence of sleep apnoea) is not usually harmful to health, and is regarding as being primarily for social rather than medical benefit and thus it is not routinely commissioned. There is limited clinical evidence of effectiveness but there are significant risks to patients. There are a number of alternative that can improve snoring, weight loss, stop smoking, reduce alcohol intake, medical treatment for nasal congestion, purchasing a mouth splint.
Tonsillectomy (If clinically indicated then adenoidectomy may be undertaken at the same time as tonsillectomy)	The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance: • Sore throats are due to acute tonsillitis AND • The episodes are disabling and prevent normal functioning AND • Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year OR • Five or more such episodes in each of the preceding two years OR • Three or more such episodes in each of the preceding three years. There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:

	• Acute and chronic renal disease resulting from acute bacterial tonsillitis. • As part of the treatment of severe guttate psoriasis. • Metabolic disorders where periods of reduced oral intake could be dangerous to health. • PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis) • Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous Further information on the Scottish Intercollegiate Guidelines Network guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include: □ Obstructive Sleep Apnoea / Sleep disordered breathing in Children *(see separate section below)* □ Suspected Cancer (e.g. asymmetry of tonsils) □ Recurrent Quinsy (abscess next to tonsil) □ Emergency Presentations (e.g. treatment of parapharyngeal abscess) It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future.
Tonsillectomy for children <16 with obstructive sleep disordered breathing (sleep apnoea) (If clinically indicated then adenoidectomy may be undertaken at the same time as tonsillectomy)	Sleep disordered breathing ranges from simple snoring to obstructive sleep apnoea. Patients with suspected severe apnoea should be referred for urgent specialist assessment. For all other patients GP to assess: • Does the patient have simple snoring or a disruptive pattern of sleep. Patients with simple snoring should not be referred to secondary care for consideration of tonsillectomy. • Documented evidence of nasal obstruction and size of tonsils • Documented impact on development, behaviour and quality of life (eg height & weight, hyperactivity, daytime somnolence)

	• Where there is evidence of obesity as a cause of sleep disordered breathing the patient should be referred for weight management If there are ongoing concerns about obstructive sleep disordered breathing then the patient may be referred to secondary care for assessment: • The Consultant will reassess the patient's clinical history and examination and if available recording of the patient's sleep. • Consult with the parent/guardian about the management options using shared decision making strategies and tools where appropriate If there is clear obstructive sleep apnoea then the patient may be considered for tonsillectomy
Tonsillectomy – Coblation	Requires PA
Tonsillectomy for treatment of Tonsilloths	The CCG will not normally fund. Submission of an Individual Funding Request would be required in exceptionality

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Adenoidectomy (where tonsillitis is not the primary condition)	Children 12 years of Age and under The CCG will fund treatment with grommets with/without adenoidectomy as a single episode of care for children under 12 years of age with persistent bilateral otitis media with effusion (OME) where any one of the following criteria apply: • The hearing level in the better ear is 25-30 dBHL (decibels hearing level) or worse averaged at 0.5, 1.2 and 4kHz (or equivalent dBA where dBHL is not available). This should be confirmed on two occasions separated by 3 months or more (results of initial formal testing and tests done after at least three months should be included in the referral letter. • The child has persistent bilateral OME with a hearing level less than 25-30 dBHL where the impact of the hearing loss on the child's developmental or educational status (eg speech delay) has been demonstrated to be significant (evidence to be provided) • A second disability such as Down's Syndrome or cleft palate (insertion of ventilation tube should be offered only as an alternative to hearing aids). • OME is overlaying sensorineural deafness or is delaying diagnosis or treatment with hearing aids or cochlear implants.
CPAP for the treatment of obstructive sleep apnoea / hypopnoea syndrome	Provision in line with the agreed protocols is without the need for PA as per NICE TA 139. All patients who do not meet the guidance criteria require PA. This criteria does not apply to paediatrics or neonates
Grommet Insertion	The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met: • All children must have had specialist audiology and ENT assessment.

	• Persistent bilateral otitis media with effusion over a period of 3 months. • Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz • Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. • Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance. It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum. For further information, please see: https://www.nice.org.uk/Guidance/CG60. The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age). The insertion of grommets or adenoidectomy for otitis media with or without effusion in children older than 12 years of age and adults will not routinely be funded. Submission of an Individual Funding Request is required.

SECTION 3 - GASTROENTEROLOGY

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Cholecystectomy (Gallbladder, gallstones, cholecystitis, biliary colic)	The NHS in Lincolnshire will fund Cholecystectomy for symptomatic gallstones with episodes of: 1. acute cholecystitis or cholangitis; OR 2. biliary colic; OR 3. gall stone induced pancreatitis; OR 4. obstructive jaundice due to gall stones OR 5. Symptomatic or asymptomatic common bile duct stones Surgery for asymptomatic gallstones requires prior approval and will only be funded in exceptional circumstances Note: Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services .
Irritable Bowel Syndrome (Adults)	For context, please refer to NICE CG61 Diagnosis and management of IBS in primary care: http://guidance.nice.org.uk/CG61/QuickRefGuide/pdf/English In the absence of red flag symptoms of malignancy, the following tests will not be funded for confirmation of diagnosis in adults who meet the IBS diagnostic criteria: ultrasound rigid/flexible sigmoidoscopy colonoscopy; barium enema thyroid function test faecal ova and parasite test faecal occult blood hydrogen breath test (for lactose intolerance and bacterial overgrowth)

Obesity / Bariatric Surgery	The following eligibility criteria should be met. Please note that referral to this service is for consideration of an intervention and is not an indication that surgery will be undertaken. Patient is aged 18 years or over Patients with a BMI>50 may be referred direct to a commissioned specialist bariatric service. For Lincolnshire this is normally to Derby Hospitals. Patients with a BMI 40 or more; or BMI 35 but less then BMI 40 in the presence of serious co-morbidity, the patient should have complied with Tier 1,2,3 weight management support both medical and psychological. Evidence that all appropriate and available non-surgical measures, which may include commercially provided weight loss support programmes have been adequately tried for a duration of 12-24 months and sustained weight loss of 5-10% or maintaining constant weight whilst stopping smoking. Patients who lose sufficient weight to fall beneath the NICE guidelines should not be considered appropriate for surgery.

SECTION 4 – GENERAL SURGERY

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Acupuncture	The Commissioner will not normally fund for any medical condition, including migraine and tension/cluster headaches, MSK/Rheumatic pain. Requires prior approval in all cases
Chronic Fatigue Syndrome – Cognitive Behavioural Therapy in the treatment of Chronic Fatigue Syndrome	The Commissioner will not routinely be approved for in-patient treatment. Patients may be referred to the Local Chronic Fatigue Service without prior approval. If a Healthcare Professional wishes to refer outside of this service then prior approval is required.
Complimentary therapies Acupuncture, Chiropractic, Osteopathy, Alexander Technique, Applied Kinesiology, Aromatherapy, Autogenic Training, Ayurveda, Chinese Medicine, Environmental Medicine, Healing, Herbal Medicine, Homeopathy, Hypnotherapy, Massage, Meditation, Naturopathy, Nutritional Therapy, Reflexology, Reiki, Shiatsu Other alternative therapies	The Commissioner will not normally fund. Complimentary medicine/alternative therapies are not generally funded by the NHS. Prior Approval is required and will be considered on a case by case basis by the Individual Funding Request (IFR) Panel. The IFR panel will require proven evidence of effectiveness of the therapy, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners.
Cosmetic Procedures	Any procedure not specifically listed elsewhere in this document that are, by general consensus, viewed as cosmetic in nature require Prior Approval e.g. the removal of non-diseased tissue.
Dialectical Behavioural Therapy	That dialectical behavioural therapy as inpatient treatment be regarded as an inappropriate use of NHS resources, and thus should not be commissioned.
Hernia Repair	The Commissioner will only fund hernia repair where the following criteria are met. For asymptomatic or minimally symptomatic hernia a watchful waiting approach, under informed consent, is advocated.

	Surgical treatment should only be considered when one of the following criteria are met. • Symptoms of pain or discomfort that interfere with activities of daily living OR • The hernia is difficult or impossible to reduce OR • It is an inguino-scrotal hernia OR • The hernia increases in size month on month Patients are to be referred to the Community Surgical Scheme (CSS) by the General Practitioner for the following types of hernia:Primary Inguinal hernia (scrotal hernia) Primary Femoral Hernia Umbilical Hernia Para-Umbilical Hernia Epigastric Hernia Spigelian Hernia If the procedure cannot be undertaken by the Community Surgical Scheme then the Provider should refer the request back to the GP. The GP should then request prior approval for the patient to be treated in secondary care. Exclusion: Incisional hernia and Irreducible recurrent hernia may be referred to secondary care (hospital).
Home Delivery of IV Antibiotics	As part of the move to home delivery of certain drugs may be considered as part of the package of care. Where the patient is discharged on IV antibiotics the arrangements will be made by the discharging hospital and charged either within the contract or a Non Contract Activity (NCA). If the charge is as NCA then notification should be made to the IFR Team who will provide the necessary reference code for payment of invoices.
New treatments and exceptional cases	It is accepted that exceptional clinical situations may arise in year which may require clinicians to consider using innovative and possibly as yet unproven treatments. Where these cannot be covered within existing resources the Trust will continue to discuss the issues with the CCGs and seek PA for funding as appropriate.

Third Medical Opinion	The Commissioners will not commission a third specialist opinion for the same problem; an opinion is considered valid if the clinician has appropriate expertise to advise and manage the presenting problem

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Ankyloglosia (Tongue Tie) and Frenulotomy in infants with feeding difficulties	The CCG will only commission frenulotomy in infants with persistent difficulties in feeding despite appropriate support and counselling from Health Professionals and this has been documented by the referring or treating clinician.
Ankyloglosia (Tongue Tie) and Frenulotomy in a child with speech problems	The CCG will only commission frenulotomy in a child where speech and language therapy assessment confirms that their speech problems are attributable to the tongue-tie.
DRUGS THERAPY	Refer to the Lincolnshire Joint Formulary. If the drug is not included in the Lincolnshire Joint Formulary or the Healthcare Professional wishes to prescribe outside of criteria and where the drug is not the responsibility of NHSE then Prior Approval is required. If the GP wishes to prescribe a drug which is not on the Lincolnshire Formulary it is advised that prior approval is sort. Consultants should adhere in all cases to the Lincolnshire Joint Formulary. If the Consultant wishes to prescribe a drug not currently available or not approved by NICE TA then an IFR is required. http://www.Lincolnshirejointformulary.nhs.uk
EPO	EPO for use in the treatment of myeloma and myelodysplasia – Where treatment in line with NICE TA then it is commissioned and in tariff. Blood related products are NHS England commissioned. Antifibrinolytics e.g. tranexamic acid is CCG commissioned.
Haemorrhoids	Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection. Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically: • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding;

	OR • Irreducible and large external haemorrhoids In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.
Insulin Pumps and consumables	PA is not required for patients who meet all the eligibility criteria set out in NICE Technology Appraisal 151.-CCGs will be charged the cost of the pumps, maintenance and consumables. PA is required for any patient who does not meet the eligibility criteria set out in NICE Technology Appraisal 151.
Surgical Treatment of Varicose Veins	Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery. Refer people to a vascular service if they have any of the following;- 1. Symptomatic * primary or recurrent varicose veins. 2. Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. 3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. 4. A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). 5. A healed venous leg ulcer. 6. Refer people with bleeding varicose veins to a vascular service immediately *Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).” For patients whose veins are purely cosmetic and are not associated with any symptoms do not

	refer for NHS treatment Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

SECTION 5 – GYNAECOLOGY AND FERTILITY

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Reversal Sterilisation – male and female sterilisation	Sterilisation is regarded as irreversible. All patients require PA. The fact that the patient has a new partner will not normally be considered to be sufficient grounds to fund this treatment.
Surrogacy	Surrogacy is not supported by the Commissioners. Submission of an Individual Funding Request would be required if considered exceptional.

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Fertility services – IVF	Patients will only be funded for IVF if they meet the agreed criteria as set out in CCG Policy for Accessing Fertility Treatment. Where a patient meets the criteria the Consultant may refer direct to commissioned provider. • For women up to 40 years the CCG offers funding for 1 full cycle of IVF treatment (+/- ICSI) • Couples who have self-funded will be entitled to 1 NHS cycle provided they have not received more than 2 privately funded cycles. • For women aged between 40-42 the CCG offers 1 full cycle provided: • They have never previously had IVF • There is no evidence of low ovarian reserve • There has been a discussion about the implications of IVF and pregnancy at this age • Ovarian Stimulation should have been completed before the women's 43rd birthday For all patients: • Women's BMI is between 19 – <30.0 • The welfare of any resulting child is paramount. In order to take into account the welfare of the child, the Fertility Centre should consider factors which are likely to cause serious physical, psychological or medical harm to the child to be born • Funding for IVF +/- ICSI will be available to couples who do not have a living child from their current or previous relationship. A child adopted by the couple or adopted in a previous relationship is considered to have the same status as a biological child. • Couples must be non-smoking for 28 days in order to access any fertility treatment and must continue to be non-smoking throughout treatment. • (FSH) of < 8.9 IU/l or one of the other measures recommended in NICE CG156 (section 1.3.3.2 – Ovarian reserve testing).

Fertility service – PGD	• Neither partner has been previously sterilised or had sterilisation reversed Falls under the remit of NHS England: Pregenetic Testing falls under the remit of NHSE EO1/P/a Pre-implantation Genetic Diagnosis (PGD)
Fertility services – Assisted Conception	Other treatments IUI, Donor egg/sperm must be provided in line with the NHS in Lincolnshire Fertility Policies
GAMETE STORAGE – MALE	Storage of sperm will only be funded for men who meet the following defined criteria. Storage of sperm will only be funded for men who have **at least one** of the following conditions: 1. About to undergo chemotherapy or radiotherapy which is likely to reduce fertility 2. About to undergo urological surgery, eg Prostate, Bladder, Testicular Biopsy. But sperm storage will not be funded for men who are about to have a vasectomy. 3. Have germ cell tumour 4. Have haemochromatosis 5. At risk of ejaculatory failure following spinal cord injury or surgery. **PLUS**, they must meet all the following criteria: • The referring centre should test for Hepatitis B, Hepatitis C, and HIV. Sperm storage will not be funded for patients who test positive for any of these diseases. • Must be aged 55 years or younger • Should not have any serious medical disability, and a family background free from any known inherited disorders. • Storage of sperm will be funded for a maximum of 10 years or until the man is aged over 55 years, whichever is sooner • Must have no living children, natural or adopted, from any relationship (to be consistent with the Fertility Policy).

GAMETE STORAGE – FEMALE Egg Freezing & Storage	Egg freezing and storage should only be funded for women who are likely to become infertile or sub fertile as a consequence of chemotherapy or radiotherapy for the treatment of cancer **and** who meet all of the following criteria: • The referring centre must test for Hepatitis B, Hepatitis C and HIV, and funding will only be provided for patients who are negative for all three diseases • Must be aged 39 years or younger Must have no living children, natural or adopted, from any relationship • Must not have any medical condition that would make pregnancy dangerous, and must not have a family history of any known serious inherited condition For women who meet **all** of the preceding criteria, egg storage will be funded for a maximum of ten years, or until the woman reaches 40 years, whichever comes sooner. The rationale for this is that frozen eggs have a "shelf-life", Treatment will only be funded at centres licensed by the Human Fertilisation and Embryology Authority.
Hysterectomy for menorrhagia	Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. The CCG will only fund hysterectomy for heavy menstrual bleeding when each of the following conditions are satisfied: • after an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) for at least 6 months and it has failed to relieve symptoms (or where it is medically inappropriate or contraindicated). AND • at least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence (NICE) guidelines: • Non-steroidal anti-inflammatory agents. • Tranexamic acid

	• Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) AND • A surgical treatment such as, endometrial ablation, uterine artery 54mbolization or myomectomy has been offered and has failed to relieve symptoms (or are not appropriate or are contra-indicated). In addition, the CCG will fund hysterectomy for heavy menstrual bleeding due to fibroids greater than 3 cm when the ALL the following criteria are met: 1. Other symptoms (e.g. pressure symptoms) are present AND 2. There is evidence of severe impact on quality of life AND 3. Other pharmaceutical options have failed AND 4. Patient has been offered myomectomy and/or uterine artery 54mbolization (unless medically contraindicated).
D&C for menorrhagia	The CCG will not fund D&C as a diagnostic tool or as a therapeutic treatment for menorrhagia (heavy menstrual bleeding). Uiltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods. For further information please refer to the EBI doc & NICE NG88

SECTION 6 – TRAUMA AND ORTHOPAEDICS

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Acromioplasty (Subacromial Decompression for shoulder pain) patient BMI >35 – cross reference to Section 4	Prior approval is required for patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months.- The referring clinician will need to demonstrate satisfactorily that there are exceptional individual circumstances.
Arthroscopy	The Commissioner will not commission arthroscopy for diagnostic purposes for ankles, elbows, knees, hips, shoulders or wrists.
Bursa – Excision of	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Patients may be referred where there is obvious pain and swelling up to 10cm maximum
Carpal Tunnel Syndrome	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Carpal tunnel syndrome is common. Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment. Cases with intermittent symptoms which interfere with activities or sleep should first be treated with: a. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness) OR

	b. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections) Surgical treatment of carpal tunnel should only be considered if one of the following criteria are met: a. Nerve Conduction studies have been undertaken to confirm carpal tunnel b. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks; OR c. There is either: i. a permanent (ever-present) reduction in sensation in the median nerve distribution; OR ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand). Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.
De-Quervains Injection of Tendonitis	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Patients may be referred where there is persistent pain after activity and resting the wrist in a splint has not helped.
Dupuytrens	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have**

	been for Prior Approval. Treatment is not indicated in cases there there is no contracture and in patients with mild (less than 20˚) contracture, or one which is not progressing and does not impair function. An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for: a. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. Or b. severe thumb contractures which interfere with function **NICE indicate that collagenase may only be used for:** b. Participants in the ongoing clinical trial (HTA-15/102/04) or b. Adult patients with a palpable cord if: i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints; and ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon
Extracorporeal Shock Wave Therapy (ESWT) (lipotripsy)	The Commissioner does not routinely commission this therapy. An Individual Funding Request is required outlining exceptionality. • Plantar fasciitis • Refractory Achilles tendinopathy • Refractory tennis elbow • Calcific tendonitis (tendinopathy) of the shoulder

Ganglions	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Not all ganglions require surgery. Referral may be made where conservative treatment has failed, eg aspiration **and** there is pain or tingling/numbness or concerns (is cancer). **Wrist/volar/foot/knee ganglia** • no treatment unless causing pain or tingling/numbness or concern (worried it is a cancer); • aspiration if causing pain, tingling/numbness or concern • surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function. **Seed ganglia that are painful** • puncture/aspirate the ganglion using a hypodermic needle • surgical excision only considered if ganglion persists or recurs after puncture/aspiration. **Mucous cysts** • no surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity.
Hip Arthroscopy	Arthroscopy of the hip will be funded, subject to prior approval, for the following groups of patients; 1. Sepsis of the hip joint. Hip arthroscopy is supported in the washout of an infected native hip joint (i.e. patients who have not had a hip replacement) in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed. 2. Loose bodies. Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

	3. Excision of radiologically proven labral tears in the absence of osteoarthritis or femor-acetabular impingement syndrome. Hip arthroscopy is supported for the excision of radiologically proven labral tears associated with an acute traumatic episode in the absence of osteoarthritis or femoral-acetabular impingement syndrome. Hip arthroscopy is not commissioned for the treatment of hip impingement syndrome, or any other indication or pathology. The Commissioner will not fund hip arthroscopy for diagnostic purposes
Hip Replacement – patient BMI>35 – cross reference to Section 4	Prior approval is required for patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months. The referring clinician will need to demonstrate satisfactorily that there are exceptional individual circumstances.
Knee Replacement for patient BMI>35 – cross reference to Section 4	Prior approval is required for patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months.- The referring clinician will need to demonstrate satisfactorily that there are exceptional individual circumstances.
Morton's Neuroma	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Patients may be referred where there is significant pain on walking with neurological signs. Conservative treatment has failed eg advice on suitable footwear.
Pain management programmes using cognitive behavioural approach	All Patients should be referred to the Lincolnshire Community Pain Management Service. No referral should be made or accepted by other providers except where patient is referred by the Lincolnshire Community Pain Management Service.
Lignocaine (Lidocaine) for management of Chronic Pain	Prior Approval is required in all cases, However, It is expected that patients will have been referred to the Community Pain Management Service and any treatment offered is as part of that service if appropriate.
Patella Resurfacing	Patella resurfacing is not commissioned as a stand-alone treatment

Residential pain management programmes	All Patients should be referred to the Lincolnshire Community Pain Management Service. No referral should be made or accepted by other providers except where patient is referred by the Lincolnshire Community Pain Management Service.
Toenail – Wedge resection of in growing toenail including Wedge Resection	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Where a GP does not wish to refer the patient to CSS then the GP should seek prior approval indicating why they feel the patient should be referred to secondary care and not to CSS.
Trigger Finger/Thumb	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Trigger finger is common. Mild cases with no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously. Where conservative management (eg night splints) has failed and where the is pain or interference with activities the following treatment may be undertaken: a. one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics; Or b. splinting of the affected finger for 3-12 weeks (weak evidence) Surgery should be considered if: c. the triggering persists or recurs after one of the above measures (particularly steroid injections);or d. the finger is permanently locked in the palm; or

	e. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods; or d. diabetics. Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).
Ulnar Nerve Release (Cubital Tunnel Syndrome) - Injection	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine eyelid cysts where they have been for Prior Approval.** Patients may be referred where there are neurological signs of tingling and numbness in the little and ring finger.

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Acromioplasty (Subacromial Decompression for shoulder pain)	Pain in the absence of associated diagnosis is called 'impingement syndrome '. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Sub-acromial decompression for pure 'impingement syndrome' normally respond to non-operative treatments such as physiotherapy and exercise programmes. For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, the Commissioner will only fund arthroscopic acromioplasty for subacromial decompression if the patient meets ALL the following criteria which should be clearly documented. a. The patient has had symptoms for at least 6 months and had trialled a period of conservative management which includes: self-care advice on modifying activities, use of NSAIDS and home exercises and where these are ineffective, the patient has completed a course of physiotherapy for longer than 3 months AND b. Symptoms are intrusive and debilitating, pain and loss of function AND c. MRI/ULTRASOUND/CLINICAL EXAMINATION CONFIRMS · Full thickness rotator cuff tear OR · Adhesive capsulitis , non-traumatic instability, calcific tendonitis, or acromioclavicular arthritis The CCG will not normally fund the following · Arthroscopy for diagnostic purposes

	· Decompression of the shoulder where there is significant osteoarthritis of the glenohumeral joint · Open Acromioplasty EXCLUSIONS: Red Flag · Trauma, pain and/or weakness – suspected acute cuff tear · Evidence of mass or swelling – suspected tumour · Red skin, fever or systemically unwell – suspect infection · Trauma/epileptic fit/electric shock leading to loss of rotation and abnormal shape – suspect an unreduced dislocation Patients who are current smokers should be referred to a smoking cessation service. If the patient does not wish to comply they should be advised of the anaesthetic risks associated with the procedure. Where criteria are not met and the referring clinician believes there are individual exceptional circumstances the Clinician may, if appropriate, submit an individual Funding Request.
Bunion (Hallux Valgus)	CCGs will NOT fund bunion surgery for prophylactic or cosmetic reasons, or fund minimal invasive bunion surgery*. The CCGs will not fund asymptomatic hallux valgus, regardless of cosmetic appearance. Where a referral is received by secondary care which has not followed the correct pathway and/or is not approved under the Prior Approval process, then secondary care should reject the referral. The CCGs will consider funding this procedure only if the patient meets the stated clinical thresholds for care. The General Practitioner needs to ensure that the patient has fulfilled all criteria before they are referred to secondary care. 1. Non-surgical treatments have been undertaken for a minimum of 6 months and have been unsuccessful. Conservative management must be evidenced by the GP in the onward referral to secondary care AND 2. The bunion is severe and causing significant, persistent pain and discomfort to the patient

	(not relieved by chronic standard analgesia), preventing activities of daily living, AND 3. Severe deformity greater than 25 degrees leading to significant functional impairment or inability to wear suitable shoes, OR 4. There is recurrent or chronic ulcers and/or infections at the site of the bunion OR 5. There is significant pain under the ball of the foot AND 6. The patient's quality of life is affected by the amount of pain. Exclusions: Urgent Referral <2/52 • Diabetic patients should be referred urgently to the diabetic service. Untreated Hallux Valgus in patients with diabetes may lead to ulceration, deep infection or even amputation. • Peripheral limb ischaemia • Non healing Skin ulcer on the toe
DISECTOMY - LUMBAR SPINE Discectomy/micro discectomy for lumbar disc prolapse Or Posterior Lumber Decompression/Discectomy Including Revision Surgery	**Lincolnshire CCGs will not fund spinal surgery for patients with lower back pain.** Lumbar decompression may be carried out for: • *Slipped disc or sciatica with nerve root compression* • *Severe central spinal stenosis with claudication symptoms of both legs* Spinal Surgery for patients with sciatica and spinal stenosis is considered a low priority procedure and will not normally be funded exception where patients meet **all** of the following criteria: Conservative management as a first line treatment unless there is evidence of abnormal or progressive neurological symptoms. If symptoms fail to settle with 6 months of conservative management (3 months in exception) then decompression/discectomy/micro discectomy may be considered where the patient has shown a willingness to comply with conservative management. The procedure will not be funded if pain is improving or where the pain is not significantly affecting quality of life. Conservative management includes medication: the correct usage of optimal tolerated doses of analgesia (Paracetamol/NSAIDs or Opioid analgesics). Bed rest, physical therapy. Patient's BMI is <35 (see notes below regarding patients with a BMI >35)

	AND The patient is 18 years or older; AND The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms; AND The patient has a corresponding neurologic deficit (asymmetrical depressed reflex, decreased sensation in a dermatomal distribution, or weakness in a myotomal distribution, altered bowel or bladder function); AND The patient has radicular pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement; OR There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise–positive between 30° and 70° or positive femoral tension sign); AND Symptoms persist despite non-operative treatments for at least 6 months (3 months in exception). AND The patient is non-smoking at the time of surgery. **Patients with BMI >35** For patients with a Body Mass Index (BMI) greater than 35 the referring clinician should stress the importance of trying to lose weight prior to surgery and the patient should commit to a documented weight loss and exercise programme (this can be gentle exercise which will contribute to weight loss) programme for 6 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain, the patient may be referred to an appropriate Healthcare Professional for consideration of surgery.

	Patients who are current smokers For patients who are current smokers then the referring clinician should refer the patient to a stop smoking programme. Where stop smoking status is achieved the patient may be referred to an appropriate Healthcare Professional for consideration of surgery. For patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months then prior approval is required. The referring clinician will need to demonstrate satisfactorily that there are exceptional individual clinical circumstances. The rationale for restrictions in patients with a BMI>35 is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who are obese or are smokers. **EXCEPTIONS:** Patients with severe symptoms requiring emergency admission and those patients with recent neurological deficit, eg foot drop and cauda equine.
DISECTOMY - CERVICAL SPINE Discectomy/Micro discectomy/ Anterior cervical decompression with or without fusion Or Un-instrumented posterior cervical decompression Including revision surgery	Spinal Surgery for patients is considered a low priority procedure and will not normally be funded except where patients meet **all** the following criteria: Conservative management as a first line treatment unless there is evidence of abnormal or progressive neurological symptoms. If symptoms fail to settle with 6 months of conservative management (3 months in exception) then decompression/discectomy/micro discectomy may be considered where the patient has shown a willingness to comply with conservative management. The procedure will not be funded if pain is improving or where the pain is not significantly affecting quality of life. Conservative management includes medication: the correct usage of optimal tolerated doses of analgesia (Paracetamol/NSAIDs or Opioid analgesics). Bed rest, physical therapy. Patient's BMI is ≤35.0 (see notes below regarding patients with a BMI >35) AND The patient is 18 years or older; AND The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or

	sequestered fragment) at a level and side corresponding to the clinical symptoms; AND The patient has a corresponding neurologic deficit OR The patient has significant weakness in their hand or arm consistent with the level of spinal involvement; arm pain worse than neck pain OR There is evidence of nerve root irritation with a positive nerve root tension. AND Symptoms persist despite non-operative treatments for at least 6 months (3 months in exception). AND The patient is non-smoking at the time of surgery. **Patients with BMI >35** For patients with a Body Mass Index (BMI) greater than 35 the referring clinician should stress the importance of trying to lose weight prior to surgery and the patient should commit to a documented weight loss and exercise programme (this can be gentle exercise which will contribute to weight loss) programme for 6 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain, the patient may be referred to an appropriate Healthcare Professional for consideration of surgery. **Patients who are current smokers** For patients who are current smokers then the referring clinician should refer the patient to a stop smoking programme. Where stop smoking status is achieved the patient may be referred to an appropriate Healthcare Professional for consideration of surgery. **EXCEPTIONS:** Patient with severe symptoms requiring emergency admission and those patients with recent neurological deficit.

SPINAL FUSION (One or two level posterior instrumented lumbar or cervical fusion	**Lincolnshire CCGs will not fund this procedure for patients with lower back pain (NICE NG59)** Spinal Fusion may be considered in selected patients with degenerative disc disease who are unresponsive to conservative therapy after one year and are being documented as significantly interfering with quality of life where the following criteria are met: Patients should have a Body Mass Index of ≤35.0 AND Conservative management should include a combined physical and psychological treatment programme. Surgery will only be considered when there is documented evidence that the patient has engaged and has participated in the full programme. AND Patients must be non-smoking at time of surgery as the rate of potential fusion is significantly affected by smoking. Where the patient is a smoker they should be referred to an NHS Stop Smoking programme and have stopped smoking for at least 8 weeks before surgery. Spinal Fusion will be only funded in the presence of ONE or more of the following – • Post discectomy or decompression • Spondylolisthesis or spondylolysis • Spinal deformity • Neurological compression with associate neural compression symptoms
Hip replacement (primary)	The CCG will fund prostheses which meet the guidelines set out in NICE Technology Appraisal Guidance 304. The CCG would anticipate cemented hip replacement being used in preference to non-cemented if clinically appropriate The Musculoskeletal Service Framework from the Department of Health and guidance from NICE suggests that management of common musculoskeletal problems, including hip pain, in primary care is ideal. The initial non-surgical management of hip pain due to Osteoarthritis should provide a package of care that may include weight reduction, activity modification, patient specific exercise programme, adequate doses of NSAIDs and analgesics, joint injection, walking aids and other forms of physical therapies. Referral should be considered when other pre-existing medical conditions have been optimised and there is evidence of weight reduction to an appropriate weight. Numerous reviews have indicated the effectiveness and cost effectiveness of the procedure.

	Guidance for hip and knee replacements have been produced by the British Orthopaedic Association (BOA) (2006) and British Orthopaedic association/British Association for Surgery of the Knee (2001) respectively. The GP should ensure that conservative management has been undertaken prior to the patient being referred to secondary care. The CCG will only fund referral for consideration of primary hip replacement where all of the following criteria are met: Conservative management has been undertaken to include: 1. Medication; the patient should be taking optimal tolerated doses of analgesia and have an understanding of the correct uses (Paracetamol/ NSAIDs or Opioid analgesics) AND 2. Physiotherapy attendance – NICE 'core' treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy - (Physiotherapy is ineffective in bone on bone osteoarthritis) AND 3. Received education in regard to lifestyle, the need to maintain or lose weight, encouragement to stop smoking – for patients who are smokers they should be referred to an NHS Stop Smoking Programme. AND 4. Where there is uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of maximal conservative treatment for up to 6 months. A diagnostic tool such as the Oxford Score with a score of ≤ 20 is a useful tool in assessing level of pain. For patients with a Body Mass Indicator (BMI) greater than 35 the referring Clinician should stress the importance of trying to lose weight prior to Surgery and the patient should commit to a documented weight loss and exercise (this can be gentle exercise which will contribute to weight loss) programme for 6 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain, patient may be referred for consideration. For patients who are current smokers then the referring Clinician should refer the patient to an NHS Stop Smoking programme. Where Stop Smoking status is achieved may be referred for consideration. Patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months then prior approval is required. The referring clinician will need to demonstrate satisfactorily that there are exceptional individual circumstances. (See pg 61)

	The rationale for restriction in patients with a BMI >35 is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who are obese or are smokers.
Knee arthroscopy for therapeutic treatment	Knee arthroscopy will not be funded for diagnostic purposes Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective, unless there is a clear history of mechanical locking. (not gelling, giving way or x-ray evidence of loose bodies) More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non- operative treatment, referral for consideration for specialist consultation of knee replacement, or joint preserving surgery such as osteotomy is appropriate for patients who have: • mechanical features of locking (not gelling, giving way or x-ray evidence of loose bodies or morning stiffness) **and** • where there is evidence provided of a comprehensive course of conservative treatment for 6 months for the following MRI/X-ray proven medical conditions: • Repair of a complete meniscal tear or resection/repair of chrondral defects (damage to the articular cartilage) • Synovectomy (removal of partial or all synovial membrane of the joint) • Removal of loose bodies such as a piece of bone which is clearly identified by MRI or X-ray and where this causes derangement/mechanical symptoms. Exclusions • History of previous malignancy • Localised hard mass adjacent to the knee • Unexplained weight loss • Severe night pain non controlled by analgesia The following procedures are not recommended by NICE are require submission of IFR:

	• Knee replacement of meniscus with biodegradable scaffold • Mosaicplasty • Trochieoplasty for patella instability • Removal of loose bodies where there is no derangement/mechanical symptoms
Knee replacement (primary) including partial knee replacement if appropriate	The CCG will fund prostheses which are standard. The Musculoskeletal Services Framework from the Department of Health (DH) and guidance from NICE suggests that management of common musculoskeletal problems, including knee pain, in primary care is ideal. The initial non-surgical management of knee pain due to Osteoarthritis should provide a package of care that may include weight reduction, activity modification, patient specific exercise programme, adequate doses of NSAIDS and analgesics, joint injection, walking aids and other forms of physical therapies. Referral should be considered when other pre-existing medical conditions have been optimised and there is evidence of weight reduction to an appropriate weight. Numerous reviews have indicated the effectiveness and cost effectiveness of the procedure. Guidance for hip and knee replacements have been produced by the British Orthopaedic Association (BOA) (2006) and British Orthopaedic Association/British Association for Surgery of the Knee (2001) respectively. The GP should ensure that conservative management has been undertaken prior to the patient being referred to secondary care The CCG will only fund referral for consideration of primary knee replacement where **all of** the following criteria are met. Conservative management has been undertaken to include: 1. Medication; the patient should be taking optimal tolerated doses of analgesia and have an understanding of the correct uses (Paracetamol/ NSAIDs or Opioid analgesics) AND 2. Physiotherapy attendance – NICE ‘core’ treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy - (NB: Physiotherapy is ineffective in bone on bone osteoarthritis) AND *3.* Received education in regard to lifestyle, the need to maintain or lose weight, encouragement to stop smoking – for patients who are smokers they should be referred to an NHS Stop Smoking Programme. AND 4. Where there is uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of

	maximal conservative treatment for up to 6 months. A diagnostic tool such as the Oxford Score with a score of ≤ 20 is a useful tool in assessing level of pain. For patients with a Body Mass Indicator (BMI) greater than 35 the referring Clinician should stress the importance of trying to lose weight prior to surgery and the patient should commit to a documented weight loss programme and exercise (this can be gentle exercise that will contribute to weight loss) programme for 6 months. Where weight loss is achieved and where there is uncontrolled, intense, persistent pain the patient may be referred for consideration. For patients who are current smokers then the referring Clinician should refer the patient to an NHS stop smoking programme Where Stop Smoking status is achieved the patient may be referred for consideration. Patients with a BMI >35 who have failed to achieve weight loss or a stopped smoking status after 6 months then prior approval is required.- The referring clinician will need to demonstrate satisfactorily that there are exceptional individual circumstances. (Cross Ref to Pg 71)The rationale for restriction in patients with a BMI >35 is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who are obese or are smokers.
KNEE: Autologous Cartilage Transplantation	Patients treated in line with NICE TA 477 do not require prior approval. If a Consultant wishes to treat outside of these criteria then prior approval is required. Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if: • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) • the defect is over 2 cm^2 and • the procedure is done at a tertiary referral centre.
Knee – Patellofemoral Arthroplasty (PFA)	The CCG will only fund Patellofemoral Arthroplasty where treatment is in compliance with the Royal College of Surgeon of England Commissioning guide (2013) painful osteoarthritis of the knee (2013) publication.

	PFA will only be considered for patients with: A. Severe knee pain not adequately controlled by six months of non-surgical management B. Grade III and above arthritis confined to a single joint compartment
Prosthetic Limbs	Charges will be made for the actual cost of the prosthesis supplied without the need for PA. Any request for a limb over and above standard NHS issue will require PA. This includes any request from a private provider such as. C-leg
Prosthetic Limbs - Hip and Knee and other joint revisions	The CCG will fund revisions using standard prosthesis.
Prosthetic Limbs - Custom-made Orthopaedic prosthesis	CCGs will be charged for the actual cost of the prosthesis, where the agreed criteria are met, without prior approval . Any request for a limb over and above the standard NHS issue will require PA It is anticipated that these will be the exception.
Spinal Cord Stimulation for Chronic Pain	Treatment in line with NICE TA159. Where a Consultant wishes to treatment outside of NICE guidance then submission of an IFR is required
Spinal injections as a treatment for Chronic lower back pain	It is expected that patients will have been referred to the Community Pain Management Service, and any treatment offered is as part of that service. Patients with nonspecific low back pain with or without sciatica should not be offered spinal or steroid injections as follows: • facet joint injections • therapeutic medial branch blocks • intradiscal therapy • prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis • Any other spinal injections not specifically covered above Radiofrequency denervation can be offered in accordance with NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain

	that has improved in response to diagnostic medical branch block. Epidural (local anaesthetic and steroid) should only be considered in patients who have acute and severe radiculopathy at the time of referral Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.
X-ray (plain) & MRI of back for low back pain	1. X-ray of lumbar spine for non-specific low back pain – Not funded (Funding only provided for investigating specific pathology) 2. MRI of lumbar spine for low back pain is funded in the following circumstances: 1. Red flag symptoms: a. Spinal malignancy b. Infection c. Fracture d. Cauda equina syndrome e. Ankylosing spondylitis or another inflammatory disorder f. Suspected osteoporotic fracture. 2. In the context of a referral for an opinion on spinal fusion 3. In the context of Disectomy for lumbar disc prolapsed (as specified elsewhere in this policy) Patients should be referred to an NHS facility in the first instance. Patients who are claustrophobic may be referred to an NHS Open Scanner such as Queens Hospital, Burton on Trent. If the patient is unable to tolerate this then a prior approval to refer to an alternative provider should be requested.

SECTION 7 – OPHTHALMOLOGY

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL	
Eye Lid Cysts	77
THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED	
Cataract Surgery	78

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Eyelid Cysts (Chalizia)	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval.** Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met: • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • a source of infection causing an abscess which requires drainage If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Cataract Surgery	Referral via GOS18 is for opinion and assessment to see if the patient fits the CCG criteria for cataract surgery. If the patient does not meet criteria the Consultant should advise the patient as appropriate with reference to clinical and personal circumstances. Surgical treatment of cataracts will be funded, without prior approval, for the following groups of patients; • Patient with a best corrected visual acuity of 6/12 or worse in either the first or second eye **AND** as a result of the cataract have impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, or increased risk of falls. OR • With a best corrected visual acuity of 6/9 in the worst eye where exceptional acuity is essential for their occupation (e HGV licence holders) or results in debilitating symptoms, such as distortion or glare Cataract surgery is indicated irrespective of visual acuity for patients who have ocular co-morbidities e.g. glaucoma, diabetic retinopathy or symptomatic anisometropia.

SECTION 8 – UROLOGY

THE FOLLOWING TREATMENTS REQUIRE PRIOR APPROVAL	
Circumcision	80
SNS for Urinary Retention	81
Vasectomy	81
THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED	
Penile Implants	82

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Circumcision	Circumcision is a surgical procedure that involves partial or complete removal of the foreskin (prepuce). Nearly all boys have a non-retractile (unable to be pulled back) foreskin at birth and as part of normal development it gradually becomes retractile without the need for intervention. The process of retractility is spontaneous and does not require manipulation. The majority of boys will have a retractile foreskin by 10 years of age and 95% by 16-17 years of age. The Commissioner will only fund circumcision on medical grounds where one or more of the following criteria are met: • Lichen Sclerosus (chronic inflation leading to a rigid fibrous foreskin) sometimes known as Balanitis Xerotica Obliterans (BXO) • Severe recurrent attacks of Balanoposthitis (recurrent bacterial infections of glands and foreskin following failure of conservative treatments • Recurrent urinary tract infections (UTIs) in children with a structurally abnormal urinary tract • Phimosis in adults leading to recurrent paraphimosis, pain on arousal or interference with sexual function • Congenital abnormalities Conservative treatment would include: • Simple bathing, topical steroids and antibiotics for inflammatory condition, eg Balanitis, Balanoposthitis, Posthitis (inflammation restricted to the foreskin itself) • Topical steroids for non-retractile health foreskin (Physiological Phimosis) • Gentle compression with a saline soaked swab followed by reduction of foreskin over the glands is usually successful – where there is inability to manipulate the foreskin back over the glands (Paraphimosis). • For hooded foreskin – refer patients with complication for assessment. NHS in Lincolnshire will not fund circumcision for non-medical reasons e.g. where it is requested on cultural, social and religious grounds. Non-Medical circumcisions do not confer any health gain

	but carry measurable health risk. PA is **not** required where this procedure is required for medical reasons **and** the patient is aged 16 years or over. PA is required in every case where the patient is aged less than 16 years. Authorisation will rarely be given where the patient is aged less than 5 years.
SNS for Urinary Retention	Prior Approval is required
Vasectomy	Patients 16 years and over should be referred to CSS in the first instance. If the procedure cannot be undertaken by the CSS then the Provider should refer the request back to the GP and the GP request prior approval before onward referral **For patients 16 years and over Hospitals may only accept routine referrals where they have been for Prior Approval** Where a GP does not wish to refer the patient to CSS then the GP should seek prior approval indicating why they feel the patient should be referred to secondary care and not to CSS.

THE FOLLOWING TREATMENTS DO NOT REQUIRE PRIOR APPROVAL BUT MUST BE DELIVERED IN LINE WITH THE CRITERIA AS DESCRIBED

Penile Implants	Penile implants are routinely funded for the treatment of severe organic erectile dysfunction (ED) with the following restrictions: • as third line treatment ONLY following adequate trials of standard therapies (including oral PDE-5 inhibitors, testosterone replacement), vacuum constriction device, and intracavernous injection therapy and intraurethral alprostadil. • ED is associated with one of the following medical conditions: Diabetes; Multiple Sclerosis Parkinson's Disease ; Poliomyelitis ; Prostate Cancer ; Prostatectomy ; Radical Pelvic Surgery Severe Pelvic Injury ; Renal Failure treated by dialysis or transplant ; Single Gene Neurological Disease ; Spinal Cord Injury ; Spina Bifida OR • there is documented evidence the patient is suffering severe distress on account of their ED • Appropriate risk factor modification and lifestyle changes such as losing weight, stopping smoking, reducing alcohol consumption, and increasing exercise should have been tried • Psychological assessment has been done and has excluded a treatable underlying psychogenic cause. • Urological assessment has been done and has excluded treatable underlying physical abnormality. • Endocrine assessment has been done and has excluded a treatable underlying hormonal cause. http://www.cks.nice.uk http://www.bssm.org.uk NICE CG 66 Type 2 Diabetes

SECTION 9 - CARDIOLOGY

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL	
Carotid Endarterectomy	84

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

<table>
<tr>
<td>Carotid Endarterectomy</td>
<td>
Prior approval is not required for carotid artery stenosis where it is at least 50% in accordance with the Carotid Endarterectomy (EC) Guideline as below (see link for full guideline details);
<table>
<tr><th>Stenosis (%)
ICA
angiographic</th><th>Recommendation</th></tr>
<tr><td>70-99%</td><td>CE is established as effective for recently symptomatic (within previous 6 months) patients with 70-99% ICA angiographic stenosis (Level A).</td></tr>
<tr><td>50-69%</td><td>CE may be considered for patients with 50-69% symptomatic stenosis (Level B) but the clinician should consider additional clinical and angiographic variables (Level C).</td></tr>
</table>
Prior Approval is required for: -

It is recommended that the patient have at least a five year life expectancy and that the perioperative stroke/death rate should be <6% for symptomatic patients (Level A) <50%
For CE for symptomatic patient with <50% stenosis (Level A). Medical management is preferred in these cases.

Treatment will not routinely be approved for Asymptomatic carotid stenosis.
</td>
</tr>
</table>

SECTION 10 – NEUROLOGY

THE FOLLOWING TREATMENTS ALL REQUIRE PRIOR APPROVAL

Functional Electrical Stimulation	PA required in line with the NHS in Lincolnshire PACEF FES Policy

Section 11 – COMMUNITY SURGICAL SCHEME

The Community Surgical Scheme (CSS) applies to those over the age of 16.

The 2006 document 'Our Health, Our Care, Our Say' set out a vision for the future of care outside hospitals. It promoted the reconfiguration of services to support redesigned patient pathways, which deliver services in more local and convenient settings. The NHS in Lincolnshire is committed to the commissioning of high quality services which are better able to meet patients' needs in the communities in which they are located.

To achieve this, the NHS in Lincolnshire commissions a Community Surgical Scheme (CSS) which sets out the requirements for service delivery and development for the needs of patients requiring minor surgical procedures. It supports best practice in the delivery of community surgical services.

An aim of the CSS is to improve the range of surgical procedures and ensure equitable access to services provided in primary care settings by commissioning alternative pathways of care.

Community Surgical Scheme procedures will be commissioned from those who are accredited and registered with the NHS in Lincolnshire.

GPs and other clinicians must refer all patients who require these procedures to the CSS in the first instance. These patients **should not** be referred to any other provider e.g. secondary care unless prior approval has been given.

Should an occasion arise where a patients' clinical need cannot be met by the Community Surgical Scheme the CSS provider will refer the patient back to the GP. The GP should then request prior approval for the patient to be treated in secondary care.

Prior Approval must be requested as detailed on page 5. The full document can be located on the individual CCG websites.

The procedures delivered under the CSS are:

Excision of benign Skin Lesions: Cyst/ (>1.5cm ≤ 5.0cm) Excision multiple Cysts/Lesions/ Excision of benign Facial Cyst (>1.5cm but < 2.5cm)	Removal of benign skin lesions will not normally be funded by the NHS for cosmetic purposes. Surgical removal or cryotherapy of benign skin lesions will only be funded where there is recurrent bleeding, rapid growth or other features suspicious of trauma leading to bleeding where at least one of the following criteria are met: • The lesion is unavoidable and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year. • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function, eg restricts joint movement • The lesion causes pressure symptoms eg on nerve or tissue • If left untreated, more invasive intervention would be required for removal
Low Risk Basal Cell Carcinoma (BCC) removal in line with NICE guidance	Patient aged 24+ years Single, primary, nodular BCCs less than 1cm and which are below the clavicle. Patient not immunosuppressed, nor have Gorlins Syndrome.
Eyelid Cyst - Meibomian Cyst (Chalazion)	Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met: • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure

	or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • a source of infection causing an abscess which requires drainage If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions
Removal of Deep Contraceptive Implant	Only where they are unable to be removed in Primary Care under Minor Surgery
Vasectomy	Patient should be counselled by the responsible surgeon even if the referring GP has already undertaken some counselling. Post procedure semen analysis – It is the responsibility of the provider to arrange this test and notify the patient of the result.
Partial /Wedge Resection of nail with or without ablation/removal of nail bed	Recurrent infection. In case of infection the whole nail should ideally be removed rather than performing a wedge resection. Persistent pain
Hernia - Primary Mesh Repair: Inguinal Hernia; Umbilical Hernia; Para-Umbilical Hernia; Femoral Hernia; Epigastric Hernia; Spigelian hernia Incisional hernia and irreducible recurrent hernia should not be treated in CSS	For asymptomatic or minimally symptomatic hernia a watchful waiting approach, under informed consent, if advocated. Surgical treatment should only be offered when one of the following criteria are met: a) Symptoms of pain or discomfort that interferes with activities of daily living OR b) The hernia is difficult or impossible to reduce OR c) It is an inquino-scrotal hernia OR d) The hernia increases in size month on month.
Carpal Tunnel Injection/Surgery	Carpal tunnel syndrome is common. Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment. Cases with intermittent symptoms which interfere with activities or sleep should first

	be treated with: a. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness) OR b. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections) Surgical treatment of carpal tunnel should only be considered if one of the following criteria are met: a. Nerve Conduction studies have been undertaken to confirm carpal tunnel b. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks; or c. There is either: i. a permanent (ever-present) reduction in sensation in the median nerve distribution; or ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand). Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.
Trigger Finger/Thumb Injection Release Trigger Finger/Thumb	Trigger finger is common. Mild cases with no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously. Where conservative management (eg night splints) has failed and where the is pain or interference with activities the following treatment may be undertaken:

	a. one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics; Or b. splinting of the affected finger for 3-12 weeks (weak evidence) Surgery should be considered if: a. the triggering persists or recurs after one of the above measures (particularly steroid injections); or b. the finger is permanently locked in the palm; or c. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods; or e. diabetics. Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).
Ganglion – Injection/Aspiration	Not all ganglions require surgery. Referral may be made where conservative treatment has failed, eg aspiration **and** there is pain or tingling/numbness or concerns (is cancer). **Wrist/volar/foot/knee ganglia** • no treatment unless causing pain or tingling/numbness or concern (worried it is a cancer); • aspiration if causing pain, tingling/numbness or concern • surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function. •

	Seed ganglia that are painful • puncture/aspirate the ganglion using a hypodermic needle • surgical excision only considered if ganglion persists or recurs after puncture/aspiration. **Mucous cysts** No surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity. ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon
Dupuytrens Contracture – Mild (reassure/observe)	NICE recommends no treatment is necessary for people with Dupuytrens who do not have contracture. Surgical treatment is not indicated in cases where there is no contracture OR in patients with mild (less than 20^0) contractures, OR where the contracture is not progressing and does not impair function. An intervention such as needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for: a. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. or b. severe thumb contractures which interfere with function **NICE indicate that collagenase may only be used for:** a. Participants in the ongoing clinical trial (HTA-15/102/04) or b. Adult patients with a palpable cord if: i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal

	interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints; AND ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon
Excision of Bursae	Patients may be referred where there is obvious pain and swelling up to 10cm maximum
De-Quervains Injection of tendonitis	Patients may be referred where there is persistent pain after activity and resting the wrist in a splint has not helped
Morton's Neuroma injection	Patients may be referred where there is significant pain on walking with neurological signs. Conservative treatment has failed eg advice on suitable footwear.
Ulna nerve release (Cubital Tunnel Syndrome) – Injection	Patients may be referred where there are neurological signs of tingling and numbness in the little and ring finger
Haemorrhoids	**Currently no provider** Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection. Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically: • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; OR • Irreducible and large external haemorrhoids In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

SECTION 12 : TREATMENTS NOT NORMALLY COMMISSIONED

The following is a list procedures not normally commissioned by the NHS in Lincolnshire and require submission of an Individual Funding Request in exceptionality. This list is not an exhaustive list but provides an indication of some of the procedures which are not normally commissioned. If a procedure is not listed it should not be assumed that this is funded by the CCG where there is no policy or NICE TA.

Autologous Blood and Platelet-Rich Plasma Injection in Tendinopathy	Platelet-rich Plasma (PRP) Injections and Autologous Blood Injections are used to treat damaged tendons, where a patient's blood is taken and re-injected into the affected area. Our blood contains platelets, which contain growth factors. These growth factors boost the healing process of the tendons, as they are injected straight to the damaged area.
Bobath Therapy for Cerebral Palsy	Bobath Therapy, also known as neurodevelopmental therapy (NDT) is a physiotherapy approach to treating patients with damage to their central nervous system, such as those with cerebral palsy. The focus is on patient and carer participation to improve muscle tone, posture and function. It aims to assess the patient's needs and adapt to individual requirements.
Chelation therapy in the treatment of cardiovascular disease, autism and chronic fatigue syndrome (CFS)	A means of removing heavy metals from the body. In addition to their use in the treatment of heavy metal poisoning and overload there is growing trend for chelating agents to be used to treat a variety of different conditions.
Gamma Core Device	For treatment of migraine.
Gastric Electrical Stimulation in Gastroparesis	Gastric electrical stimulation helps to control the chronic nausea and vomiting associated with gastroparesis.
Infrared A Induced Whole Body Hyperthermia -	Artificial warming of the body to improve symptoms for various medical condition eg (Arterial hypertension, muscle tension, chronic back pain, fibromyalgia syndrome, neuralgia, migraine, chronic inflammatory disorders, chronic rhinitis, bronchial asthma, Seasonal Affective Disorder, rehabilitation in sports medicine, detoxification in those exposed to pollutants, chronic viral illness)

Laser Treatment of Myopia (Short Sightedness)	Correction of short sightedness using lasers
Liposuction for Lipoedema	Lipoedema is a long-term (chronic) condition typically involving an abnormal build-up of fat cells in the legs, thighs and buttocks.
Lycra Dynamic Splinting for Children with Neurological Impairment	
Topical Negative Pressure (TNP) for wound closure - (vacuum-assisted wound closure (VAC)	NICE IPG 467 – Nice have a list of products and it is in the BNF so is this a recognised treatment for some medical conditions
Occipital Nerve Stimulation for adults with intractable chronic migraines and medically refractory chronic cluster headaches	See IPG 452 - This should be by IFR
Percutaneous tibial nerve stimulation (PTNS)	For treatment of overactive bladder.
Scotopic Sensitivity Syndrome (Mears-Irlen Syndrome) and coloured filtered / tinted lenses	Provision of coloured filters/ tinted lenses for specific reading difficulty (SRD)
Toric Intra-ocular lenses	For corneal astigmatism correction in patients undergoing cataract surgery.
Wheelchairs	Wheelchairs for short term (less than six months) or occasional use (ie not daily) are not commissioned except for end of life (six months or less to live)