NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Abdominoplasty / Apronectomy and removal of excessive skin from other areas of the body
Background:	Abdominoplasty (also known as tummy tuck) is a surgical procedure performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss. However, surgery is not part of the usual response to these normal, physiological processes.
Commissioning position:	Not routinely funded. NHS North Yorkshire CCG does not routinely commission Abdominoplasty / Apronectomy or removal of excessive skin from other areas of the body. The clinician needs to submit an application to the CCG's Individual Funding Request Panel (IFR).
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Any operation involving a general anaesthetic should be approached with caution, especially if for cosmetic reasons. Generally, the more extensive the procedure, the higher the risk. Cosmetic procedures are regarded as low priority.
Date:	March 2020
Review Date:	July 2023
Contact:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

1. Royal College of Surgeons Commissioning guide: Massive Weight Loss Body Contouring March 2014 file:///C:/Users/suzanne.savage/Downloads/Massive%20Weight%20Loss%20Body%20Countouring%20%20Commissioning%20Guide.pdf

2. Information for Commissioners of Plastic Surgery Services - Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London

NHS
North Yorkshire
Clinical Commissioning Group

Referral Criteria/Commissioning Position:

Condition or Treatment:	Acne
Commissioning position:	*Refer to specialist services such as GPwSI in dermatology or to secondary care if patient:* • Has moderate acne which has failed to respond to treatment which should include at least 2 courses of oral antibiotics for at least 3 months each, with appropriate topical treatment. The success or failure of treatment is best assessed subjectively by the patient • is at risk of, or is developing, scarring despite primary care therapies • has a very severe variant such as fulminating acne with systemic symptoms (acne fulminans) or gram negative folliculate acne • has severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin • is experiencing severe social or psychological impact, including a morbid fear of deformity (dysmorphophobia) **Investigations prior to referral** • FBC, U&E, LFT, fasting cholesterol and triglycerides. • Organise contraception in all sexually active females (or those likely to become so shortly) before referral if oral isotretinoin may be considered. Isotretinoin can be combined with any oral contraceptive. • Discussion of most effective forms of contraception e.g. implant, IUS, should be had with patient to ensure they understand the effects on foetal development if an unplanned pregnancy occurs and can make fully informed decision on safest choice of contraceptive if considering isotretinoin. https://www.contraceptionchoices.org/infographic
Referral Guidance:	The GP referral letter should contain: • Details of how the patient meets the criteria • Current and previous treatments including t results, • Drug history (prescribed and non-prescribed) • Relevant past medical/surgical history • Current regular medication • BMI • Smoking status • Alcohol consumption • Contraception status
Effective From:	1 July 2021
Summary of evidence/ rationale:	Acne: http://www.patient.co.uk/health/acne

North Yorkshire
Clinical Commissioning Group

Date:	November 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Acquired Ear Lobe Clefts
Background:	The external ear lobe can split partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
Commissioning position:	Surgical repair of acquired ear lobe clefts is NOT routinely commissioned as this is considered a cosmetic procedure. This indication includes: • partially split lobes (i.e. where the split does not reach the edge of the lobe); • elongated holes in lobes; • a split that recurs after a previously repaired earlobe has been pierced
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Adult Snoring Surgery (in the absence of OSA)
OPCS Codes:	F324; F325; F326
Description:	In two systematic reviews of 72 primary research studies, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has up to 16% risk of severe complications (bleeding, airway compromise, death). A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion.
Summary of Intervention:	Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment for OSA. It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.
Commissioning position:	NHS North Yorkshire CCG does not commission adult snoring surgery in the absence of evidence of OSA. The CCG does not commission surgery in the presence of OSA unless Continuous Positive Airway Pressure (CPAP) and other lifestyle changes (e.g. weight loss, reduction in alcohol consumption where needed) have failed to improve symptoms.

NHS
North Yorkshire
Clinical Commissioning Group

	All requests for funding should be submitted to the CCG IFR panel. This is on the basis of limited clinical evidence of effectiveness and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring. **Alternative Treatments** There are a number of alternatives to surgery that can improve the symptom of snoring. These include: • Weight loss • Stopping smoking • Reducing alcohol intake • Medical treatment of nasal congestion (rhinitis) • Mouth splints (to move jaw forward when sleeping)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (>2 years) and there is no long term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance and nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.
Date:	April 2020
Review Date:	July 2023

NHS
North Yorkshire
Clinical Commissioning Group

Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

- Franklin KA, Anttila H, Axelsson S, Gislason T, Maasilta P, Myhre KI, Rehnqvist N. Effects and side-effects of surgery for snoring and obstructive sleep apnoea – a systematic review. Sleep. 2009 Jan. 32 (1): 27-36
- Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and nonsurgical devices for the management of non-apnoeic snoring; a systematic review of clinical effects and associated treatment costs. Health Technol Assess 2009; 13 (3). https://www.ncbi.nlm.nih.gov/pubmed/19091167
- Jones TM, Earis JE, Calverley PM, De S, Swift AC. Snoring surgery: A retrospective review. Laryngoscope. 2005 Nov 115 (11): 2015-20 https://www.ncbi.nlm.nih.gov/pubmed/16319615

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Alternative and Complementary Therapies
Commissioning position:	Alternative and complementary therapies are not routinely commissioned by the CCG due to a paucity of information on clinical effectiveness. Requests for funding are to be made, via the Individual Funding Request Panel (IFR) detailing: • the grounds of clinical exceptionality **Therapies covered:** 1. Alternative therapies (professionally organised) • Acupuncture • Chiropractic • Herbal medicine • Homeopathy • Osteopathy 2. Complementary therapies • Alexander Technique • Yoga • Pilates • Aromatherapy • Bach and other flower remedies • Massage • Meditation • Reflexology • Shiatsu • Healing Nutritional medicine • Hypnotherapy 3. Alternative disciplines • Anthroposophical medicine • Maharishi Ayurvedic medicine • Chinese herbal medicine • Eastern medicine • Naturopathy • Traditional Chinese medicine 4. Other alternative disciplines • Crystal therapy • Dowsing • Iridology • Kinesiology • Radionics and all other alternative and complementary therapies **Investigations prior to referral** None

NHS
North Yorkshire
Clinical Commissioning Group

Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form *The GP referral letter should contain:* • Details of how the patient meets this requirement • Treatments and interventions tried including the results • Drug history (prescribed and non-prescribed) • Relevant past medical/surgical history • Current regular medication • BMI • Smoking status • Alcohol consumption
Effective From:	1 July 2021
Summary of evidence/ rationale:	It is the responsibility of NHS North Yorkshire CCG to commission the most clinically and cost effective treatments for its local population within the resources available to it. Treatments which are primarily cosmetic in nature are, therefore, considered a low priority.
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor, North Yorkshire CCG

References & Additional information:

1. House of Lords Select Committee (House of Lords Select Committee on Science and Technology (2000); Complementary and Alternative Medicine. (The Stationery Office, London)

2. Bandolier review of complementary and alternative therapies.

3. NICE (May 2009) Low back pain; early management of persistent non-specific low back pain

4. Lewith GT, Breen A, Filshie J, et al; Complementary medicine; evidence base, competence to practice and regulation. Clin Med. 2003 May-Jun; 3(3):235-40.

5. Ernst E. Massage therapy for low back pain; A systematic review. Journal of Pain & Symptom Management 1999; 17:56-69

6. Dennis J, Cates. Alexander technique for chronic asthma. The Cochrane Database of Systematic Reviews: Reviews 2000; 2.

7. Thorgrimsen L, Spector A, Wiles A, Orrell M. Aroma therapy for dementia. The Cochrance Database of Systematic Reviews: Reviews 2003, Issue 3.

8. de Izquierdo Santiago A, Khan M. Hypnosis for schizophrenia. The Cochrane Database of Systematic Reviews: Reviews 2004 Issue 3

North Yorkshire
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Commissioning Statement:

Condition or Treatment:	Anal Fissure (Surgery)
Background:	An anal fissure is a tear in the lining of the lower rectum (anal canal) that causes pain during bowel movements.
Commissioning position:	Policy: For referral to secondary care the patient should meet at least one of the following criteria: • Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease OR • Children whose anal fissure has not healed after 2 weeks OR • Severe pain refractory to conservative therapy and impacting on patient wellbeing OR • Persisting anal fissure not healed after 8 weeks of conservative management OR • Symptoms suggestive of systemic disease e.g. inflammatory bowel disease Consider referring an elderly person earlier to exclude an anal or low rectal malignancy. A 2 week wait referral should be considered for patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding and any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron-deficiency anaemia'.
Effective From:	1 July 2021
Summary of evidence/ rationale:	Effectiveness of topical nitrates for healing Evidence on the effectiveness of topical nitrates for healing anal fissure: A Cochrane systematic review concluded that, from the available evidence, glyceryl trinitrate (GTN) may be applied to acute or chronic fissures in adults, and to acute fissures in children with a chance of a cure that is marginally better than placebo. However, late recurrence of anal fissure is common (in approximately 50% of those initially healed). A Cochrane systematic review (August 2010) aimed to assess the efficacy and morbidity of several medical treatments for anal fissure [Nelson et al, 2012].

	Meta-analysis of 18 randomized controlled trials (n = 1315) compared the healing rate of anal fissure in people treated with topical GTN with people treated with placebo. Four of the trials included only children (n = 165). GTN was significantly better than placebo in a combined analysis and also in all of the sensitivity analyses related to adults. No significant difference in healing rates was found in children after a study with an abnormally low placebo response was excluded. • Benefits of treatment: The healing rate in the treatment group in all of the 18 studies was 49% compared with 36% in the placebo group (P = 0.0009) • Harms of treatment: The risk of headache when using GTN was 30%, using figures from all of the twenty-four studies that used GTN. (Six additional studies made other comparisons with GTN: botulinum toxin, calcium channel blockers, lidocaine, 'healer cream', home dilators and partial, lateral, and internal sphincterotomy.) Two case series of people who had apparently been cured by GTN reported recurrence rates of 51% and 67% Effectiveness of topical nitrates for relieving pain Evidence on the effectiveness of topical nitrates relieving pain from anal fissure: In a non-systematic review of evidence from three randomized controlled trials (RCTs), a clinically-significant reduction in pain from chronic anal fissure when treated with rectal glyceryl trinitrate ointment (4 mg/gram compared with placebo) was demonstrated. A non-systematic review investigated the therapeutic efficacy of 0.4% nitroglycerin ointment for relieving pain from a chronic anal fissure [Fenton et al, 2006]. • The authors discussed three moderate-sized RCTs which involved 'intention to treat' analyses. • The authors concluded that 0.4% nitroglycerin ointment significantly decreased pain scores in people with a chronic anal fissure.
Date:	January 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

Additional Information/References:

Clinical Knowledge Summaries Anal Fissure November 2012

https://cks.nice.org.uk/topics/anal-fissure/#!scenario

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	**Bariatric Surgery (Tier 4 Weight Management)**
Background:	Where all other tiers of support have failed, for some complex patients, bariatric surgery may be a suitable option. This policy sets out the commissioning position and threshold criteria that patients need to meet in order to be eligible for this treatment option, and covers gastric banding, gastric bypass and sleeve gastrectomy.
Commissioning position:	**This policy is excluded from general weight threshold requirements as described by "Optimising Outcomes from All Elective Surgery (Health Optimisation)".** Surgery will only be considered as a treatment option for adults with morbid obesity providing all of the following criteria are fulfilled: • The individual is considered morbidly obese – classified as adults with a BMI of 40kg/m2 or more; OR • The individual is between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases that would be improved by weight loss; AND • There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity / complexity assessment, risk stratification / scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway. AND • The individual has recently received and complied with a specialist obesity service weight loss programme (non-surgical Tier 3 / 4), as described below. ***Weight Loss Programmes (non-surgical Tier 3 / 4)*** • This will have been for a duration of 12-24 months. • For patients with BMI of 50kg/m2 or more attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of

	local MDT structure. • Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care, the service will select and refer appropriate patients for consideration for bariatric surgery
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval.
Effective From:	2nd March 2022
Summary of evidence/ rationale:	NICE Clinical Guideline CG189: https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations#surgical-interventions
Date:	February 2022
Review Date:	January 2024
Contact:	Dr Emma O'Neill, Clinical Advisor, North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Removal of benign skin lesions
Background:	Removal of benign skin lesions means treating asymptomatic lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a small risk of infection, bleeding or scarring and is not usually offered by the NHS if it is just to improve appearance. In certain cases, treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to pre-malignant lesions and other lesions with potential to cause harm.
Commissioning position:	This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below. The diagnosis of a suspected benign lesion should be reconsidered in any lesion that is enlarging. Examples of benign skin lesions include: • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • dermatofibroma • lipomas • 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 The benign skin lesions, of which examples are listed above, must meet at least ONE of the following criteria to be removed: • 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 • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue

	• If left untreated, more invasive intervention would be required for removal • Facial viral warts • Facial spider naevi in children causing significant psychological impact The following are outside the scope of this policy recommendation: • Lesions and Lipomas that are suspicious of malignancy should be treated and referred urgently according to local 2 week wait pathways and NICE skin cancer guidelines. • Pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care. • Removal of lesions other than those listed above. • Lesions with diagnostic uncertainty which should be referred to dermatology Referral to appropriate speciality service (eg dermatology or plastic surgery): • The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria. • This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwer), independent providers, and community or intermediate services. For further information, please see: https://www.nice.org.uk/guidance/csg8 https://www.nice.org.uk/guidance/ng12
Effective From:	1 July 2021
Summary of evidence/ rationale:	There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning. References 1. Higgins JC, Maher MH, Douglas MS. Diagnosing Common Benign Skin Tumors. Am Fam Physician. 2015 Oct 1;92(7):601-7. PubMed PMID: 26447443. 2. Tan E, Levell NJ, Garioch JJ. The effect of a dermatology restricted-referral list upon the volume of referrals. Clin Exp Dermatol. 2007

North Yorkshire
Clinical Commissioning Group

	Jan;32(1):114-5. PubMed PMID: 17305918.
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Blepharoplasty
Background:	Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. It is usually done for cosmetic reasons. Consideration should be given to whether blepharoplasty or brow lift is the more appropriate procedure, particularly in the case of obscured visual fields.
Commissioning Position:	Blepharoplasty will only be funded in accordance with the criteria specified below: • Impairment of visual fields in the relaxed, non-compensated state OR • Clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow. Direct referral to secondary care may also be made where a diagnostic ophthalmology opinion is required (e.g. to exclude underlying causes such as thyroid related orbitiopathy, orbital tumours, iatrogenic Horner's syndrome, basal cell carcinoma and myasthenia gravis). Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Effective From:	1 July 2021
Date:	December 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Breast Implants Removal
Definition:	The presence of breast implants may cause patients a range of symptoms over time. These include a change in appearance of implants or increased associated pain. Common problems include age related sagging; calcification of breast tissue; capsular correction; leak from implant; implant wrinkling or rippling; infection; inflammation or irritation. Concerns about cosmetic appearance should not be referred to secondary care. These procedures will not be funded.
Red Flag Symptoms:	**In all cases exclude Red Flag Symptoms and if present, refer 2WW or to symptomatic breast clinic**
Exclusions:	This policy does not apply to breast reconstruction as part of the treatment for breast cancer
Commissioning position:	NHS North Yorkshire CCG does not routinely commission the removal of breast implants. Where there is a clinical indication for removal of breast implants this will only be commissioned in the following circumstances: • Breast cancer • Breast Implant associated – Anaplastic Large Cell Lymphoma (BIA-ALCL) is suspected • Implants complicated by recurrent infections • Implants with capsule formation that is associated with severe pain • Implant is proven to be ruptured (intra or extra capsular) • Baker Grade IV capsular contracture • Implants with a capsule formation that interferes with breast imaging • Implant is a PiP implant This commissioning decision applies regardless of funding source of the original surgery (i.e. whether funded by the NHS or on a private basis**). Patients will be offered the choice of removing both prostheses in the event that only one has been ruptured with the intention of ensuring symmetry.

North Yorkshire
Clinical Commissioning Group

	This policy does not include replacement of removed implants – please see separate policy. ** in the first instance the patient should be directed back to the original private provider for the procedure. If the private provider is unable to support the patient, the NHS will undertake removal only. The CCG reserves the right to seek reimbursement from the provider.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
OPCS Codes:	B30
Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

Poly implant Prothese (PiP) breast implants; Final report of the Expert Group June 2012 Sir Bruce Keogh NHS Medical Director https://www.gov.uk/government/publications/poly-implant-prothese-pip-breast-implants-final-report-of-the-expert-group

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Breast Implants Replacement
Definition:	The presence of breast implants may cause patients a range of symptoms over time. These include a change in appearance of implants or increased associated pain. Common problems include age related sagging; calcification of breast tissue; capsular correction; leak from implant; implant wrinkling or rippling; infection; inflammation or irritation. Concerns about cosmetic appearance should not be referred to secondary care. These procedures will not be funded.
Red Flag Symptoms:	**In all cases exclude Red Flag Symptoms and if present, refer 2WW or to symptomatic breast clinic**
Exclusions:	This policy does not apply to breast reconstruction as part of the treatment for breast cancer
Commissioning position:	NHS North Yorkshire CCG does not routinely commission the replacement of breast implants. Where revision surgery is being carried out for implant failure, the CCG will support the removal of failed implants in certain circumstances (see separate policy) but will not approve their replacement, other than where clinical exceptionality may apply and where approval for funding is granted by the IFR panel. Replacement of implants will only be considered when patients meet the criteria for removal (see separate policy) and both of the following indications are met: • The original procedure was provided by the NHS AND • The original implant insertion was following cancer surgery, trauma or developmental asymmetry The replacement of breast implants for patients whose original surgery was paid for on a privately funded basis is not commissioned unless undertaken following cancer surgery
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval.

North Yorkshire
Clinical Commissioning Group

	• HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
OPCS Codes:	B30
Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr E O'Neill, Clinical Advisor, North Yorkshire CCG

Additional Information/References:

Poly implant Prothese (PiP) breast implants; Final report of the Expert Group June 2012 Sir Bruce Keogh NHS Medical Director https://www.gov.uk/government/publications/poly-implant-prothese-pip-breast-implants-final-report-of-the-expert-group

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Breast reduction
Background:	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.
Commissioning Position:	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 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. • In 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. • 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. Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 -200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months. Resection weights, for bilateral or unilateral (both breasts or one breast)

	breast reduction should be recorded for audit purposes. **Gynaecomastia**: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.
Effective From:	1 July 2021
Summary of evidence/ rationale:	One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery. Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010). Pages 13 & 14

2. Royal College of Surgeons – https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/breast-reduction-guide/

3. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. British Journal of Plastic Surgery, 56(3), 230–236.

4. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. Chiropractic & Osteopathy, 16(1), 1-7.

5. Singh KA, Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. Plast Reconstr Surg. 2012 Mar;129(3):562-70. PubMed: PM22090252

6. Strong B, Hall-Findlay EJ. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammaplasty Patients? Ann Plast Surg. 2014 Apr 10. PubMed: PM24727444

7. Valtonen JP, Setala LP, Mustonen PK, Blom M. Can the efficacy of reduction mammoplasty be predicted? The applicability and predictive value of breast-related symptoms questionnaire in measuring breast-related symptoms pre-and postoperatively. J Plast Reconstr Aesthet Surg. 2014 May;67(5):676-81. PubMed: PM24508223

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North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Hallux Valgus (Bunions)
Background	Degeneration of the small joints of the toes and feet is a common problem. It is often caused by inappropriate footwear. It can usually be managed conservatively by changing footwear. Surgery is sometimes sought to avoid the need to change footwear or for cosmetic purposes.
Commissioning position:	Referral for surgery for bunions will only be considered when the following criteria are met: • the patient has been referred to a podiatrist and conservative management has failed (including avoiding high heels, exercises, applying ice, appropriate analgesia, non-surgical treatment) AND • the patient suffers from severe deformity that causes significant functional impairment OR • the patient suffers from severe pain that causes significant functional impairment OR • there is recurrent or chronic ulceration (or infection) due to the deformity OR • there is recurrent or chronic bursitis or tendinitis at the first metatarsal head due to the deformity Exclusions: If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not affect the existing diabetic foot pathway This policy does not apply to surgery to correct deformity due to acute trauma. Before referral patients must be informed that: • They will be unable to drive for 6-8 weeks • It will take at least a further 2 months to regain full function • They will be out of sedentary work for up to 6 weeks and out of

	physical work for up to 3 months • The prognosis for treated and untreated Hallux Valgus is very variable • Recurrence of deformity occurs in 8-15% patients • There is very little good evidence with which to assess the effectiveness of either conservative or operative treatments or the potential benefit of one over the other
Effective From:	1 July 2021
Summary of evidence/ rationale:	NICE CKS makes clear that referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes. Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery. Referral for orthopaedic or podiatric surgery consultation may be of benefit if the deformity is painful and worsening; the second toe is involved; the person has difficulty obtaining suitable shoes; or there is significant disruption to lifestyle or activities. If the person is referred for consideration of surgery, advise that surgery is usually done as a day case. Bunion surgery may help relieve pain and improve the alignment of the toe in most people (85%–90%); but there is no guarantee that the foot will be perfectly straight or pain-free after surgery. Complications after bunion surgery may include infection, joint stiffness, transfer pain (pain under the ball of the foot), hallux varus (overcorrection), bunion recurrence, damage to the nerves, fractures, metalwork removal and continued long-term pain. There is very little good evidence with which to assess the effectiveness of either conservative or operative treatments or the potential benefit of one over the other. Untreated Hallux valgus in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even amputation.
Date:	January 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

Additional Information/References:

1. NICE Clinical Knowledge Summaries (2016) https://cks.nice.org.uk/topics/bunions/

2. Royal College of Surgeons Commissioning guide: Painful deformed great toe in adults.(2017) https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/painful-deformed-toe/

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NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Revisions of Breast reconstruction surgery and repeated courses of nipple tattooing
Background:	Breast reconstruction is surgery to make a new breast after removal of the breast or part of the breast due to cancer. The aim is to make a breast of similar size and shape to the original breast. Breast reconstruction can be done at the same time as the cancer surgery (immediate reconstruction), or after cancer surgery (delayed reconstruction) and may involve the use of implants to achieve the desired effect. Nipple tattooing is also a recognised procedure in relation to breast reconstruction surgery following treatment for breast cancer in order to improve the appearance of the breast.
Commissioning position:	A full course of treatment will be funded for patients undergoing either immediate or delayed breast reconstruction surgery, to include all aspects of the reconstruction. This includes the provision of implant(s) for the reconstruction, and one course of treatment for Nipple Tattooing. Revisions of reconstruction surgery for purely cosmetic reasons and further courses of Nipple Tattooing will not be funded. Please Note: Breast Reconstruction Surgery Post Mastectomy does NOT require Prior Approval
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

North Yorkshire Clinical Commissioning Group

Carpal Tunnel Syndrome Commissioning Policy

Intervention	**Treatment for Carpal tunnel syndrome may be called carpal tunnel release (CTR) or carpal tunnel decompression surgery.**
For the treatment of	**Carpal tunnel syndrome**
Commissioning position	Nerve conduction studies (NCS) are NOT available from primary care (see commissioning statement). The need for NCS to confirm and predict positive surgical outcome in specific cases is a matter for surgeons and neurophysiologists consideration. NHS North Yorkshire CCG will commission surgical decompression under local anaesthetic, for the treatment of carpal tunnel syndrome only in the following circumstances. For classification of symptoms of CTS, please see Appendix 1. **Moderate symptoms** Patients are experiencing symptoms that are interfering with activities of daily living **AND** all of the following have been tried: • The patient has not responded to a minimum of 6 months of conservative management, including at least 8 weeks of night time use of well-fitting wrist splints **and** • Appropriate analgesia has been tried **and** • Corticosteroid injections (given at least once prior to referral, unless clinically contraindicated) **and** • Lifestyle/workplace modification e.g. weight loss, if appropriate **OR** **Severe symptoms** • Patient is experiencing advanced or severe, neurological symptoms of Carpal Tunnel Syndrome such as constant pins and needles, numbness, muscle wasting and prominent pain **or** • Sudden or traumatic in origin Surgery should only be undertaken under local anaesthetic. Fear of the procedure, or patient choice are **not** adequate reasons for requesting surgery under GA, unless supporting mitigating factors are submitted to the IFR panel by the requesting clinician. **Patients who do not meet the criteria outlined above, can be considered on an individual basis where their GP or Consultant believes there is an exceptional clinical need that justifies deviation from this policy. In those instances an application should be made to the IFR panel.** In all cases the patient should have been informed about the shared decision making tool for Carpal Tunnel Syndrome

	Both splinting and steroid injection produce improvement in the majority of patients at least temporarily and should both be tried for patients with less severe symptoms and findings who are likely to include the 35% of patients who will not need further intervention.
Summary of evidence / rationale	Overall, patients whose CTS symptoms are significantly troublesome and who have mild or moderate impairment of the median nerve function should be offered splinting and local steroid injection. Patients failing such conservative management and those who present at a later stage with objective neurological signs or delayed motor conduction on nerve conduction systems should be offered the option of surgical decompression. All should be advised of the potential risks of the different treatments. An estimated 35% of patients with carpal tunnel syndrome will improve without surgical intervention. This is more likely when the patient is younger, when the symptoms are unilateral and/or of shorter duration or when Phalen's test is negative. A survey of over 4,000 patients having surgery under usual NHS circumstances found that about two years after surgery, only 75% considered the operation an unqualified success and 8% thought that they were worse off.
Date effective from	1 July 2021
Review Date	July 2023

References:

1. NICE CKS Carpal tunnel syndrome
2. Clinical Evidence – Carpal Tunnel Syndrome updated August 2014
3. Bland JDP. Carpal tunnel syndrome. Curr Opin Neurol 2005;18:581-5. [PubMed]
4. Bland J (2007) Clinical Review: Carpal tunnel syndrome. BMJ 2007;335;p343- 346
5. BSSH Evidence for Surgical Treatment 1 - CTS 2010
6. Royal College of Surgeons Commissioning Guide: Treatment of painful tingling fingers (November 2013)
7. NHS Choices – Carpal tunnel syndrome – Treatment
8. Evidence Based Intervention Policy – NHSE – published November 2018

Version	Created /actioned by	Nature of Amendment	Approved by	Date
0.1	Suzanne Savage	North Yorkshire CCG to adopt VOY CCG policy		

Appendix 1 – Classification of Carpal Tunnel Syndrome (CTS) Symptoms

CTS is a condition that involves pain and tingling in the first three or four fingers of one or both hands, which usually occurs at night. It is caused by pressure on the median nerve as it passes under the strong ligament that lies across the front of the wrist. Mild or moderate symptoms often resolve within 6 months.

There are a variety of treatment options which may be applied to the syndrome, depending on the severity of symptoms which can be mild, moderate or severe. An indication of each classification is detailed below:-

Assessment and Management in Primary Care		
	Symptoms	**Treatment**
Mild CTS	The sensory symptoms occur: ➢ No more than once during the day ➢ Once or twice a week during the night ➢ Lasting for up to 10 minutes ➢ Pain is not present	Explanation of condition and that it may improve spontaneously Lifestyle advice
Moderate CTS	The sensory symptoms occur: ➢ Two or three times during the day ➢ Once most nights ➢ Last for more than 10 minutes ➢ Pain may be present	Lifestyle advice Well fitted nocturnal wrists splints if waking at night is troublesome Appropriate analgesia Corticosteroid injection
Severe CTS	The sensory symptoms occur: ➢ Frequently each day and can last for more than an hour at a time ➢ Can be continuous ➢ Sleep is disturbed with more than two wakings every night ➢ Pain can be prominent ➢ Wasting and weakness of the thenar muscles may be present, together with sensory loss in the median supplied digits.	Consider early or immediate referral for surgery

Cataract Commissioning Policy

Treatment	**Cataract Surgery**
Background	NHS North Yorkshire CCG and NHS Vale of York CCG are responsible for commissioning activity in secondary care. This policy defines the commissioning position for cataract surgery and aims to: • Ensure cataract surgery is commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness. • Reduce variation in access. • Prioritise on the basis of surgical need. • Ensure that patients are aware of the implications of surgery and confirms their wish to proceed.
Commissioning Position	**NHS North Yorkshire CCG and NHS Vale of York CCG do not routinely commission cataract surgery based purely on the presence of a cataract. There will be a need to demonstrate that a patient's condition, in terms of visual acuity and impact on lifestyle/activities of daily living, exceeds the commissioning threshold for referral.** **First Eye** The presence of a cataract in itself does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risk and benefits of surgery. Where both eyes are affected by cataract, the first eye referred for cataract surgery is expected to be the eye cataract that has caused the greatest reduction in visual acuity. Referral of patients with cataracts to Ophthalmologists should be based on the following indications: • Visual acuity and impact on lifestyle/activities of daily living exceeding the commissioning threshold for referral as identified in the direct cataract referral form (See Appendix 1). **AND** • There has been a discussion on the risks and benefits of cataract surgery. **AND**

	• The patient has understood what a cataract surgical procedure involves and wishes to have surgery. **Second Eye** Second eye surgery referred at a time after first eye surgery has been completed will follow the same criteria as the first eye, see above. ***Exclusions*** The following categories of patient or ophthalmic conditions are exempt from application of the access criteria and may be referred directly for possible cataract surgery: • There is resultant significant optical imbalance (anisometropia - difference in refractive error) where the difference between the two eyes is more than 2.50 dioptres) AND which causes poor binocular vision (VA 6/12 or worse) or diplopia affecting daily living. • Patients with diabetes in whom the removal of cataract is considered necessary to facilitate effective digital retinopathy; • Patients with narrow angle glaucoma where removal of cataract (s) will prevent angle closure and blindness; ***Exceptionality*** Patients who do not meet any of the above indications nor exclusions, can still be referred to the CCG Individual Funding Request (IFR) panel for consideration of exceptional circumstances.
Summary of evidence / rationale	With the current volume of cataract surgery and the likely increases in the future, it is critical to be able to optimise the safety and cost effectiveness of this procedure and to prioritise use of limited NHS resources. Whilst patients with mild visual impairment due to cataracts may want surgery their need, in terms of health gain and function, may not be significant. Most cataracts are age-related and therefore surgeries are performed on older individuals with correspondingly high systemic and ocular comorbidities. It is therefore more important to ensure the right balance of risk to benefit[7]. Cataract surgery does not always result in an improvement in visual acuity or patient satisfaction with visual function[8]. The judgement of when to offer surgery depends both upon the risks of surgery and the impact of the cataract on the patient's

	quality of life. NICE Guidance (NG77), published in October 2017, advises that the decision to refer, a person with a cataract, for surgery should be based on a discussion with them that includes: how the cataract affects the person's vision and quality of life; whether one or both eyes are affected; what cataract surgery involves, including possible risks and benefits; how the person's quality of life may be affected if they choose not to have cataract surgery and whether the person wants to have cataract surgery. NG77 also emphasises that the offer for second-eye cataract surgery should be done using the same criteria as for the first-eye surgery. It is well known that patients with bilateral cataracts are at greater risk of falls and their quality of life is impaired. In the NHS locally there are long waits for surgery following diagnosis and this creates a longer period of risk for patients. Cataracts can reduce the ability to socialise, to drive and have confidence in normal living. The CCGs are keen to minimise the risk to as many patients, as fast as possible and treat at least one eye in all patients with bilateral cataracts. Whilst many patients will benefit from second eye surgery, the CCGs want to prioritise treating the first eye before those who have already had benefit from one cataract operation. Patients may have falsely raised expectations that having the second eye is either routine, imperative or necessary for other reasons. The rate at which cataracts progress is unpredictable. Reading glasses are usually needed after cataract surgery. Some people may require glasses for distance vision who did not previously require them[6]. Whilst in most patients having second eye surgery should give a better result, all surgery carries some risk. The need to take that risk depends on patient satisfaction, the degree of function after first eye surgery and any continuing imbalance with the second eye. Some may have a satisfactory return to function after just one operation and decide they can live with mild impairment. As a result their discussion, about the risks and benefits of a second operation, may lead to the conclusion not to undertake surgery. Patients with poor vision due to other ophthalmic conditions may achieve limited improvement after surgery to the first eye and may not get much better improvement after second eye surgery.

	After first eye surgery good refraction may achieve good vision with an up-to-date pair of spectacles after the first surgery. Second eye surgery may not benefit the patient a lot more in terms of their functional needs. Some CCGs require second eye surgery to meet the same criteria as first eye (Rotherham 2019), Dorset 2019). Note these follow NICE [NG77] guidance that the offer for second-eye cataract surgery should be done using the same criteria as for the first-eye surgery. Cambridgeshire and Peterborough CCG's policy (July 2018) states: "NICE [NG77] used four studies to explore what should be the optimal clinical thresholds, in terms of severity and impairment for referral for cataract surgery, and did not find any tool was suitable to set a threshold for surgery[1,2]. For the cost-effectiveness analysis NICE used a [newly developed] economic model with "potentially serious limitations" [as it is] based on a cohort of patients already triaged for surgery with policy criteria that might vary depending on their CCG location[2]." Significant improvements in visual symptoms and visual function may occur following first eye cataract surgery even where the preoperative visual acuity is better than 6/12 but the RCOphth guidance also recognises that "the risk of *worse* visual acuity after surgery increases where the preoperative visual acuity is very good *so surgery should be considered only where the patient is experiencing significant symptoms attributable to cataract*"[3]. There is good evidence (as stated in the RCOphth guidance and confirmed by two systematic reviews) of *significant improvement following first eye surgery, including a reduction in the rate of falls in older people receiving expedited cataract surgery for the first eye - but receiving second cataract surgery does not improve the risk of falling[4]. At least 5 studies have reported less visual function gain with second eye surgery compared with first, although this could be attributed to worse pre-operative VAs[5].* There are risks associated with cataract surgery, some common and many very rare. With such a common procedure, it is all the more important to select the patients most likely to benefit. There is no set level of vision for which an operation is essential[6].
Date effective from	1 July 2021
Date published	1 July 2021

Review date	July 2023
Approved by	Vale of York CCG Executive Committee and North Yorkshire CCG Business Committee
Responsible officer	Simon Cox

References:

1. Cataracts in adults:management; NICE NG77 (Nov 2017)
2. Cataracts Cambridge and Peterborough CCG Surgical Threshold Policy July 2018
3. Royal College of Ophthalmologists January 2018 Commissioning Guide: Adult Cataract Surgery https://www.rcophth.ac.uk/wp-content/uploads/2018/02/Cataract-Commissioning-Guide-January-2018.pdf
4. Foss et al Falls and health status in elderly women following second eye cataract surgery: an RCT Age and Ageing 2006;35(1) 66-71
5. London Choosing Wisely (guidance for all London CCGs); Healthy London Sept 2018 Cataract Surgery Appx 9a https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-9a-Cataract-Surgery-Policy.pdf (ref to RCOphth 2010 guidelines)
6. NICE Clinical Knowledge Summaries: Cataracts 2015 https://cks.nice.org.uk/cataracts#!scenario
7. Routine pre-operative medical testing for cataract surgery Cochrane database 2012 http://www.cochrane.org/CD007293/EYES_routine-preoperative-medical-testing-for-cataract-surgery
8. Day A, Donachie PHJ, Sparrow JM, Johnston RL. The Royal College of Ophthalmologists' National Ophthalmology Database Study of Cataract Surgery: Report 1, Visual Outcomes and Complications. Eye. Feb 2015 http://www.nature.com/eye/journal/v29/n4/full/eye20153a.html

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinicians and Head of Transformation & Delivery	New policy covering VoY & NY CCGs	n/a	April 20
1.1	Head of Transformation & Delivery	Encompass suggested amendments.	n/a	April 20

NHS North Yorkshire Clinical Commissioning Group

NHS Vale of York Clinical Commissioning Group

Appendix 1: Cataract Referral Form

DIRECT CATARACT REFERRAL FORM
Please note that referrals relevant to this form should go via the Choice Office reflecting the requirements of the North Yorkshire/Vale of York CCGs Cataract Commissioning Statement and not be for the identified excluded patients.

Patient Choice Office
Referral Management Service
West Offices, Station Rise
York, YO1 6GA
Telephone: 0300 3030060

DATE OF REFERRAL__/__/__
(Is this as a result of a follow-up assessment? Y/N)

Patient Name DOB __/__/__ Address Telephone NHS Number GP Name and Surgery	Practice Stamp

■ Surgery required on: Tick appropriate boxes - First eye ☐ Second eye ☐ Right eye ☐ Left eye ☐

VISUAL ACUITY

	Unaided VA	Sphere	Cyl	Axis	Prism	Base	New VA	Add	Near VA	Previous Corrected VA: Date:
RE										
LE										

Total Visual Acuity 'score' for this patient (i.e. add the scores for both eyes as below) (VA of 6/6 and 6/4 = score of '0', VA of 6/9= '1', VA of 6/12= '2', VA of 6/18= '3', VA worse than 6/18= '10') ☐

LIFESTYLE QUESTIONS TO THE PATIENT

Does the patient have any difficulty with mobility (including all aspects of travel, e.g. driving, using buses)?
Score '2' for 'yes' and '0' for 'no' ☐

Is the patient affected by glare in sunlight or at night (e.g. car headlights)?
Score '1' for 'yes' and '0' for 'no' ☐

Is the patient's quality of life affected by vision difficulties (e.g. car driving, watching TV, doing hobbies, etc)?
Score '3' for 'very much', '2' for 'moderately', '1' for 'slightly', '0' for 'not at all' ☐

Is the patient's 'social functioning' affected by vision difficulties (e.g. crossing roads, recognising people, recognising coins, etc)?
Score '3' for 'very much', '2' for 'moderately', '1' for 'slightly', '0' for 'not at all' ☐

Is the patient's vision affecting their ability to carry out daily tasks?
Score '2' for 'yes' and '0' for 'no' ☐

TOTAL ASSESSMENT SCORE (VA SCORE PLUS LIFESTYLE SCORE) ☐

Important
A patient with a total assessment score of 10 and over should be referred, unless you have indicated reasons below for not referring. ***Please provide description of cataract and any known co-morbidities below.***
A patient with a total assessment score of under 10 should be advised that a referral for a cataract operation is not essential at this time – the patient should be advised to have a follow-up assessment in 6 months. If the patient has a score of less than 10 but you feel a referral is still required, please state why.

.....
.....

I claim payment as per the Direct Cataract Referral Scheme.
To be completed by the contractor or authorised signatory:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Chalazia Removal
Background:	This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.
Commissioning position:	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 daily 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 • Is 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
Effective From:	1 July 2021
Summary of evidence/ rationale:	NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics, as per North Yorkshire CCG antibiotic prescribing guidelines for primary care, be used. Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical

	steroids around the eye does carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks. Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm however there are a small number which are persistent, very large, or can cause other problems such as distortion of vision. In these cases surgery can remove the contents from a chalazion. However all surgery carries risks. Most people will experience some discomfort, swelling and often bruising of the eyelids and the cyst can take a few weeks to disappear even after successful surgery. Surgery also carries a small risk of infection, bleeding and scarring, and there is a remote but serious risk to the eye and vision from any procedure on the eyelids. Lastly in a proportion of successful procedures the chalazion can come back. The alternative option of an injection of a steroid (triamcinolone) also carries a small risk of serious complications such as raised eye pressure, eye perforation or bleeding. Some trials comparing the two treatments suggest that using a single triamcinolone acetonide injection followed by lid massage is almost as effective as incision and curettage in the treatment of chalazia and with similar patient satisfaction but less pain and patient inconvenience. However this is controversial and other studies show that steroid injection is less effective than surgery. Therefore both options can be considered for suitable patients.
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

References:

1. NICE clinical knowledge summaries - https://cks.nice.org.uk/topics/meibomian-cyst-chalazion/
2. Moorfield's Eye Hospital Patient Information - https://www.moorfields.nhs.uk/sites/default/files/Chalazion.pdf
3. Wu AY, Gervasio KA, Gergoudis KN, Wei C, Oestreicher JH, Harvey JT. Conservative therapy for chalazia: is it really effective? Acta Ophthalmol. 2018 Jan 16. doi: 10.1111/aos.13675. [Epub ahead of print] PubMed PMID: 29338124.
4. Goawalla A, Lee V. A prospective randomized treatment study comparing three treatment options for chalazia: triamcinolone acetonide injections, incision and curettage and treatment with hot compresses. Clin Exp Ophthalmol. 2007 Nov;35(8):706-12. PubMed PMID: 17997772.

5. Watson P, Austin DJ. Treatment of chalazions with injection of a steroid Suspension. British Journal of Ophthalmology, 1984, 68, 833-835.

6. Ben Simon, G.J., Huang, L., Nakra, T. et al. Intralesional triamcinolone acetonide injection for primary and recurrent chalazia (is it really effective?) . Ophthalmology. 2005; 112: 913–917.

7. Papalkar D, Francis IC. Injections for Chalazia? Ophthalmology 2006; 113:355–356. Incision and curettage vs steroid injection for the treatment of chalazia: a metaanalysis. Aycinena A, Achrion A et al. Ophthalmic Plastic and reconstructive surgery. 2016;32:220-224.

8. McStay. Stye and Chalazion. BMJ Best Practice https://bestpractice.bmj.com/topics/en-gb/214 (accessed 18/10/18)

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Cholecystectomy
Background:	Gallstones are small stones usually made of cholesterol that form in the gallbladder. The majority of people with gallbladder stones remain asymptomatic and require no treatment. Patients with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral. Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy. Primary and secondary care discussions with patients should include identifying options (surgery versus no surgery), including the risks and benefits of each.
Commissioning position:	**Primary Care** Referral for a surgical opinion should only be made if there are any of the following circumstances: • Symptomatic Gallstones • Dilated common bile duct on ultrasound. If no gallstones, consider other causes and undertake appropriate investigations. • Asymptomatic gallstones with abnormal liver function tests results • Asymptomatic gall bladder polyps on ultrasound • Symptomatic gall bladder 'sludge' on ultrasound In addition the following information should also be available: • A recent ultrasound report has been conducted prior to referral • A liver function test report has been conducted within 1 month of referral Documentation that the threshold criteria are fulfilled is mandatory in the referral letter or form and the referral letter should, as a minimum, contain: • A clear indication of the grounds for referral against the threshold criteria • Any relevant medical history and current medication • Any known factors affecting the patient's fitness for day surgery

	If the gall bladder is sent for histological examination, the results should be reviewed by the requesting consultant and communicated to the GP. NB: although this policy is not subject to NHS North Yorkshire CCG's Health Optimisation thresholds patients should be encouraged by their GP and surgeon to lose weight prior to surgery and given appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. GPs can refer patients for a surgical opinion whilst patients lose weight and surgeons (and anaesthetists) can consider the safety of surgery. There is a clinical balance between risk of surgical complications with obesity and with potential complications of gallstones whilst delaying surgery.
Referral Guidance:	Exceptional cases should be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	November 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

Additional Information/References:

1. Royal College of Surgeons Commissioning Guide: Gallstone disease October 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones
2. Ahmed, R., Freeman, J.V., Ross, B., Kohler, B., Nicholl J.P., Johnson, A.G. Long-term response to gallstone treatment – problems and surprises. The European Journal of Surgery 2000 V. 166 (6) pp: 447-54. http://www.ncbi.nlm.nih.gov/pubmed/10890540
3. British Society of Gastroenterology (January 2017) Guidelines on the management of common bile duct stones: https://www.bsg.org.uk/resource/Updated-guideline-on-the-management-of-common-bile-duct-stones-(CBDS).html
4. Fazili, FM. (President WALS (World Association of Laparoscopic Surgeons. To operate or not to operate on asymptomatic gallstone in laparoscopy era. May 2010. http://www.wals.org.uk/article.htm
5. Halldestam-I, Enell-E-L, Kullman-E Borch-K. 'Development of symptoms and complications in individuals with asymptomatic gallstones'. The British Journal of Surgery. 2004.Vol:91(6),Pg. 734-8. http://onlinelibrary.wiley.com/doi/10.1002/bjs.4547/abstract
6. Meshikhes, A.W. Asymptomatic gallstones in the laparoscopic era. Journal of the Royal College of Surgeons of Edinburgh. 47(6):742-8 2002. http://www.ncbi.nlm.nih.gov/pubmed/12510966
7. NICE IPG 346 - Single incision laparoscopic cholecystectomy. NICE Interventional Procedure Guideline (May 2010): http://guidance.nice.org.uk/IPG346

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Circumcision
Background:	Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications.
Commissioning position:	Circumcision for both Adults and Children is not funded for social, cultural, or religious reasons. Circumcision will only be funded for specific medical reasons in accordance with the criteria specified below. GPs should seek advice regarding the use of steroid treatment (see "Summary of evidence/rationale" below) Medical reasons for funding circumcision include: • Carcinoma of the penis OR • Pathological phimosis: the commonest cause is lichen sclerosus – balanitis xerotica obliterans (BXO) is an old-fashioned descriptive term OR • Recurrent episodes of balanoposthitis OR • Leukoplakia (suspicion of cancer) Relative indications for circumcision or other foreskin surgery: • Prevention of urinary tract infection in patients with an abnormal urinary tract OR • Recurrent paraphimosis OR • Traumatic (e.g. zipper injury) OR • Tight foreskin causing pain on arousal/ interfering with physical function OR • Congenital abnormalities
Effective From:	1st July 2021
Summary of evidence/ rationale:	Nearly all boys are born with non-retractable foreskins as they are still in the process of developing and are often non-retractable up to the age of 3 years old. During normal development, the foreskin gradually becomes retractable without the need for any intervention. The majority of boys will have a retractable foreskin by 10 years of

	age and 95% by 16-17 years of age. Inability to retract the foreskin in boys up to at least the age of 16, in the absence of scarring, is, therefore, physiologically normal and does not require any intervention. Paraphimosis (where the foreskin becomes trapped behind the glans and cannot go forward again) can usually be reduced under local anaesthetic and recurrence avoided by not forcibly retracting the foreskin. It should not be regarded as a routine indication for circumcision. There are several alternatives to treating retraction difficulties before circumcision is carried out. The BMA (ref 3) states that to circumcise for therapeutic reasons, where medical research has shown other techniques (such as topical steroids or manual stretching under local anaesthetic) to be at least as effective and less invasive, would be unethical and inappropriate. Common risks of surgical circumcision include bleeding, local sepsis, oozing, discomfort >7 days, meatal scabbing or stenosis, removal of too much or too little skin, urethral injury, amputation of the glans and inclusion cyst. Furthermore, long-term psychological trauma and possible decreased sexual pleasure have also been reported. There are claims that there may be health benefits associated with this procedure, for example a lower rate of penile cancer and a reduced chance of sexual transmitted diseases (including HIV among heterosexual men). However, the overall clinical and cost-effectiveness evidence is inconclusive. Condoms are far more effective (98% effective if used correctly) than circumcision for preventing STIs.
Date:	January 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

NHS
North Yorkshire
Clinical Commissioning Group

Additional Information/References:

1. Female Genital Mutilation Act 2003
   http://www.legislation.gov.uk/ukpga/2003/31

2. Royal College of Surgeons Commissioning guide: Foreskin conditions October 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions

3. British Medical Association (2006), London. The law and ethics of male circumcision: guidance for doctors. J Med Ethics 2004; 30: 259–263.
   http://jme.bmj.com/content/30/3/259.full.pdf+html

4. NHS Choices – Information on Circumcision and medical reasons why it may be necessary.
   http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Corrective Surgery, Lens Implants and Laser Treatment
Commissioning Position:	Non-essential corrective surgery or lens implants for focusing (refractive) errors such as short sightedness (myopia), astigmatism and long sightedness (hyperopia) are not routinely commissioned by North Yorkshire CCG as these conditions are usually corrected by wearing spectacles or contact lenses. Requests for funding must be considered, via the Individual Funding Request Panel (IFR), requests should include: • Evidence of a clear clinical case of need, such as treatment for keratoconus (a rare eye condition where the cornea is conical shaped) that cannot be corrected by other means
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form The GP referral letter should contain: • Details of how the patient meets this requirement • Treatments and interventions tried including the results • Drug history (prescribed and non-prescribed) • Relevant past medical/surgical history • Current regular medication • BMI • Smoking status • Alcohol consumption
Effective From:	1st July 2021
Date:	April 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP NHS North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Cosmetic Breast Procedures
Definition:	Cosmetic surgery is any surgery carried out to enhance outward appearance. It may be carried out on people who perceive their appearance is abnormal from a range of clinical or congenital conditions or syndromes or as a result of surgery or injury. It can also be carried out to enhance appearance changes due to ageing or obesity. This guideline covers a group of surgical procedures with cosmetic indications.
Red Flag Symptoms:	**In all cases exclude Red Flag Symptoms and if present, refer 2WW or to symptomatic breast clinic**
Exclusions:	This policy does not apply to patients requiring plastic surgery and is covered in our commissioning statement ' Cosmetic/Plastic Surgery': Plastic surgery is routinely commissioned for patients undergoing treatment for: • *trauma reconstruction surgery; acute repair and acute reconstruction* • *cancer surgery and associated reconstruction* • *burns,acute care.* Patients in these circumstances may be referred directly to secondary care
Background:	**Breast asymmetry**: Breast asymmetry is a degree of difference in the size of an individual's breasts and is entirely normal. The difference can be corrected surgically and may involve breast reduction surgery or breast augmentation surgery (see separate North Yorkshire CCG commissioning statement for Breast Reduction referral criteria) **Breast augmentation**: Breast augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape. **Breast mastopexy**: Breasts begin to sag and droop with age as a natural process. Pregnancy, lactation and substantial weight loss may escalate this process. This is sometimes complicated by the presence of a prosthesis which becomes separated from the main breast tissue leading to 'double bubble' appearance. **Breast nipple correction**: The term inverted nipple refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological

	disturbance. Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. **Breast reduction**: Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape. (see separate North Yorkshire CCG commissioning statement for Breast Reduction referral criteria) **Gynaecomastia**: Gynaecomastia is a benign enlargement of the male breast. Most cases are idiopathic. For other cases, endocrinological disorders and certain drugs such as oestrogens, gonadotrophins, digoxin, spironolactone, cimetidine; proton pump inhibitors or drugs for treatment of prostate cancer could be the primary cause. Obesity can also give the appearance of breast development as part of the wide distribution of excess adipose tissue. Early onset gynaecomastia is often tender but this usually resolves in 3 to 4 months. Full assessment of men with gynaecomastia should be undertaken, including screening for endocrinological and drug related causes and necessary treatment is given prior to request for NHS funding. It is important to exclude inappropriate use of anabolic steroids or cannabis.
Commissioning position:	NHS North Yorkshire CCG does not routinely commission the above procedures for cosmetic reasons. Patients should not be referred unless clinical exceptionality is demonstrated and approved prior to initial referral by the Individual Funding Request panel.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
OPCS Codes:	Z15 Breast Z151 Upper inner quadrant of breast Z152 Upper outer quadrant of breast Z153 Lower inner quadrant of breast Z154 Lower outer quadrant of breast Z155 Axillary tail of breast

North Yorkshire
Clinical Commissioning Group

	Z156 Nipple Z158 Specified breast NEC Z159 Breast NEC Breast Asymmetry/Breast augmentation – B30.1/.8/.9; B31.2; B37.5 Breast –Inverted nipple correction – B35.4/.6 Breast – Mastopexy – B31.3 Breast – Prosthesis Removal and/or replacement – B30.- Breast – reduction – B31.1 Gynaecomastia – B31.1
Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHSE Evidence Based Interventions Policy – published November 2018 – https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi_statutory-guidance-v2.pdf

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Commissioning Statement:

Condition or Treatment:	Cosmetic / Plastic Surgery
Commissioning position:	Plastic surgery is routinely commissioned for patients undergoing treatment for: • *trauma reconstruction surgery; acute repair and acute reconstruction* • *cancer surgery and associated reconstruction* • *burns,acute care.* Patients in these circumstances may be referred directly to secondary care Cosmetic surgical procedures for the correction of changes associated with age, pregnancy, weight or because of unhappiness with body image are of low priority. These will not be routinely commissioned. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies. Specifically, psychological factors are not routinely taken into consideration in determining NHS funding. Whilst some degree of distress is usual among people who consider aspects of their physical appearance as undesirable, the degree of this will not routinely be taken into account in any funding decision. Further, it is expected clinicians consider the possibility of psychological problems including Body Dysmorphic Syndrome NICE Guidance CG31 assess for these and ensure appropriate management before considering any referral for plastic surgery.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	It is the responsibility of NHS North Yorkshire CCG to commission the most clinically and cost effective treatments for its local population within the resources available to it. Treatments which are primarily cosmetic in nature are, therefore, considered a low priority.
Date:	March 2020
Review Date:	July 2023

North Yorkshire
Clinical Commissioning Group

Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

Information for Commissioners of Plastic Surgery Services – Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London 2005

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Paediatric Foot Problems – Curly Toe
Commissioning position:	Referral to Secondary Care Services • If the deformity is severe, as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe. • When there is significant history of pain All patients to be referred to local podiatry services prior to referral to secondary care.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

https://patient.info/doctor/orthopaedic-problems-in-childhood#ref7

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Dilation & Curettage for menorrhagia or diagnostic purposes
OPCS Codes:	Q10 Curettage of uterus Q101 Dilation of cervix uteri and curettage of products of conception from uterus Q103 Dilation of cervix uteri and curettage of uterus NEC Q108 Other specified curettage of uterus Q109 Unspecified curettage of uterus
Background:	Dilation and Curettage (D&C) is a procedure performed under general anaesthetic in which the lining of the uterus (the endometrium) is biopsied (diagnostic D&C) or removed (therapeutic D&C) by scraping with a sharp metal instrument (curette) in a systematic fashion. This commissioning policy is needed because these surgical procedures are of limited clinical value and are currently not routinely commissioned. Such requests therefore have to be made on the grounds of clinical exceptionality via the Individual Funding Request Panel (IFR).
Commissioning position:	NHS North Yorkshire CCG does NOT commission D&C: • As a diagnostic tool for uterine bleeding disorders • As a treatment for heavy menstrual bleeding • As a therapeutic treatment for other uterine bleeding disorders • As a method of removing unwanted tissue, endometrial polyps or benign tumours from the womb or an IUD that has become embedded in the wall of the womb All requests for D&C should be submitted to the IFR Panel
Referral Guidance:	All requests for D&C should be submitted to the IFR Panel: • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	**Diagnostic D&C:** Ultrasound (1st line) or hysteroscopy (with or without biopsy) (2nd line) are recommended as diagnostic techniques to investigate uterine bleeding disorders. Hysteroscopy and biopsy is also the preferred technique to remove polyps and other benign lesions, as it

	allows targeted removal. If a tissue sample is required and there is no lesion visible on a scan then an endometrial biopsy may be done. **Therapeutic D&C**: There is limited evidence on the effectiveness of D&C in the management of menorrhagia. The one study that was identified by NICE showed that any effect was temporary. NICE guidance states that D&C should not be used as a therapeutic treatment **Evacuation of retained products of conception (ERPC):** where surgical evacuation after incomplete miscarriage or delivery is clinically indicated over medical management and watchful waiting, vacuum aspiration has superseded D&C as it is quicker, safer, easier and less painful. **Gestational trophoblastic disease**: Suction/vacuum curettage is the preferred method of evacuation irrespective of uterine size in patients with suspected hydatidiform mole who want to preserve fertility
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

1. Investigation of Post-Menopausal Bleeding. SIGN Publication No.61; 2002
2. National Institute for Health and Clinical Excellence. Heavy Menstrual Bleeding. Investigation and Treatment. London: NICE; 2007
3. NICE. Heavy Menstrual Bleeding. January 2007. Do Not Do – D&C alone should not be used as a diagnostic tool
4. NICE. Heavy Menstrual Bleeding. January 2007. Do Not Do – D&C alone should not be used as a therapeutic treatment

Intervention	Surgical Treatment for Dupuytren's Contracture
For the treatment of:	Dupuytren's contracture
Background	Dupuytren's contracture is a progressive disorder that affects the palmar fascia, causing the fibrous tissue to shorten and thicken, which may prevent full extension of the fingers and limit function. All treatments aim to straighten the finger/s to restore and retain hand function, but none cure the condition - which can recur after any intervention so that further interventions are required[1]. Several treatments are available: percutaneous needle fasciotomy and collagenase injections are outpatient procedures whereas fasciectomy and dermatofasciectomy are open surgical procedures. No procedure is entirely satisfactory with some having slower recovery periods, higher complication rates or higher need for further surgery (for recurrence) than others[1]. It is unclear which intervention is best for restoring and maintaining hand function and which are the most cost-effective in the long term. Research studies are trying to address these questions and patients should discuss the latest understanding with surgeons. A Patient information leaflet can be found here North Yorkshire CCG's commissioning statement is a modified version of the national Evidence Based Commissioning (EBI) policy thresholds
Commissioning position	Treatment is **not indicated** where there is no contracture or it is mild (less than 20º) or not progressing and does not impair function[1] NHS North Yorkshire CCG will commission surgical treatment for Dupuytren's Contracture only in the following circumstances. An intervention (collagenase injections; needle fasciotomy; fasciectomy and dermofasciectomy) should **only** be considered (and IFR approval is not required), when the patient meets **at least one** of the following functional difficulties. • finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. See here on how to measure the angles using a goniometer **OR** • thumb contractures which interfere with function **AND** • There is a current material impairment of hand function **AND** • Surgery is likely to restore function **Treatment in all other circumstances is not routinely**

	commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request panel. NICE concluded that collagenase treatment (Xiapex) should only be used for[2]: a. Participants in the ongoing clinical trial (HTA-15/102/04) **or** b. Adult patients with a palpable cord **if all of the following apply**: • 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 • percutaneous needle fasciotomy is not considered appropriate, but limited open fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting.
Summary of evidence / rationale	Dupuytren's disease is a benign, slowly progressive condition of unknown origin, characterised by connective tissue thickening in the palm of the hand, forming nodules and cords, which leads to difficulty in extending the fingers[3]. Early symptoms are usually often mild and painless and do not require treatment but can include reduced range of motion, reduced hand function and pain. Most patients are affected in both hands. Most patients do neither need treatment nor a referral to secondary care but do need explanation and reassurance. They do not require monitoring. It is important to emphasise that contractures can progress and only need treatment if symptomatic (usually 20 – 30 degrees) Contractures that do impact on function are better treated earlier as they can pull the joints into a permanently flexed position, making it difficult to straighten fully with any treatment if allowed to progress too far. The condition often occurs in later life, and is most common in men aged over 40. Around one in six men over the age of 65 are affected by early, asymptomatic disease in the UK. It can be associated with diabetes, liver disease and alcohol excess. Although there is great variation in the rate of progress, it is usually possible to distinguish the more aggressive form of the disease early

	on by its rapid progression. Recurrence following treatment is more likely in younger patients if the original contracture was severe or if there is a strong family history of the condition. Intervention is almost exclusively surgical, but surgery is not curative, complications and recurrence rates can be high (an overall complication rate of 26% has been reported for fasciectomy and fasciotomy[3] of which 4% have infection, numbness and stiffness). The evidence base provides no clarity about the best approach, which has to be judged for the individual patient. **To justify the risks of surgery a flexion deformity must be present.** Recent developments have been towards outpatient procedures, percutaneous needle fasciotomy (PNF) and collagenase injection (CCH) (more experimental, but supported by NICE TA459[2]). NICE guidance for PNF only exists as an IPG from 2004[4]. CCH is a potential (but more expensive) option if PNF is not considered appropriate by the clinician. Although NICE TA459 suggests it in defined circumstances (including access to the ongoing clinical trial), its cost-effectiveness has not yet been demonstrated. A recent Swedish RCT, with institutional not industry funding and high internal validity, randomised around 150 patients (with involvement of only one finger and no earlier treatments) between PNF and collagenase treatment[5]. They found no significant differences between the two methods with regard to any outcome measurement at any time during the 2 year follow up. Most (around 75%) retained a straight finger although there was a significant recurrence rate of palpable cords. They point out that in the US, the introduction of CCH has increased the percentage of Dupuytren's contractures that are treated with minimally invasive techniques from 14% (2007) to 39% (2013), while the number of PNFs remains steady (and the number of open surgical procedures has declined). There is a substantial difference in cost, with CCH treatment almost 3 times more expensive. Another study has reported a significantly inferior outcome for CCH at 2 years[6]. Patient selection therefore has to be made carefully according to agreed criteria, with a preference for PNF while the benefits of CCH (in particular its cost-effectiveness) remain unproven.
OPCS codes	T521, T522, T525, T526, T528, T529, T541, T549, T561 T562 ICD code: M720

Date effective from	1 July 2021
Review date	July 2023

References:

1. Evidence-Based Interventions: Guidance for CCGs N. Dupuytren's contracture release in adults**.** NHSE/NHSI Nov 2018, updated Jan 2019 https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf
2. NICE TA459 Collagenase clostridium histolyticum for treating Dupuytren's contracture. July 2017. https://www.nice.org.uk/Guidance/TA459
3. NICE Clinical Knowledge Summaries (CKS) 2015 https://cks.nice.org.uk/dupuytrens-disease#!scenario
4. National Institute for Health and Clinical Excellence (NICE). Needle fasciotomy for Dupuytren's contracture. IPG43. London: NICE; 2004 https://www.nice.org.uk/guidance/ipg43
5. Percutaneous Needle Fasciotomy Versus Collagenase Treatment for Dupuytren Contracture: A Randomized Controlled Trial with a Two-Year Follow-up Stromberg et al al J Bone and Joint Surgery July 2018 https://journals.lww.com/jbjsjournal/Fulltext/2018/07050/Percutaneous_Needle_Fasciotomy_Versus_Collagenase.1.aspx
6. Injectable collagenase versus percutaneous needle fasciotomy for Dupuytrens contracture in PIP joints: an RCT Skov et al J Hand Surg Am 2017

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Service Improvement Manager	Adopt VoY CCG policy	Policy Harmonisation Working Group	July 2021

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Endoscopic Thoracic Sympathectomy for Hyperhidrosis
Commissioning Position:	Thoracic Sympathectomy (Endoscopic or Open) for the treatment of hyperhidrosis is not routinely funded.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form •
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Exogen Therapy
Commissioning position:	Exogen may be funded under the following circumstances: Fractures of long bone fractures with non-union (failure to heal 9 months after fracture), where surgery is otherwise the option, if: • fracture gap is ≤ 1 cm, AND • non-union is not related/secondary to malignancy, AND • non-union confirmed by 2 radiographs minimum 90 days apart • and physician statement of no clinical evidence of fracture healing For the purposes of this evaluation, long bone fractures are defined as fractures of the humerus, ulna, radius, femur, tibia and fibula. If the fracture is unstable or inter-fragment gap >1 cm then surgery is the expected option. Exogen will NOT be funded for: Delayed healing (no radiological evidence of healing between 3 and 9 months) Additional information needed on referral: • Date of fracture • Dates of radiography confirming non-union and no further progression towards radiographic healing For the purposes of exceptionality, the cohort is defined as: Non-union fracture of long bone, where surgery is otherwise an option, and where fracture is stable, aligned and inter fragment gap is <1cm. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy Investigations prior to referral • None
Referral Guidance:	This is a Secondary Care policy – Prior Approval for treatment to be completed by the Orthopaedic Surgeon
Effective From:	1 July 2021
Date:	November 2020

NHS
North Yorkshire
Clinical Commissioning Group

Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Face and/or Brow Lift
Background:	These surgical procedures are performed to lift the loose skin of the face and forehead to get a firm and smoother appearance of the face. These procedures will not be funded to treat the natural processes of ageing or to achieve a cosmetic outcome.
Commissioning position:	Face lift or brow lift will only be funded in accordance with the criteria specified below. These procedures will **only** be considered for treatment of the functional impairments arising from: • Congenital facial abnormalities • Facial palsy (congenital or acquired paralysis) • As part of the treatment of specific conditions affecting the facial skin eg. Cutis laxa, pseudoxanthoma elasticum, neurofibromatosis • To correct the functional consequences of trauma • To correct functional consequences of deformity following surgery • In some cases of impaired visual fields, where it may be a more appropriate primary procedure than blepharoplasty Surgery for primarily cosmetic reasons is not eligible for NHS funding
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Flash Glucose Monitoring System for use in adults, young people and children for ,onitoring glucose levels in adults and children over 4 years of age with type 1 diabetes mellitus
Commissioning position:	Flash Glucose Monitoring System (FGS) is only commissioned for: 1. People with Type 1 Diabetes OR with any form of diabetes on haemodialysis and on insulin treatment who, in either of the above, are clinically indicated as requiring intensive monitoring of over 8 times daily by their diabetes specialist, as demonstrated on a meter download/review over the past 3 months OR with diabetes associated with cystic fibrosis on insulin treatment 2. Pregnant women with Type 1 Diabetes, eligible for 12 months in total, inclusive of post-delivery period. 3. People with Type 1 diabetes unable to routinely self-monitor blood glucose due to disability who require carers to support glucose monitoring and insulin management. 4. People with Type 1 diabetes for whom the specialist diabetes MDT determines have occupational (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) or psychosocial circumstances that warrant a 6 month trial of FGS with appropriate adjunct support. 5. Previous self-funders of FGS with Type 1 diabetes where those with clinical responsibility for their diabetes care are satisfied that their clinical history suggests that they would have satisfied one or more of the above criteria, prior to them commencing use of FGS, had these criteria been in place prior to April 2019 AND have shown improvement in HbA1c since self-funding. 6. For those with Type 1 diabetes and recurrent severe hypoglycaemia or impaired awareness of hypoglycaemia, NICE suggests that Continuous Glucose Monitoring with an alarm is the standard. Other evidence-based alternatives with NICE guidance or NICE TA support are:

- pump therapy,
- psychological support,
- structured education,
- islet transplantation
- whole pancreas transplantation.

However, if the person with diabetes and their clinician consider that a Flash Glucose Monitoring system would be more appropriate for the individual's specific situation, then this can be considered.

7. People with Type 1 diabetes who have had 2 or more admissions due to diabetic ketoacidosis in the previous 12 months.

8. Patients with type 1 diabetes who meet the NICE criteria for insulin pump therapy where a trial of FGS may avoid the need to initiate an insulin pump.

9. People with Type 1 diabetes or insulin treated Type 2 diabetes who are living with a learning disability and recorded on their GP Learning Disability register

Other requirements:

- Education on Flash Glucose Monitoring has been provided (online or in person)
- Agreement to scan glucose levels at least 8 times per day and use the sensor over 70% of the time
- Agreement to regular reviews with the local clinical team
- Previous attendance, or due consideration given to future attendance, at a Type 1 diabetes structured education programme, such as BITES or DAFNE

The initiation of patients on to FGS will be the responsibility of the diabetes specialist team in secondary care, continued supplies will be the responsibility of primary care prescribers.

Continued prescription for long-term use of FGS, following 6 month review, would be contingent upon evidence of agreeing with the above conditions and that on-going use of FGS is demonstrably improving diabetes self-management. The decision to continue will be made by the diabetes specialist team in secondary care only if one or more of the following are demonstrated:

	• Reduction in usage of blood glucose test strips (approximate target to be agreed, however it is acknowledged that more frequent testing may be required in certain circumstances e.g. during periods of illness or to fulfil DVLA requirements). • Reduction in hypoglycaemia frequency • Reversal of impaired awareness of hypoglycaemia • Reduction in episodes of diabetic ketoacidosis • Improvement of HbA1c or time in range. • Reduction in hospital admissions • Improvement in psycho-social wellbeing
Secondary Care Specialist Team Responsibilities:	Diabetes Specialist Teams Responsibilities 1. Assess type 1 diabetic patients for suitability for flash glucose monitoring and ensure any appropriate patients meet the criteria within the NHSE guidance before considering initiation. Record the criteria for initiation in patient's medical record. 2. Discuss use of flash glucose monitoring with patient and ensure they are aware that continuation of supply beyond 6 months is contingent on achieving a demonstrable improvement and engagement with other diabetes care processes. The expected improvement or benefit from treatment should be recorded and agreed with the patient. 3. Patients need to sign up to share their scan data with the diabetes team on Libreview.com or other suitable platform. 4. Arrange training on the use of flash glucose monitoring products with a suitable trained member of the team or group training. 5. Supply a starter pack to patient (monitor and minimum of one sensor lasting two weeks) 6. Inform patient of safe disposal of sensors as clinical waste, supply clinical waste bags or large sharps bins as per local arrangement. 7. Inform GP practice in timely manner that patient has been initiated on flash glucose monitoring. For Cystic Fibrosis and Haemodialysis patients inform all relevant clinicians involved in their care. Communications should include the following information: a) The criteria the patient meets for initiation of flash glucose monitoring b) The expected improvement or benefit at 6 months from flash glucose monitoring c) The frequency of ongoing need for patient to continue BGTS as well as flash glucose monitoring - State expected reduction in BGTS usage. d) Next review appointment 8. Arrange to review the patient at an appropriate interval but no later than 7 months after initiation. 9. Review the patient at 6 months to determine whether they have

	achieved the expected improvement or benefit to continue flash glucose monitoring (see under 'Review') and record outcome on agreed audit tool as appropriate. 10. At 6 month review: Inform GP practice as soon as practical and within seven days whether the patient should continue on flash glucose monitoring. Communications should include the following information: a) The improvement or benefit achieved from flash glucose monitoring. b) Whether patient is continuing on flash glucose monitoring or agreed to stop due to lack or benefit or patient choice. c) The frequency of ongoing need for patient to continue BGTS as well as flash glucose monitoring. Expected reduction in BGTS usage. d) Next review appointment
Primary Care GP Responsibilities	Primary Care Prescribers Responsibilities 1. Do not initiate diabetic patients on flash glucose monitoring in primary care. Refer patients to discuss their eligibility with the diabetes team at their next planned review. 2. Patients who do not meet the NHSE criteria may purchase privately. Continue to prescribe sensors for patients who have been initiated by NHS commissioned diabetes specialist team on flash glucose monitoring. 3. Following receipt of communication (letter/task) from the diabetes specialist team add Freestyle Libre sensors to the patients repeat prescription authorised for 6 months. Add a note so that all prescribers can see when the review date is due. NB. 2 sensors last for 28 days If the sensors fall off within 14 days the patient should contact Abbott Customer Care to obtain a replacement they should not be issued again on prescription. 4. Reduce the quantity of BGTS from the patient's prescription record in line with the diabetes team instructions regarding need for ongoing monitoring. 5. At the end of the initial 6 months' supply ensure the patient has been reviewed by the specialist team and has achieved the planned improvements or benefits before re-authorising further supply of sensors. NB the practice should receive communication following this specialist review to confirm success or failure of flash glucose monitoring 6. Ensure the patient receives an ongoing review of flash glucose monitoring as part of their regular diabetes reviews.
Further information	Secondary care specialist teams are responsible for completing audit data when FGS is first started and after six months. If audit data is not collected within four weeks of the end of the six month trial, the patient will not be eligible for FGS. Patients will need to be made aware of this and sign a contract agreeing to the terms of use of FGS. Treatment outcomes must be audited in all patients started on FGS by

	specialist teams. The specialist teams will be responsible for ensuring FGS is being appropriately used by ensuring patients satisfy the above criteria. The specialist team will provide audit data to the CCG if requested who will periodically review the data. All patients (or carers) must be willing to undertake training in the use of FGS. They must commit to regular scans of the device demonstrating evidence of FGS use in self-management, and commit to ongoing regular follow-up and monitoring. They must also agree the expected outcomes with usage and that NHS provision of FreeStyle Libre® will be withdrawn if one or more of the above criteria are not met. Prescribing instructions: • The specialist team will provide the patient with a 2 week sensor supply and the FGS device. • The specialist team will notify the GP their patient has been initiated on FGS • GPs will need to then issue a prescription for 2 FGS sensors per month. • After 6 months, the specialist team will advise if the patient is eligible for continued supplies of FGS sensors on prescription. Adjunct blood testing strips should be prescribed according to locally agreed best value guidelines with an expectation that demand/frequency of supply will be reduced. Patients with Type 2 Diabetes who do not meet the above criteria are NOT eligible for FGS on the NHS. Reluctance to carry out finger prick testing (e.g. due to distress or inconvenience) alone is not considered to be criteria qualifying the use of FGS. Patients already purchasing FGS who do not meet the above criteria will not be entitled to NHS prescriptions. A clinician can make an Individual Funding Request (IFR) for treatment when a patient does not meet the stated criteria for funding. Funding can only be approved if a case of “exceptional clinical need” has been demonstrated.
Summary of clinical evidence:	FGS measures interstitial glucose levels from a sensor applied to the skin as an alternative to routine finger-prick blood glucose testing, and can produce a near-continuous record of measurements which can be accessed on demand. It can also indicate glucose level trends over time. Glucose readings can be seen anytime by scanning the sensor with a FGS reader or an android mobile device with ‘Near-field Communication’ (NFC) capabilities via the LibreLink companion app. FreeStyle Libre® is indicated in people aged 4 or over with diabetes mellitus, who have multiple daily injections of insulin or who use insulin pumps and are self-managing their diabetes. FreeStyle Libre® received European CE mark certification in August 2014. For more details on the device, please refer to NICE Medtech innovation briefing 110. The main points from the evidence are from 5 studies involving 700 people. These include 2 randomised controlled trials, 1 including people

	with type 1 diabetes (n=241; the IMPACT study) and the other including people with type 2 diabetes (n=224; the REPLACE study). Three of the studies reported device accuracy compared with self-monitored blood glucose, with results ranging from 84% to 88% accuracy and from 99% to 100% clinical acceptability, using an error grid. One study reported device accuracy and acceptability of 97% to 99% compared with venous blood sampling. The evidence suggests that using FreeStyle Libre® for up to 12 months reduces time spent in hypoglycaemia compared with self-monitoring of blood glucose using finger-prick tests, and reduces the average number of finger-prick blood glucose tests needed. In the IMPACT study, patients using FreeStyle Libre® experienced less time in hypoglycaemia than patients using self-monitored blood glucose (SMBG), averaging 1.24 hours per day (SE 0.24) or 38% less time ($p<0.0001$) in hypoglycaemia and 1 hour more per day in euglycaemia ($p=0.0006$). The number of hypoglycaemic events per day reduced by mean of 0.45 (by over 25%;$p<0.0001$). The mean number of SMBG tests per day reduced from 5.5 (SD 2.0) to 0.5 (SD 0.7) in the FreeStyle Libre® group. FreeStyle Libre® does not include an alarm that alerts users when glucose levels are too high or too low. The device measures interstitial glucose levels and finger-prick blood glucose testing would still be needed: • During times of rapidly changing glucose levels when interstitial fluid glucose levels may not accurately reflect blood glucose levels • If FreeStyle Libre® shows hypoglycaemia or impending hypoglycaemia • When symptoms do not match the system readings • To fulfil Driving and Vehicle Licensing Authority requirements to assess fitness to drive.
Safety:	There are currently limited safety data on the use of FreeStyle Libre® . The most commonly reported adverse effect related to sensor use in trials was skin reactions e.g. itching, rash, erythema, allergy, oedema and blisters. Some users may need to use a skin covering in order to be able to use the sensor. Accuracy of FreeStyle Libre® readings compared to capillary blood glucose testing has been found to be broadly comparable. However capillary blood glucose testing is still recommended during times of rapidly changing glucose levels when interstitial fluid glucose levels may not accurately reflect blood glucose levels (e.g. acute illness such as Influenza, diarrhoea and vomiting), or if hypoglycaemia or impending hypoglycaemia is reported, or the symptoms do not match the system readings.
Cost:	The annual cost of sensors is currently £910 per patient (Dec 2020). The reader is not prescribable on the NHS but provided free of charge by the

	manufacturer. The use of FreeStyle Libre® is expected to be cost neutral if a patient is currently finger prick testing 8 or more times daily, and the introduction of FreeStyle Libre reduces the testing frequency to an average of 0.5 times daily. The resource impact depends upon the extent to which improved glucose control through the adoption of FreeStyle Libre® translates into fewer complications (hypoglycaemia and the longer term microvascular and macrovascular complications of hyperglycaemia), reduced admissions and reduced use of glucose test strips.
Effective from:	1 July 2021
Date:	December 2020
Review Date:	July 2023
Contact:	Chris Ranson, Senior Pharmacist, North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Functional Electrical Stimulation
Background:	Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve mobility. It is particularly used as a treatment for drop foot. Drop foot is caused by disruption in the nerve pathway to and from the brain, rather than in nerves within the leg muscles.
Commissioning Position:	**Non-Implantable Devices:** **Policy: Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG278, providing normal arrangements are in place for clinical governance, consent and audit, and provided ALL of the following criteria are met:** • Drop foot is impeding gait and in whom the use of all orthotics (AFO) has proven to be unsuccessful following specialist assessment; AND • The patient has demonstrable functional improvement from an individual trial of FES; AND • The intervention is recommended by a multidisciplinary team specialised in rehabilitation. **Implantable Devices:** **Policy: The wireless or implantable device is NOT routinely commissioned. Funding will only be considered where there are exceptional clinical circumstances. The clinician needs to submit an application to the Individual Funding Request Panel.**
Effective From:	1st July 2021
Date:	March 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP NHS North Yorkshire CCG

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Intervention:	Gamete harvesting and storage (Cryopreservation)
For the treatment of:	Harvesting and storage of viable gametes in patients undergoing NHS funded medical treatment(s) that cause infertility
Background:	This is a formal policy on gamete harvesting and preservation for patients undergoing medical treatments that may leave them infertile. Cryopreservation is the process of freezing and storing sperm, oocytes and embryos so that they can potentially be used at a later date, typically in an attempt to conceive a pregnancy. The CCG has a comprehensive fertility policy available on their website which covers the commissioning of cryopreservation for routine infertility treatment. One circumstance which is not covered by the fertility policy is the provision of cryopreservation for an individual who is expected to undergo NHS funded medical treatment(s) that cause infertility.
Commissioning position:	NHS North Yorkshire CCG agrees to fund the harvesting and subsequent storage (cryopreservation) of viable gametes, for an initial period of 10 years, for patients undergoing NHS funded medical treatment that may leave them infertile. If after the initial 10 year period storage is still required, an IFR application should be made as an exceptional request, provided the patient wishes to keep their sample for potential future use. Each case will be considered on its own merit and in line with the HFEA legislation. Approval for harvesting and cryopreservation does not guarantee future funding of assisted conception or fertility treatment – in this instance the CCG policy for assisted conception should be applied. Prior to fertility preservation, the secondary care clinician at the organisation providing the fertility service must confirm: • That the planned treatment is likely to affect future fertility (and document this for the commissioner's audit purposes) • That the impact of the treatment on fertility has been discussed with the patient • That the patient is able to make an informed choice to undertake gamete harvesting and cryopreservation of semen, oocytes or embryos for an initial period of 10 years • That the patient is aware that funding for gamete harvesting and cryopreservation does not guarantee future funding of assisted conception treatment

Cryopreservation in males

In general, it is recommended that at least two semen samples are collected over a period of one week. The CCG will commission a maximum of three samples of semen; this is considered sufficient to provide future fertility.

Testicular tissue freezing is considered experimental and will not be funded.

Note: testicular sperm retrieval is commissioned by NHS England and not by the CCG.

Cryopreservation in Females

The CCG will normally fund one cycle of egg retrieval, with or without fertilisation. If fewer than 10 eggs are retrieved following this first cycle of egg retrieval, then one further cycle can be offered.

Ovarian tissue storage is considered experimental and will not be funded.

Age

There are no specific age limits to this policy for males or females. The decision to attempt to preserve fertility is a clinical decision.

Previous sterilisation

Gamete retrieval and cryopreservation will not be funded where the patient has previously been sterilised.

NHS Funded Assisted Conception

Access to NHS funded harvesting and cryopreservation will not be affected by previous attempts at assisted conception. However, funding for further assisted conception attempts will be subject to the criteria stated in the CCG's IVF policy at the time of any funding application.

Expectations of Providers

Cryopreservation of gametes or embryos must meet the current legislative standards, i.e. under Human Embryo and Fertility Act 1990

The provider of the service must ensure the patient receives appropriate counselling and provides full consent. The patient and their partner must be made aware of the legal position on embryo ownership should one partner remove consent to their ongoing storage or use.

North Yorkshire
Clinical Commissioning Group

	The provider of the service must ensure patients are aware of legal issues on posthumous use of gametes and embryos should they wish a partner to be able to use these should their treatment not be successful. Patients will need to provide annual consent for continued storage. The provider must ensure appropriate consent to storage is in place and that the patient understands the need for on-going consent and has outlined the purposes for which they can be used. **Expectation of the Patient** The patient will be responsible for ensuring the storage provider has up to date contact details. Failure to provide on-going consent may result in the destruction of stored materials.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Following notification of a recent legal challenge[i] having been brought against NHS England by the Equality and Human Rights Commission (EHRC), the CCG wishes to ensure that all patients undergoing medical treatments that may affect fertility, including transgender treatments, have the same access to gamete preservation services as patients undergoing cancer treatment. The challenge relates to the commissioning and provision of gamete retrieval and storage services for transgender patients. The EHRC argues that: • *NHS England wrongly interprets the words "Gender Identity Disorder Services" at paragraph 57, Schedule 4 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations") as not including gamete retrieval and storage, and has thereby misdirected itself as to its obligation to provide that service to transgender patients;* • *NHS England has unlawfully failed to exercise its power under s.2 of the National Health Service Act 2006 ("the 2006 Act"), in the light of its obligations under domestic and European equalities provisions, to provide gamete retrieval and storage to transgender patients;*

North Yorkshire
Clinical Commissioning Group

	• *NHS England has unlawfully failed to exercise its power to issue guidance to clinical commissioning groups ("CCGs") to discourage them from unlawfully failing to arrange for the provision of gamete retrieval and storage to transgender patients.* NHS England's position is that the commissioning of gamete retrieval and storage services is appropriately the commissioning responsibility of CCGs. Responsibility for developing clinical commissioning policy in this area extends as much to trans patients as it does to patients, for example, undergoing chemotherapy. When formulating clinical commissioning policy in this, and indeed all areas of commissioning responsibility, CCGs are under a number of legal duties including the Public Sector Equality Duty. NHS England's position is that no additional statutory guidance on this issue is required. NHS England advised CCGs: 'in light of this challenge, [CCGs] may wish to review any commissioning policies … in place in this area and how they apply to different groups of patients.
Date:	May 2020
Review Date:	July 2023
Contact:	Dr Christopher Ives, Governing Body GP

Additional Information/References:

[i] NHS England CCG Bulletin - Issue 247 - 25 October 2018, Review of clinical commissioning policies for gamete retrieval and preservation

- NICE (CG156 Fertility Problems: assessment and management)
- Human Fertilisation and Embryology Act (1990) guidelines https://www.hfea.gov.uk/
- Human Tissue Authority guidelines https://www.hta.gov.uk/
- Leeds CCG Gynaecology and Urology Commissioning Policy

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Ganglion excision
Background:	Ganglia are cystic swellings containing jelly-like fluid which form around the wrists, the hand or other joints. In most cases wrist ganglia cause only mild symptoms which do not restrict function, and many resolve without treatment within a year. Wrist ganglion rarely press on a nerve or other structure, causing pain and reduced hand function. Ganglia in the palm of the hand (seed ganglia) can cause pain when carrying objects. Ganglia which form just below the nail (mucous cysts) can deform the nail bed and discharge fluid, but occasionally become infected and can result in septic arthritis of the distal finger joint.
Commissioning position:	Wrist 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.
Effective From:	1 July 2021
Summary of evidence/ rationale:	Most wrist ganglia get better on their own. Surgery causes restricted wrist and hand function for 4-6 weeks, may leave an unsightly scar and be complicated by recurrent ganglion formation. Aspiration of wrist ganglia may relieve pain and restore hand function, and “cure” a minority (30%). Most ganglia reform after aspiration but they may then be painless. Aspiration also reassures the patient that the swelling is not a cancer but a benign cyst full of jelly. Complication and recurrence are rare after aspiration and surgery for seed ganglia.

North Yorkshire
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Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

References:

1. Head L, Gencarelli JR, Allen M, Boyd KU. Wrist ganglion treatment: Systematic review and meta-analysis. J Hand Surg Am. 2015, 40: 546-53 e8.

2. Naam NH, Carr SB, Massoud AH. Intraneural Ganglions of the Hand and Wrist. J Hand Surg Am. 2015 Aug;40(8):1625-30. doi: 10.1016/j.jhsa.2015.05.025. PubMed PMID: 26213199.

3. https://www.bssh.ac.uk/patients/conditions/20/ganglion_cysts

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Gastroelectrical Stimulation (GES) / Gastric Neuromodulation
Commissioning position:	Gastric neuromodulation (GNM) has been advocated for the treatment of drug refractory gastroparesis or persistent nausea and vomiting in the absence of a mechanical bowel obstruction. There is, however, little in the way of objective data to support its use, particularly with regards to its effects on gastric emptying.
Referral Guidance:	Gastric Neuromodulation for gastroparesis is NOT routinely commissioned. All requests for this treatment must be sent to the IFR Panel for consideration. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

References:

NICE Interventional procedures guidance (IPG489): Gastroelectrical stimulation for gastroparesis

https://www.nice.org.uk/guidance/ipg489

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention for Grommets for Glue Ear in Children
Background:	This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children. Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing. Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems. Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include: • Recurrent acute otitis media • Atrophic tympanic membranes • Access to middle ear for transtympanic instillation of medication Investigation of unilateral glue ear in adults
Commissioning Position:	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). Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities. The NHS should only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit.
Date:	September 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. NICE guidance: https://www.nice.org.uk/Guidance/CG60
2. Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3

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Commissioning Statement:

Condition or Treatment:	Haemorrhoidectomy
OPCS Codes:	**H51 Excision of haemorrhoid** H511 Haemorrhoidectomy H512 Partial internal sphincterotomy for haemorrhoid H513 Stapled haemorrhoidectomy H518 Other specified excision of haemorrhoid H519 Unspecified excision of haemorrhoid **H52 Destruction of haemorrhoid** H521 Cryotherapy to haemorrhoid H522 Infrared photocoagulation of haemorrhoid H523 Injection of sclerosing substance into haemorrhoid H524 Rubber band ligation of haemorrhoid H528 Other specified destruction of haemorrhoid H529 Unspecified destruction of haemorrhoid **H53 Other operations on haemorrhoid** H531 Evacuation of perianal haematoma H532 Forced manual dilation of anus for haemorrhoid H533 Manual reduction of prolapsed haemorrhoid H538 Other specified other operations on haemorrhoid H539 Unspecified other operations on haemorrhoid
Background:	Haemorrhoids are enlarged vascular cushions in the anal canal and may be external or internal. They are the commonest cause of rectal bleeding Definition of degrees of haemorrhoids: • First grade: the haemorrhoids remain inside at all times • Second grade: the haemorrhoids extend out of the rectum during a bowel movement but return on their own • Third grade: the haemorrhoids extend out during a bowel movement but can be pushed back inside

NHS
North Yorkshire
Clinical Commissioning Group

	• Fourth grade: the haemorrhoid is always outside
Commissioning Position:	NHS North Yorkshire CCG will only commission haemorrhoidectomy (and haemorrhoidopexy) in the following circumstances: • Grade I or II haemorrhoids with severe symptoms which include bleeding, faecal soiling, itching or pain which have failed to respond to conservative management for 6 months • Grade III or IV haemorrhoids (i.e. prolapsed) **Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request Panel prior to referral**
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Grade I or II haemorrhoids may be managed by diet modification, use of laxatives or treated by topical applications. Interventional treatments include rubber band ligation, sclerosant injections, infra-red coagulation or bipolar electrocoagulation using diathermy. Treatment for Grade III and IV haemorrhoids include bipolar electrocoagulation using diathermy, stapled haemorrhoidopexy or haemorrhoidal artery ligation (IPG 525) There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure. Short term efficacy and cost effectiveness is similar.
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

NHS
North Yorkshire
Clinical Commissioning Group

Additional Information/References:

Stapled haemorrhoidopexy for the treatment of haemorrhoids. NICE technology appraisal guidance 128. Sept 2007. https://www.nice.org.uk/guidance/ta128

NICE Clinical Knowledge Summary (Haemorrhoids) January 2013
http://cks.nice.org.uk/haemorrhoids

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Hussain-A 'Haemorrhoids: essentials of clinical management' Australian Family Physician. 2001 Jan; Vol.30; no.1: p.29-35, 53-5

Sutherland, L.M., Sweeny, J.L., Bokey, E.L., Childs, R.A., Waxman, B.P., Roberts, A.K et al. A systematic review of stapled haemorrhoidectomy. Royal Australian College of Surgeons, Australian Safety and Efficacy Register of New Interventional Procedures (ASERNIP) – surgical 2002

Jayaraman S, Colquhoun PHD, Malthaner RA. Stapled versus conventional surgery for haemorrhoids. Cochrane Database of Systematic Reviews 2006, Issue 4.
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005393.pub2/abstract

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Ashraf-s, Srivastava-P, Hersham-MJ. 'Stapled haemorrhoidectomy: a novel procedure'. London Hospital medicine. 2003 ; Vol.64,no.9,p.526-9.References:

BMJ Clinical Review – Management of haemorrhoids – BMJ2008; 336 doi; BMJ 2008;336:380 http://www.bmj.com/content/336/7640/380

Jama Surgery - Long-term Outcomes of Stapled Hemorrhoidopexy vs Conventional Hemorrhoidectomy A Meta-analysis of Randomized Controlled Trials Pasquale Giordano, MD, FRCSEd, FRCS; Gianpiero Gravante, MD; Roberto Sorge, PhD; Lauren Ovens, MBChB, MRCS; Piero Nastro, MD, MRCS

Arch Surg. 2009;144(3):266-272. doi:10.1001/archsurg.2008.591.
https://pubmed.ncbi.nlm.nih.gov/19289667/

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Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Hair Loss Treatment
Background:	Hair loss, also known as alopecia or baldness, refers to a loss of hair from the head or body. Baldness can refer to general hair loss or male pattern hair loss.
Commissioning position:	Hair loss treatment will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender. This includes: Surgical treatments for hair loss e.g. hair transplantation • The 'Intralace' hair system • Dermatography (tattooing) • Drugs for the treatment of baldness e.g. Finasteride Hair loss treatment may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma. To manage hair loss for solely cosmetic reasons: It should be noted that the provision of wigs or hair loss treatment for Gender Dysphoria patients is NOT part of the NHS commissioned pathway for transgender patients and is not routinely commissioned Additionally, it should be noted that this policy does NOT affect the existing local NHS pathways that exist for the provision of wigs to chemotherapy or alopecia patients. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form

North Yorkshire
Clinical Commissioning Group

Effective From:	1 July 2021
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

- A.G. Messenger et al, British Association of Dermatologists' guidelines for the management of alopecia areata 2012. British Journal of Dermatology 2012 166, pp916–926. http://www.ncbi.nlm.nih.gov/pubmed/22524397
- NHS Wig Policy http://www.nhs.uk/nhsengland/Healthcosts/pages/Wigsandfabricsupports.aspx
- NHS UK – Hair loss treatments http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx
- NHS Choices – Hair Loss http://www.nhs.uk/conditions/hair-loss/Pages/Introduction.aspx

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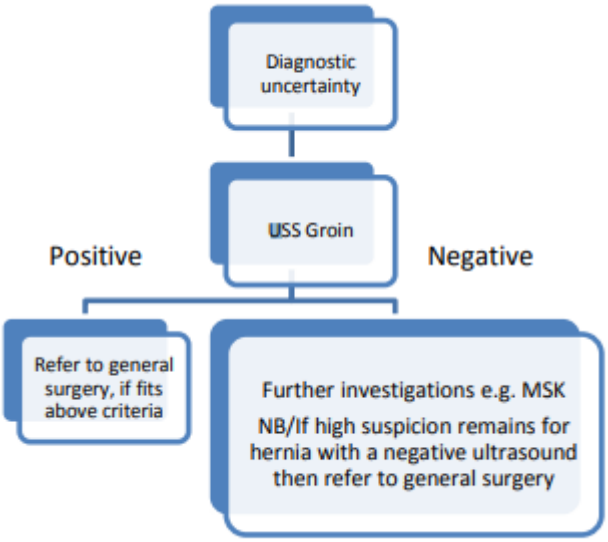
Commissioning Statement:

Condition or Treatment:	Hernia Repair
Background:	A hernia is the protrusion of tissue or part of an organ through the cavity in which it is contained. There are different forms of abdominal hernia including inguinal, femoral, umbilical, para-umbilical, epigastric and incisional hernias. Groin hernia repair is one of the most common surgical procedures in England and Wales, with 71,000 carried out in 2014-151 with 98% of inguinal hernias occurring in men (1) The national Evidence Based Interventions (List 2) (4) recommends that "*watchful waiting is a safe option for people with minimally symptomatic inguinal hernias. Delaying and not doing surgical repair unless symptoms increase is acceptable because acute hernia incarcerations occur rarely. Many people with an inguinal hernia are asymptomatic or minimally symptomatic and may never need surgery*."
Commissioning position:	Referral for a surgical opinion should only be made if there are any of the following circumstances: 1. Umbilical, Para-umbilical & Epigastric (Please note; Congenital Umbilical hernia not included in this policy, generally most resolve spontaneously) Symptomatic – Patient complaining of pain and / or atrophic skin changes Asymptomatic but increasing in size 2. Incisional Hernia Symptomatic Asymptomatic but increasing in size 3. Female groin hernia – refer all due to the increased likelihood of a femoral hernia in this group. NB/ Patients with a high BMI are at higher risk of developing a femoral hernia. 4. Male femoral hernia – refer all due to the increased risk of incarceration or strangulation of femoral hernias. NB/ Patients with a high BMI are at higher risk of developing a femoral hernia. 5. Male Inguinal hernias that meet one of the following criteria: • Visible hernia on clinical examination (asymmetry on visual clinical examination whilst patient standing / coughing) AND

	symptomatic (pain, affecting activities of daily living or work) • Large inguinal / inguinal scrotal hernia – refer for opinion even if asymptomatic • The hernia increases in size month on month • Men with inguinal hernia that is asymptomatic or minimally symptomatic (minimal pain, minimal effect on activities of daily living or work) should be cared for with a watchful waiting approach, providing reassurance and informed consent. • If no hernia is seen on clinical examination but there is persistent groin pain and diagnostic uncertainty, then options may include referral to Musculoskeletal services and/or ultrasound of groin if locally available before referral to surgical specialty for diagnostic uncertainty. 
Effective From:	1st July 2021
Summary of evidence/ rationale:	Inguinal hernia repair is one of the most common surgical procedures, and how effectively this is done in a healthcare system has a substantial social and economic impact. In 2016, The 'Hernia Surge' Group developed recommendations regarding groin hernia management including diagnosis, referral and surgical Diagnostic uncertainty USS Groin Refer to general surgery, if fits above criteria Further investigations e.g. MSK NB/If high suspicion remains for hernia with a negative ultrasound then refer to general surgery Positive Negative management (2). The suggestion from this document is that surgery is recommended in men with symptomatic inguinal hernia and watchful waiting is recommended in men with

	asymptomatic or minimally symptomatic inguinal hernia as the risk of incarceration or strangulation in this group is low. The authors suggest that all women with a groin hernia should be referred for assessment and repair on an urgent basis. These guidelines agree with those developed by NHS England in 2013 (3)
Date:	March 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. References 1. NICE, 2004, Laparoscopic surgery for inguinal hernia repair, website accessed Feb 2017: https://www.nice.org.uk/guidance/ta83
2. The HerniaSurge Group, 2016, World Guidelines for Groin Hernia Management, HerniaSurgeGuidelinesPART1TREATMENT.pdf (europeanherniasociety.eu)
3. NHS England, 2013, Interim Clinical Commissioning Policy: Abdominal Wall Hernia Management and Repair in Adults
4. National NHSEI Evidence Based Interventions programme: https://www.aomrc.org.uk/evidence-based-interventions/

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Commissioning Statement Hip Arthroscopy

Condition or Treatment:	Hip arthroscopy
Commissioning Position:	This commissioning statement refers to arthroscopic hip surgery for children and adults with: • Femoroacetabular impingement • Labral tears **Policy Exclusions:** • Patients with advanced / severe degenerative OA on a preoperative X-ray • Patients who have hip dysplasia or considerable protrusion unless they have mechanical symptoms • Patients with osteonecrosis with femoral head collapse • Patients with joint ankyloses The commissioning of hip arthroscopy (from surgeons with specialist expertise in this type of surgery) is in line with the requirements stipulated by NICE IPG 408 Details of all patients undergoing this procedure should be entered into a register established by the British Hip Society (4). The current evidence and guidance supports referral of patients with the following conditions to the hospital services and only for patients who fulfil all of the following criteria: Diagnosis of definite labral pathology and/or hip impingement syndrome and/or other conditions where a minimally invasive approach is preferred as defined through clinical and radiological investigation (e.g. X-rays, MRI, CT scans) **AND** A surgeon with specialist expertise in hip arthroscopy has confirmed the diagnosis, which should include imaging reported by a specialist musculoskeletal radiologist **AND** Severe symptoms with compromised function measured by objective scoring tools and with a duration of at least six months where diagnosis has been made **AND**

Failure to respond to conservative treatment including activity modification, comprehensive physiotherapy with review by advanced practice physiotherapist, and drug therapy (non-steroidal anti-inflammatory drugs and paracetamol) for a period of three months.

Intra-articular injection (steroid / anaesthetic) is recommended for diagnostic clarity or to support further, effective conservative management. This should be image guided in a specialist practice setting.

Patients under the age of 16 or over the age of 50 should only proceed to surgery after a wider multidisciplinary team discussion.

Conservative management

- Patients with hip pain, and without red flag or acute trauma indications, should be managed in line with the locally agreed MSK pathway and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.
- Patients with persistent pain which is not amenable to surgical intervention should be considered for referral to pain management services.

Lifestyle factors

- All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long-term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment.

Shared decision-making

- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision-making conversation to consider referral for surgical assessment. This should include an understanding of rehabilitation requirements and likely

	duration. The evidence for risks, benefits and differences in outcomes between surgical intervention and continued nonoperative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention. **Diagnostic and imaging requirements** • AP X-ray of pelvis with marker ball. This should be done prior to referral for specialist assessment to exclude structural pathology. • Lateral hip X-ray of affected side • Hip MRI OR arthrogram (Secondary Care only) **MRI scans should not be requested by primary care, and should only be requested following specialist clinical assessment** • MRI or MR arthrogram should be reported by and MSK specialist radiologist or reporting radiographer • Imaging technique will be determined by availability of 1.5T or 3T MRI • Hip CT should only be requested following assessment by orthopaedic specialist or when the patient is not suitable for MRI See also the 2017 commissioning guide for pain arising from the hip in adults from the British Hip Society.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1st July 2021
Summary of evidence/ rationale:	Hip impingement syndrome is caused by abnormal contact between the top of the thigh bone and the hip socket. This results in 'clicking' of the hip, limited movement and pain, which can be made worse when the hip is bent or after sitting for a long time. The condition may be caused by an unusually shaped thigh bone or hip socket and usually affects young, often active people. Hip impingement syndrome is usually managed by changes to lifestyle and drug treatment.

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	Rational for surgical treatment of FAI / labral tears in selected patients In patients nonresponsive to conservative measures, open or arthroscopic surgery for proven FAI / labral tears has been shown to produce short and medium term benefits in terms of pain management and functional improvement in the hip (1-5). Evidence for reduction in progression to advanced hip osteoarthritis is speculative. **Rationale for arthroscopic vs open surgical treatment of FAI** No significant differences in outcome have been demonstrated between open and arthroscopic surgery for FAI. As the HRG Code costs are the same, but arthroscopic intervention is a day case procedure, requiring no excess bed day costs, and is associated with a faster patient recovery time, surgical FAI interventions should be arthroscopic for a quicker recovery and to minimise costs. **Rationale for treatment in specialist / high volume centres** The number of operations performed for FAI, particularly hip arthroscopy, has increased rapidly in recent years in the UK. Hip arthroscopy is technically demanding with a steep learning curve. It is also important to identify which patients are appropriate to select for surgery, to streamline their work-up and perioperative care, and in particular to fine-tune rehabilitation protocols to optimize outcomes for both rehabilitation and surgery.
Date:	May 2021
Review Date:	July 2023
Contact:	Dr Christopher Ives, Governing Body GP/Acute Commissioning lead

Additional Information/References:

1. Bedi A, Chen N, Robertson W & Kelly B T. The Management of Labral Tears and Femoroacetabular Impingement of the Hip in the Young, Active Patient. Arthrosc. J. Arthrosc. Relat. Surg. 24, 1135–1145 (2008).
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Commissioning Statement:

Condition or Treatment:	**Hip Replacement for Hip Arthritis**
Summary of Intervention:	Many people with hip osteoarthritis do not require joint surgery and can adequately manage their symptoms with compliance to a comprehensive non-surgical programme including appropriate use of analgesia, lifestyle modification, weight reduction and exercise therapy. Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery should ensure that the person has been offered the recommended non-surgical treatment options (NICE CG177) and meet the criteria listed in this policy. Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should share in the decision for referral for surgical assessment. This should include: • Confirmation of willingness to undergo surgery • The benefits and risks of surgery • The potential consequences of not having surgery • Recovery timescales and rehabilitation requirements after surgery
Policy Exclusions:	This policy does not apply to: • Children under 16 • Hip replacements required due to acute trauma • Cancer
Commissioning Position:	Referrals for surgical opinion should be made if patients present with one of the following: • Patient complains of intense or severe pain (please refer to the classification of symptomology table below) OR • Patient has radiological features of severe degenerative change or bone loss OR • Patients who have demonstrated good compliance to a comprehensive non-operative programme including NSAID's and analgesics, weight reduction, lifestyle modification and participation in therapy programmes

AND

continue to present with symptoms (please refer to the classification of symptomology table below)

For Hip Replacement: Classification of Symptoms

Variable	Definition
Mild	Sporadic pain. Able to carry out daily activities (those requiring great physical activity may be limited). Analgesia medication controls pain with no/few side effects.
Moderate	Occasional pain. Pain walking on level surfaces (half an hour, or standing) Some limitation of daily activities. Analgesia medication controls pain with no/few side effects.
Intense	Pain of almost continuous nature. Pain walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of analgesia medication to take effect. Requires the sporadic use of walking aid
Severe	Continuous pain. Pain at rest. Daily activities significantly limited constantly. Continuous use of analgesia medication with adverse effects or poor response. Requires more constant use of walking aid Rapid joint deformity / leg shortening

Oxford Hip Score

The Oxford hip score provides a single summed score which reflects the severity of problems that the respondent has with their hip and can be used when considering referral.

It may help a clinician assess the severity of this hip disease but should **not** be used as an arbitrary threshold. A score below 20 may indicate severe hip arthritis and it is highly likely that these patients may well require some form of surgical intervention and therefore may benefit from a surgical opinion.

The Oxford Hip Score can be found at:

http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

Further guidance available at:

http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full

Conservative Management

- Patients with hip pain, and without red flag or acute trauma indications, should be managed in line with the North Yorkshire CCG MSK pathway and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective or are judged likely to be ineffective.
- Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted / failed.
- Conservative measures include weight reduction, analgesia, education on OA and the management of symptoms, referral to physiotherapy if required, lifestyle modification such as increased physical activity, exercise, and introducing a walking aid.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.

Shared Decision Making

- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment.
- This should include an understanding of rehabilitation requirements and likely duration of recovery and confirmation of willingness to undergo surgery.
- The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals.
- The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention.

Lifestyle Factors

- All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at

	appropriate stages in their conservative management and in all instances before referral is made for surgical assessment. • Patients with a BMI of >40 (the super-obese) are at increased risk of surgical complications and careful consideration should be given for surgery • If there are specific indications where delay would increase bone loss and prolong suffering, the individual decision should be made by the clinician, with the patient, balancing the clinical risk against the perceived benefits.
Effective From:	1 July 2021
Summary of evidence/ rationale:	Osteoarthritis may not be progressive and a proportion of patients will not need surgery with their symptoms adequately controlled by non-surgical measures as outlined by NICE. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years. When patient's symptoms are not controlled by up to 3 months of non-operative treatment they become candidates for assessment for joint surgery. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support such as the NHS Decision Aid for managing osteoarthritis. https://musculoskeletal.cochrane.org/sites/musculoskeletal.cochrane.org/files/public/uploads/What%20are%20my%20options%20for%20managing%20hip%20or%20knee%20osteoarthritis%20%20June%2015.pdf Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischemic heart disease (IHD), hypertension (HT) and sleep apnoea. Some years ago, an Arthritis Research Campaign Report stated that joint surgery is less successful in obese patients because: • Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (e.g. longer operations, excess blood loss requiring transfusions, deep vein thrombosis (DVT) and wound complications including infection). • The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (e.g. they are less likely to regain normal functioning or reduction in pain and stiffness). • The implant is likely to fail more quickly, requiring further surgery (e.g. within 7 years, obese patients are more than ten times as likely to have an implant failure). • People who have joint replacement surgery because of obesity related osteoarthritis are more likely to gain weight post

	operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels). It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". A recent extensive literature review advises assessment of "timely weight loss as a part of conservative care" It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

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3. Obesity prevention NICE CG 43 Dec 2006; last amended March 2015 https://www.nice.org.uk/guidance/cg43

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5. NHS Choices: http://www.nhs.uk/chq/Pages/849.aspx?CategoryID=51&SubCategoryID=165

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https://www.boa.ac.uk/uploads/assets/2a2182ef-979a-447b-95f671b7e73e15a9/pain%20arising%20from%20the%20hip%20guide.pdf

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Commissioning Statement:

Condition or Treatment:	Hyperhidrosis (Referral)
Background:	Hyperhidrosis is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.
Commissioning position:	Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics, wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods or crowded areas. Underlying anxiety should be treated. More patient information and support is available from Hyperhidrosis UK. http://hyperhidrosisuk.org/ Referral for Hyperhidrosis will only be funded in accordance with the criteria below: • The search for an underlying cause has been exhausted AND • Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4 AND • Trial of lifestyle management for a minimum of 2 months AND • The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021

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Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

http://cks.nice.org.uk/hyperhidrosis#!scenario

http://www.bad.org.uk/

http://hyperhidrosisuk.org/

North Yorkshire
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Commissioning Statement:

Condition or Treatment:	Hyperhidrosis (Referral)
Background:	Hyperhidrosis is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.
Commissioning position:	Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics, wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods or crowded areas. Underlying anxiety should be treated. More patient information and support is available from Hyperhidrosis UK. http://hyperhidrosisuk.org/ Referral for Hyperhidrosis will only be funded in accordance with the criteria below: • The search for an underlying cause has been exhausted AND • Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4 AND • Trial of lifestyle management for a minimum of 2 months AND • The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021

North Yorkshire
Clinical Commissioning Group

Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

http://cks.nice.org.uk/hyperhidrosis#!scenario

http://www.bad.org.uk/

http://hyperhidrosisuk.org/

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Commissioning Statement:

Condition or Treatment:	Hyperhidrosis Treatment with Botulinium Toxin
Background:	Hyperhidrosis is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. The principal management strategies for hyperhidrosis are medical https://cks.nice.org.uk/hyperhidrosis Botulinum Toxin is only licensed for the treatment of severe axillary hyperhidrosis and its cost effectiveness compared to other treatment options is yet to be established.
Commissioning Position:	Botulinum Toxin will only be funded in the management of severe axillary hyperhidrosis in accordance with the criteria below: • The search for an underlying cause has been exhausted AND • Advice on lifestyle management has been followed (use an antiperspirant frequently, Avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat) AND • 20% aluminium chloride hexahydrate has failed or is contraindicated AND • Any underlying anxiety has been identified and managed AND • In the opinion of an experienced dermatologist, other treatment options have been exhausted AND • The patient is 17 years or older There must be a minimum of 6 months duration between Botulin Toxin injections.

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Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

North Yorkshire
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Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Hysterectomy for heavy menstrual bleeding
Background:	Hysterectomy is the surgical removal of the uterus.
Commissioning position:	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. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices. Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility. *1.13.1.1.1 NICE guideline NG88 1.5 Management of HMB* 1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain. *1.13.1.1.2 Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis* 1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis. 1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens. 1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB. 1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy. 1.5.6 For women with submucosal fibroids, consider hysteroscopic removal. *1.13.1.1.3 Treatments for women with fibroids of 3 cm or more in diameter*

	1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter. 1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs. 1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial. 1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy. 1.5.12 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter. 1.5.13 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007] 1.5.14 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions. 1.5.15 If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation 1.5.10. 1.5.16 Pre-treatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus. For further information, please see: https://www.nice.org.uk/guidance/ng88 https://www.nhs.uk/conditions/heavy-periods/#Causes
Effective From:	1 July 2021
Summary of evidence/ rationale:	NICE's Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual bleeding. The Group placed a high value on the need for education and information provision for women with heavy menstrual bleeding.

	Complications following hysterectomy are usually rare but infection occurs commonly. Less common complications include: intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if the ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.
Date:	September 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. NICE guidance: https://www.nice.org.uk/guidance/ng88

2. NHS website: https://www.nhs.uk/conditions/heavy-periods/#Causes

3. Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63.

4. Learman LA, Summitt Jr RL, Varner RE, et al. Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. Obstetrics and Gynecology 2004;103(5 I):824–33.

5. Zupi E, Zullo F, Marconi D, et al. Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. American Journal of Obstetrics and Gynecology 2003;188(1):7–12.

6. Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284.

7. Hehenkamp WJ, Volkers NA, Donderwinkel PF, et al. Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri-and postprocedural results from a randomized controlled trial. American Journal of Obstetrics and Gynecology 2005;193(5):1618–29.

8. Pinto I, Chimeno P, Romo A, et al. Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical trial. Radiology 2003;226(2):425–31.

North Yorkshire
Clinical Commissioning Group

Access to Infertility Treatment –

Commissioning Policy Document

Yorkshire and Humber

Adopted by
North Yorkshire CCG

1 July 2021 – July 2023

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CHANGE RECORD

Version	Author	Nature of Change	Uploaded
11.1	Suzanne Savage	Adopted by North Yorkshire CCG	01.07.21
14	Bobbi Phillips	Clarification to section 5.5 regarding abandoned cycles and further cycles as recommended by the Yorkshire and Humber Expert Fertility Panel	XXXX

Any locally held old paper copies must be destroyed. ***When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on the CCG website: https://www.northyorkshireccg.nhs.uk/***

Commissioning Policy Statement:

Commissioning

This document represents the commissioning policy of North Yorkshire CCG for the clinical pathway which provides access to specialist fertility services. This commissioning policy has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel. It is intended to provide a framework for the commissioning of services for those couples who are infertile and require infertility interventions.

The policy was developed jointly by Clinical Commissioning Groups in the Yorkshire and Humber area and provides a common view of the clinical pathway and criteria for commissioning services which have been adopted by North Yorkshire CCG.

Funding

The policy on funding of specialist fertility services for individual patients is a policy of North Yorkshire CCG and is not part of the shared policy set out in the rest of this document. The number of full IVF cycles currently funded by the North Yorkshire CCG for patients who meet the access criteria set out in the shared policy is one. This is unchanged from the previous funding policy in March 2016. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

Immigration Health Surcharge; Right to Assisted Conception Services

Amendments to the NHS (Charges to Overseas Visitors) Regulations 2015 were introduced into Parliament on 19 July 2017. As a result, from 21 August 2017, assisted conception services are no longer included in the scope of services.

However, the October 2019 Guidance on Implementing Overseas Visitors Regulations says that: 'Where two people are seeking assisted conception services with NHS funding, and one of the two people is covered by health surcharge arrangements and the other is ordinarily resident in the UK and therefore not subject to charge, the services required by the health surcharge payer will be chargeable. Any services required by the ordinarily resident person will continue to be freely available, subject to the established local or national commissioning arrangements'.

Our eligibility criteria for access to assisted conception services relates to couples rather than individuals. Therefore in light of this guidance, to enable the ordinarily resident person to have freely available access to services, where at least one partner is eligible for these services, the couple will be considered as eligible for services.

Working group membership and Conflicts of Interest

See appendices E and F

For Further Information about this policy.

Please contact your local Clinical Commissioning Group. https://www.northyorkshireccg.nhs.uk/

Contents

1. Aim of Paper 5
2. Background 5
3. Clinical Effectiveness 6
4. Cost Effectiveness 6
5 Description of the Treatment 7
5.1 Principles of Care 7
5.2 The Care Pathway for fertility investigation and referral (fig, 1) 8
5.3 Definition of a Full Cycle 10
5.4 Frozen Embryo 10
5.5 Abandoned Cycles 10
5.6 IUI and DI 10
5.7 Gametes and Embryo Storage 11
5.8 HIV/HEP B/ HEP C 12
5.9 Surrogacy 12
5.10 Single Embryo Transfer 12
5.11 Counselling and Psychological Support 12
5.12 Sperm washing and pre-implantation diagnosis 12
5.13 Service Providers 12
6.0 Eligibility Criteria for Treatment 13
6.1 Application of Eligibility Criteria 13
6.2 Overarching Principles 13
6.3 Existing Children 13
6.4 Female Age 13
6.6 Reversal of Sterilisation 14
6.7 Previous Cycles 14
6.8 Length of Relationship 14
6.9 Welfare of the child 14
Appendix A 15
Appendix B 16
Appendix C 17
Appendix D 20
Appendix E 24
Appendix F 27

1. Aim of Paper

1.1 This document represents the commissioning policy for specialist fertility services for adults registered with a Clinical Commissioning Group (CCG) in the Yorkshire and Humber region.

1.2 The policy aims to ensure that those most in need in keeping with current eligibility, are able to benefit from NHS funded treatment and are given equitable access to specialist fertility services across the Yorkshire and Humber Area, by identifying the clinical care pathway and relevant access criteria.

2. Background

2.1 On April 1st, 2013 Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy[1]. In February 2013 NICE published revised guidance[2] which was reviewed and updated in 2016.

2.2 CCGs across the Yorkshire and the Humber agreed to work collaboratively to update the existing policy in light of the new NICE guidance and changing commissioning landscape.

2.3 In this policy document infertility is defined as:

Definition of Infertility:

The inability to conceive through regular sexual intercourse for a period of 2 years in the absence of known reproductive pathology, or less than 2 years if there is specific reproductive pathology identified.

Where attempting to conceive by regular sexual intercourse is not possible (for example for people with a physical disability, people with psychosexual disorders or transgender and same sex couples) this will be considered as inability to conceive for the purposes of this policy.

2.4 Fertility problems are common in the UK and it is estimated that they affect 1 in 7 couples with 80% of couples in the general population conceiving within 1 year, if:

- The woman is aged under 40 years and
- They do not use contraception and have regular sexual intercourse (NICE 2013)

Of those who do not conceive in the first year about half will do so in the second year (cumulative pregnancy rate is 90%).

The remaining 10% of couples will be unable to conceive without medical intervention and are therefore considered infertile.

2.5 In 25% of infertility cases, the cause cannot be identified. However, it is thought that in the remaining couples about 30% of cases are due to the male partner being unable to produce or ejaculate sufficient normal sperm, 30% are due to problems found with the female partner such as failure to ovulate or blockage to the passage of the eggs, and 10% are due to problems with both partners.

2.6 The most recent DH costing tool estimates that there are 98 attendances at a fertility clinic for every 10,000 head of population. In Yorkshire and the Humber, this could range between 4000 and 5000 attendances per year which would result in approximately 1450 couples likely to be assessed as eligible for IVF treatment.

2.7 Specialist fertility services include IUI, ICSI and IVF. They may also include the provision of donor sperm and donor eggs. The majority of treatment in the UK is statutorily regulated by the Human Fertility and Embryo Authority (HFEA)[3]. All specialist providers of fertility services must be licensed with the HFEA in order to be commissioned under this policy.

2.8 NICE Clinical Guidelines 156 (2013) covering infertility recommends that:

> Up to three full cycles of IVF will be offered to eligible couples where the woman is aged between 18 and 39 and 1 cycle for eligible couples where the woman is aged 40 - 42.

North Yorkshire CCG will fund *one* cycle of IVF treatment. Where an individual feels that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an individual funding request to their local CCG.

2.9 In addition to commissioning effective healthcare, CCGs are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore CCGs' will need to exercise discretion as to the number of cycles of IVF that they will fund up to the maximum recommended by NICE.

3. Clinical Effectiveness

It is considered to be clinically effective by NICE to offer up to 3 stimulated cycles of IVF treatment to couples where the woman is aged between 18 – 39 and 1 cycle where the woman is aged between 40 – 42 and who have an identified cause for their infertility or who have infertility of at least 2 years duration.

4. Cost Effectiveness

4.1 Evidence shows (NICE 2013) that as the woman gets older the chances of successful pregnancy following IVF treatment falls. In light of this, NICE has recommended that the most cost effective treatment is for women aged 18 – 42 who have known or unknown fertility problems.

4.2 As research within this field is fast moving, new interventions and new evidence needs to be considered on an on-going basis to inform commissioning decisions.

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[1] Yorkshire and the Humber Commissioning Policy for Fertility Services, 2010.

[2] Fertility: Assessment and treatment for people with fertility problems 2012, NICE Clinical Guideline 156.

[3] https://www.hfea.gov.uk/

4.3 Risks

Fertility treatment is not without risks. A summary of potential risks is outlined below:

Risks

- There are risks of multiple pregnancies during fertility treatment, which is associated with a higher morbidity and mortality rate for mothers and babies.
- Women who undergo fertility treatment are at slightly higher risk of ectopic pregnancy.
- Ovarian hyper stimulation, which is a potentially fatal condition, is also a risk. The exact incidence of this has not been determined but the suggested number is between 0.2 – 1% of all assisted reproductive cycles.
- Current research shows no cause for concern about the health of children born as the result of assisted reproduction.
- A possible association between ovulation induction therapy and ovarian cancer in women who have undergone treatment is uncertain.
- Further research is needed to assess the long-term effects of ovulation induction agents.

5 Description of the Treatment

5.1 Principles of Care

5.1.1 Couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment.

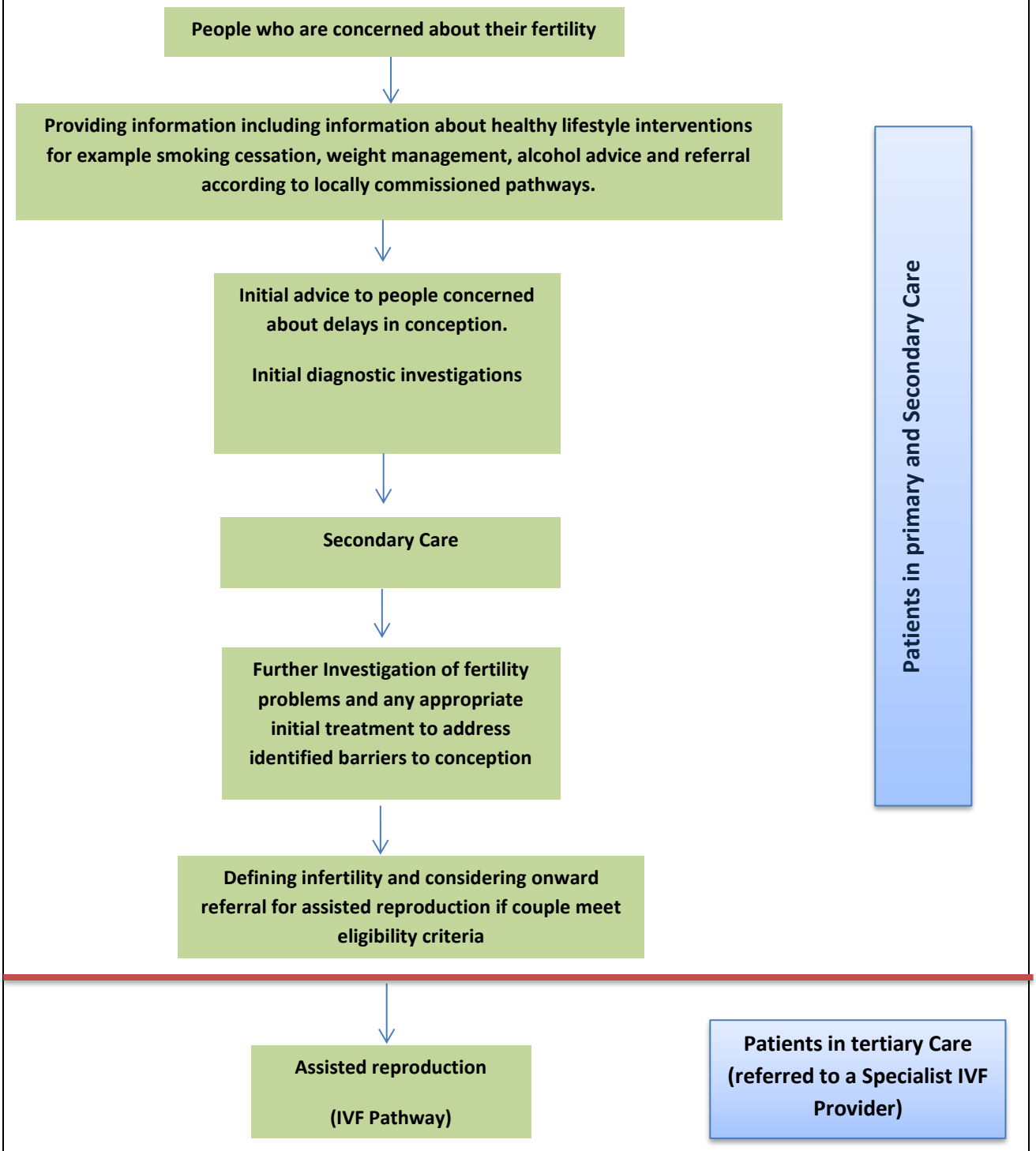
5.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Information should be provided in the following formats:

- Face to face discussions with couples
- Written information and advice
- Culturally sensitive
- Sensitive to those with additional needs e.g. physical or cognitive, or those for whom English is not their first language.

5.1.3 As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway.

5.2 The Care Pathway for fertility investigation and referral (fig, 1)



The Care pathway for fertility investigation and referral will take account of NICE guidance.

5.2.1 Treatment for infertility problems may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF.

- Providers of specialist fertility services are expected to deliver appropriate interventions to support lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies. Recommendations covering screening, brief advice and onward referral are outlined in NICE Public Health Guidance (PH49) and, specifically in relation to fertility and pre-conception, smoking (PH 26, PH48), weight management (PH27, PH53), healthy eating and physical activity (PH11, NG7) and alcohol (PH24).

- Use any appointment or meeting as an opportunity to ask women and their partners about their general lifestyle including smoking, alcohol consumption, and physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle.

- Offer those who would benefit from this, a referral to local wellbeing services and/or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information such as the national 'One You' website or local websites.

- Record this in the hand-held record or accepted local equivalent.

The care pathway (fig 1) begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention.

If primary care interventions are not effective, initial assessment such as semen analysis will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed.

If secondary care interventions are not successful and the couple fulfils the eligibility criteria in section 6.0, they may then be referred through to specialist care for assessment for assisted conception techniques, such as IVF, DI, IUI, and ICSI.

5.2.2 IVF involves:

- Controlled ovarian stimulation
- Monitoring the development of the eggs in the ovary
- Ultrasound guided egg collection from the ovary
- Processing of sperm
- Production of a fertilized embryo from sperm and egg cells in the laboratory
- Culture of embryos to blastocyst (*if clinically appropriate*)
- Single embryo transfer (subject to multiple birth minimisation policy)

- Use of progesterone to make the uterus receptive to implantation
- Transfer of selected embryos and freezing of those suitable but not transferred

The panel will review annually, following the HFEA[4] annual review via their traffic light report, any other emerging technologies which may then need consideration for incorporation in this policy.

5.3 Definition of a Full Cycle

Full cycle is the term used to define a full IVF treatment; it should include one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s) (NICE 2013). Or

The definition of a single full treatment cycle is the replacement of a fresh embryo and subsequent sequential replacement of all frozen embryos derived from the cycle until pregnancy is successful or harvested embryos have been exhausted.

Adherence in this way to the NICE guidelines would encourage and not disadvantage patients agreeing to single embryo transfer.

5.4 Frozen Embryo

Embryos that are not used during the fresh transfer should be quality graded using the UK NEQAS embryo morphology scheme and may be frozen for subsequent use within the cycle.

All stored and viable embryos should be used before a new cycle commences. This includes embryos resulting from previously self-funded cycles.

5.5 Abandoned Cycles

An abandoned IVF/ICSI cycle is defined as the failure of egg retrieval, usually due to lack of response (where less than three mature follicles are present) or excessive response to gonadotrophins; failure of fertilisation and failure of cleavage of embryos. Beyond this stage, a cycle will be counted as complete whether or not a transfer is attempted.
One abandoned cycle should not affect the couple's entitlement to further IVF/ICSI (up to the maximum number of cycles provided by their CCG), providing that additional cycles are clinically appropriate. Further cycles will not be offered after a second abandoned cycle, but the clinician may submit an Individual Funding Request if there are exceptional circumstances.

5.6 IUI and DI

IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.

5.6.1 People with physical disabilities, psychosexual problems, or other specific conditions with infertility (as defined in section 2.3 Definition of Infertility):

[4] https://www.hfea.gov.uk/

Where a medical condition exists, such as physical disability up to 6 cycles of IUI may be funded, followed by further assisted conception if required. In some circumstances, IUI may be impractical and so is not a requirement for further fertility treatment.

5.6.2 IUI and DI in same-sex relationships:
Up to 6 cycles of IUI will be funded as a treatment option for people in same-sex relationships, followed by further assisted conception if required.

5.6.3 People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse:
IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance.

5.6.4 Gonadotrophin Therapy - for women with anovulatory infertility, ovulation induction with gonadotrophin therapy should be funded for up to 6 cycles, with or without IUI depending on the circumstances of the couple.

5.6.5 Donor Gametes including azoospermia:
Patients who require donor gametes will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria is still met. If it is anticipated that there will be difficulty finding a suitable donor exceptionality would need to be considered. At this point consideration may need to be given to sourcing from alternative providers via IFR.

Donor Sperm

Where clinically indicated up to six cycles of donor insemination will be offered. This is dependent on the availability of donor sperm which is currently limited in the UK.
The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG.

Donor Eggs

Patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment with donor eggs. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment.

5.7 Gametes and Embryo Storage

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG. Storage will be funded by the CCG for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.

Any embryos frozen prior to implementation of this policy will be funded by the CCG to remain frozen for a maximum period of 3 years from the date of policy adoption.
Any embryo storage funded privately prior to the implementation of this policy will remain privately funded.

5.8 HIV/HEP B/ HEP C

People undergoing IVF treatment should be offered testing for HIV, hepatitis B and hepatitis C (NICE 2013).
People found to test positive for one or more of HIV, hepatitis B, or hepatitis C should be offered specialist advice and counselling and appropriate clinical management (NICE 2013).

5.9 Surrogacy

Any costs associated with use of a surrogacy arrangement will not be covered by funding from CCGs. We will, however, fund provision of fertility treatment (IVF treatment and storage) to identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the couple meets the eligibility criteria for specialist fertility services set out in this policy.

5.10 Single Embryo Transfer

Please refer to 5.3 for the definition of a full cycle.
Multiple births are associated with greater risk to mothers and children and the HFEA[5] therefore recommends that steps are taken by providers to minimize them. This is currently achieved by only transferring a single embryo for couples who are at high risk.
We support the HFEA guidance on single embryo transfer and will be performance monitoring all specialist providers to ensure that HFEA targets are met. All providers are required to have a multiple births minimisation strategy. The target for multiple births should now be an upper limit of 10% of all pregnancies.
We commission ultrasound guided embryo transfer in line with NICE Fertility Guideline.

5.11 Counselling and Psychological Support

As infertility and infertility treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment.

5.12 Sperm washing and pre-implantation diagnosis

Sperm washing and pre-implantation genetic diagnosis are not treatments for infertility and fall outside the scope of this policy. Prior approval is required.

5.13 Service Providers

Providers of fertility treatment must be HFEA registered and comply with any service specification drawn up by Yorkshire and the Humber Clinical Commissioning Groups.

[5] https://www.hfea.gov.uk/

6.0 Eligibility Criteria for Treatment

6.1 Application of Eligibility Criteria

Eligibility criteria should apply at the point at which patients are referred to specialist care (with the exception of 6.10, which should be undertaken within specialist care). Couples must meet the definition of infertility as described in section 2.3.

6.2 Overarching Principles

6.2.1 All clinically appropriate individuals/couples are entitled to medical advice and investigation. Couples may be referred to a secondary care clinic for further investigation.

6.2.*2* Assisted conception is only funded for those couples who meet the eligibility criteria.

6.2.3. Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in heterosexual and same-sex couples.

6.3 Existing Children

Neither partner should have any living children (this includes adopted children but not fostered) from that or any previous relationship.

6.4 Female Age

Age as a criterion for access to fertility treatments is applied in line with the NICE Clinical Guideline on Fertility which is based on a comprehensive review of the relationship between age and the clinical effectiveness of fertility treatment.

The woman intending to become pregnant must be between the ages of 18 – 42 years. No new cycle should start after the woman's 43rd birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles.

Women aged 40–42 years who meet the eligibility criteria for infertility in Section 2.3, will receive 1 full cycle of IVF, with or without ICSI, provided the following criteria are fulfilled:

- they have never previously had IVF treatment and there is no evidence of low ovarian reserve (defined as FSH 9 IU/l or more (using Leeds assay); OR antral follicle count of 4 or less; OR AMH of 5 pmol/l or less
- there has been a discussion of the additional implications of IVF and pregnancy at this age
- where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, women aged between 40-42 should be referred directly to a specialist team for IVF treatment

6.5 Pre – Referral Requirement for Specialist Care

6.5.1 Female BMI

The female patient's BMI should be between 19 and 30 prior to referral to specialist services. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range.

6.5.2 Smoking Status

GP should discuss smoking with couples prior to referral to secondary care, support their efforts in stopping smoking by referring to a smoking cessation programme.

People should be informed that maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF treatment.

6.6 Reversal of Sterilisation

We will not fund IVF treatment for patients who have been sterilised or have unsuccessfully undergone reversal of sterilisation.

6.7 Previous Cycles

Previous cycles whether self-funded or NHS funded will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be offered by the NHS. This includes where either person has had a previous cycle with a previous partner.

6.8 Length of Relationship

The stability of the relationship is very important with regards to the welfare of children; as such couples must have been in a stable relationship for a minimum of 2 years and currently co-habiting to be entitled to treatment.

6.9 Welfare of the child

HFEA guidance concerning the welfare of the child should be followed.

Appendix, A

Abbreviations

Abbreviations used	
BMI	Body Mass Index
DI	Donor Insemination
GP	General Practitioner
HFEA	Human Fertilisation and Embryology Authority
ICSI	Intracytoplasmic sperm injection
IUI	Intra-uterine insemination
IVF	In vitro fertilisation
NICE	National Institute of Clinical Excellence
CCG	Clinical Commissioning Group

Appendix, B

Contents

Term	Definition	Further information
BMI	The healthy weight range is based on a measurement known as the Body Mass Index (BMI). This can be determined if you know your weight and your height. This is calculated as your weight in kilograms divided by the square of your height in metres. In England, people with a body mass index between 25 and 30 are categorised as overweight, and those with an index above 30 are categorised as obese.	BBC Healthy Living http://www.bbc.co.uk NHS http://www.nhs.uk
ICSI	**Intra Cytoplasmic Sperm Injection (ICSI)**: Where a single sperm is directly injected into the egg.	Glossary, HFEA http://www.hfea.gov.uk
IUI	**Intra Uterine Insemination (IUI)**: Insemination of sperm into the uterus of a woman.	As above
IVF	**In Vitro Fertilisation (IVF)**: Patient's eggs and her partner's sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the female patient.	As above
DI	**Donor Insemination (DI)**: The introduction of donor sperm into the vagina, the cervix or womb itself.	As above

Appendix C, Equality Impact Assessment

Title of policy	Fertility Policy	
Names and roles of people completing the assessment	Philippa Doyle Hempsons Solicitors	
Date of Assessment from – to Review date	Aug 2018 Nov 2019	Feb 2021 April 2023

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the relevant CCG to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about the fertility policy. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for specialist fertility treatment.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

2. Evidence, data or research	
Give details of evidence, data or research used to inform the analysis of impact	NICE fertility guidance https://www.nice.org.uk/guidance/cg156 (accessed 3/3/17)

3. Consultation, engagement	
Give details of all consultation and engagement activities used to inform the analysis of impact	Discussion with panel of experts in Yorkshire and Humber representing commissioners and providers. All changes from the previous policy are in line with NICE guidelines which have had extensive engagement and consultation. See https://www.nice.org.uk/guidance/cg156/history

4. Analysis of impact

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to;

eliminate unlawful discrimination; advance equality of opportunity; foster good relations

	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	Yes. IVF is only available to women aged between 18 and 42. As a woman ages the chances of successful pregnancy fall.	Both	Action cannot be taken to prevent this it is therefore incumbent simply to ensure clear age limitations are identified
Carers	No		
Disability	Yes. The policy has been enhanced to offer funding to couples who by reason of disability cannot conceive naturally	positive	The fact of this new change and opportunity to such couples can be publicised
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	Yes. The policy has been enhanced to offer funding to couples in a same sex relationship without having to demonstrate they have self-funded other trials	positive	The fact of this new change and opportunity to such couples can be publicised
Gender reassignment	Yes	positive	Gender reassignment is specifically referenced in the definition of infertility
Pregnancy and maternity	Yes. The policy enhances the ability to access fertility	positive	

	treatment and the potential to achieve pregnancy		
Marriage and civil partnership	No		
Other relevant group			

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Each CCG to monitor individual funding requests for this procedure and identify if there are issues with the policy which require a policy refresh.		
Lead Officer	Suzanne Savage, Service Improvement Manager	**Review date:**	4 February 2021

6.Sign off on behalf of the local CCG			
Lead Officer	NY CCG QCGC		
Director		**Date approved:**	4 February 2021

Appendix D, Version Control

VERSION	DATE	AUTHOR	STATUS	COMMENT
V14	March 2022	Bobbi Phillips		Clarification to section 5.5 regarding abandoned cycles and further cycles as recommended by the Yorkshire and Humber Expert Fertility Panel
V11.1	July 2021	S Savage		Adopted by North Yorkshire CCG
V11	Feb 19	H Lewis and M Thompson		Changes to page 3 – immigration health surcharge – reworked following updated advice Moved list of panel members to Appendix for easier access to contents of document
V10	November 2019	M Thompson on behalf of Panel		Changes to: - Page 2 & 3 – Immigration Health Surcharge – sentences reworded - 6.5.2 – Smoking Status – sentences reworded - 6.7 – Previous Self-funded Cycles – titles changed to Previous Cycles - sentences reworded - 6.8 – Previous Self-Funded Cycles - sentence removed - 6.10 – Welfare of the Child - sentence reworded

V9	January 2019	M Thompson on behalf of Panel	Draft	Changes to: - Funding - Immigration health surcharge – sentence added - 1.2 - sentence reworded - 2.3 – change of order in sentence in brackets - 5.2 – sentence included after pathway - 5.2.1 – third bullet point, wording changed - 5.2.2 – first two bullet points replaced with Controlled Ovarian Stimulation - 5.4 – heading changed to Frozen Embryo - 5.6.1 – sentence reworded - 5.6.3 – link to mild male factor infertility removed - 5.6.3 – wording added - 5.6.4 – spelling corrected - 5.6.5 – new paragraph inserted - 5.6.5 - Donor Sperm - sentence reworded - 5.7 – sentence reworded - 6.2.1 and 6.2.2 - swopped around and reworded - 6.5.2 – title changed - 6.5.2 – sentence reworded - 6.9 – sentence reworded

v8	June 2018	M. Thompson on behalf of Panel	Draft	Changes to:- - 2.3 Definition of Infertility - 5.2.2. – IVF involves – additional bullets added - 5.3 – Definition of cycles – removed sentence in brackets - 5.6.4 - Gonadotrophin Therapy added - 5.6.5 – renumbered – added “all couples” where this is a clinical requirement (to replace the reference to male azoospermia) added limited to UK Added additional sentence - 6.5 – title updated to – Pre-referral requirement to specialist care - 6.5.2 – non-smokers section added. - 6.9 – Updated to include the stability of the relationship
v7	Jan 2018	M. Thompson on behalf of Panel	Draft	- Changes to 5.2 pathway - Changes to funding – adding refugees and asylum seekers - Removal of summary of CCGs - 2.3 – clarification of definition of infertility - 6.7 updated to NHS Funded full cycles - 6.10 – added section - Change tertiary to specialist throughout the policy.

Review 2017	22.2.17	F Day on behalf of panel	Final draft	- changes to the definition of infertility for same sex and patients with psychosexual issues and disabilities to be more clear - the addition of public health requirements for providers in line with NICE guidance - clarification of the definition of an abandoned cycle - sections on intrauterine insemination and also egg donation updated in line with NICE guidance - Addition of People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse in line with NICE guidance - wording changed in various sections based on patient feedback to be more clear, not materially changed in content - embryo transfer wording updated to reflect NICE guidance - Addition of definition of low ovarian reserve (previously undefined)

Appendix E

Panel Members: (March 2017)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Chris Edward	Accountable Officer - Rotherham CCG
Dr Steve Maguiness	Medical Director - The Hull IVF Unit, Hull Women and Children's Hospital and honorary contract with HEY
Dr John Robinson	Scientific Director - IVF Unit, Hull and East Yorkshire Hospitals FT
Prof Adam Balen	Professor of Reproductive Medicine and Surgery - Leeds Teaching Hospitals NHS Trust
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Richard Maxted	Service Manager, Directorate of Obstetrics, Gynaecology and Neonatology - Sheffield Teaching Hospital NHS Trust
Dr Margaret Ainger	Clinical Director for Children, YP and Maternity - NHS Sheffield CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Dr Clare Freeman	Medical Advisor to IFR Panel - South Yorkshire and Bassetlaw CCGs

Panel Members (amendments January 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Karen Thirsk	Fertility Policy Manager – NHS England
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG.
Clare Freeman	Lead Medical Advisor – Sheffield CCG.

Panel Members (amendments June 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Dr Bryan Power	(GP) - NHS Leeds CCG

Adam Balen	(Consultant) - Leeds Fertility
Clare Freeman	Lead Medical Advisor – Sheffield CCG

Panel Members (amendments January 2019)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Martine Tune	Acting Chief Nurse – NHS Barnsley CCG
Liz Micklethwaite	Business Manager IFR - NHS Leeds CCG

Commissioner Final Proof Read Panel (Amendments November 2019)

Michelle Thompson	Assistant Director, Women's and Children's Services – NHS North East Lincolnshire CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Clare Freeman	Lead Medical Advisor – Sheffield CCG
Karen Leivers	Head of Strategy and Delivery, Planned Care - Doncaster CCG
Debbie Stovin	Commissioning Manager – Elective Care – Sheffield CCG

Appendix F Relevant Conflicts of Interest Declared:

Dr Steve Maguiness:

IVF in Hull is provided by a private company (ERFS Co Ltd), of which I am a Director and employee.

Prof Adam Balen:

NHS Consultant in Reproductive Medicine and Clinical lead for the Leeds Centre for Reproductive Medicine, which performs all fertility treatments funded by the NHS. Partner in Genesis LLP, the private arm of the Leeds Centre for Reproductive Medicine, which performs self-funded fertility treatments using identical protocols to the NHS. Chair, British Fertility Society. Chair, NHS England IVF Pricing Development Expert Advisory Group. Chair World Health Organisation Expert Working Group on Global Infertility Guidelines: Management of PCOS. Chair, British Fertility Society. Consultant for ad hoc advisory boards for Ferring Pharmaceuticals, Astra Zeneca, Merck Serono, Gideon Richter, Uteron Pharma. Research funding received in the past. Pharmasure / IBSA- Key note lecture at ESHRE 2016 & hospitality to attend meetings. OvaScience- Member of international ethics committee. Clear Blue National medical advisory board. IVI, UK- Chair, Clinical Board

Virginia Beckett FRCO:

I have a private practice where I see fertility patients.

I have received sponsorship from Pharmasure, Ferring & Serono to attend conferences.

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	IPL, Laser or Electrolysis for Hair Removal for the treatment of Hirsutism or other Hair Removal requests
Commissioning position:	***Referral policy for Primary Care***: NHS North Yorkshire CCG does not routinely commission IPL, electrolysis or laser therapy for permanent or semi-permanent hair removal purposes. Patients concerned with the appearance of their body and facial hair should be routinely advised to self-manage their condition by conservative methods e.g. shaving, waxing, or depilatory creams. In addition, NICE Clinical Knowledge Summaries and NY Prescribing formulary guidance on the pharmacological treatment of facial hirsutism in women should be followed. ***Referral policy for Secondary Care***: • One course of treatment will be funded for those patients who are undergoing treatment for pilonidal sinuses to reduce recurrence **Surgery for primarily cosmetic reasons is not eligible for NHS funding.**
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Unwanted hair growth is a common problem and some people may spend considerable amounts of time and money on short term hair removal methods, traditionally by shaving, waxing and plucking. Hirsutism is excessive hair growth in women in areas of the body where only men tend to develop coarse hair, usually on the face and neck area. It is suggested that it affects 5 - 15% of women. Possible underlying causes include PCOS (polycystic ovary syndrome), other rare hormone disorders (eg. congenital adrenal hyperplasia) and some forms of medication. Hair depilation involves permanent removal/reduction of hair from face, neck, legs, armpits and other areas of body usually for cosmetic reasons. Intense pulsed light (IPL) is now the standard treatment with traditional laser and electrolysis as reserve options. Reported side effects of using the Lumina IPL system and Vasculight-SR multi-functional laser and IPL system to treat hair removal in hirsute patients include burning, leukotrichia, paradoxical hypertrichosis and folliculitis. In addition pain, skin redness, swelling,

	burned hairs and pigment changes were infrequently reported adverse effects . Common side effects of laser depilation can include pigment changes, occasional blistering and rarely scarring. Other untoward effects can include: new growth of hair outside the treatment area, increase in co-existing vellus hair in the treatment area, induction or aggravation of acne, rosacea-like rash, premature greyness of hair, tunnelling of hair under the skin, prolonged diffuse redness and oedema of the face, focal hypopigmentation of the lip, angular cheilitis, allergic reaction, and inflammatory and pigment changes of pre-existing moles. Case series evidence suggests that after laser depilation, hair growth is reduced for a period of weeks to months, but multiple treatments may be required to achieve complete hair loss.
Date:	January 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, NHS North Yorkshire CCG

References:

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NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement Knee Arthroscopy

Condition or Treatment:	Knee arthroscopy for diagnostic or therapeutic reasons
Background:	Knee arthroscopy is a surgical procedure for inspection and treatment of problems arising in the knee joint such as inflammation or an injury. It can include repair or removal of any damaged tissue or cartilage. It has been used extensively in the past to diagnose knee problems, but this is no longer appropriate due to the invasive nature of the procedure and the increasing access to less invasive diagnostic methods such as MRI. With such a common procedure, it is important to ensure that the evidence base is robust so that patients are not exposed to the risks without good evidence of benefit. It is important for the NHS to optimise the safety and cost-effectiveness of procedures to ensure maximum benefit for the risks and costs involved. The figures suggest that this could represent an area of improvement in cost-effectiveness and possible cost saving. Surgery should be performed in-line with BASK guidelines as supported by EBI2 https://baskonline.com/professional/wp-content/uploads/sites/5/2018/07/BASK-Meniscal-Surgery-Guideline-2018.pdf
Commissioning Position:	NHS North Yorkshire CCG does NOT routinely commission referral to secondary care for knee arthroscopy and will ONLY commission knee arthroscopy in adults where the following criteria are met: **1) Washout and debridement in Osteoarthritis** Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, (in line with NICE guidance) **unless** the person has a clear documented history of **mechanical locking** (2, 3) **2) Diagnostic Arthroscopy** Patients who have knee pain with persistent mechanical symptoms (locking, catching and intermittent sudden pain on movement) that have not responded to three months of initial non-operative care may have a symptomatic meniscal tear. These patients should be referred for further investigation via agreed local MSK pathways

	where MRI scan may be requested by a MSK specialist. The majority of patients who present to primary care with knee pain **do not** require initial investigation with an MRI scan once red flag symptoms and signs have been excluded. Patients who have a clear history of a significant acute traumatic knee injury and mechanical symptoms or who have a locked knee or present with red flags require referral without delay to secondary care and should undergo MRI investigation (where clinically appropriate). As investigation of knee pain with locking should start with less invasive MRI scanning to identify meniscal tears and loose bodies diagnostic arthroscopy of the knee is therefore **not** routinely funded **unless** one of the following criteria apply: ➢ Significant knee pain having functional impact with diagnostic uncertainty following an MRI scan **OR** ➢ Suspected malignancy, infection, bony fracture or avascular necrosis (i.e. urgent need for investigation) **OR** ➢ Where there are contraindications to MRI scan **3) Therapeutic Arthroscopy** The CCG will ONLY commission therapeutic knee arthroscopy in adults where: ➢ The patient has clear mechanical features of true locking or urgent need for treatment e.g. knee trauma causing fracture or ligament avulsion, red flag conditions **OR** ➢ Clinical examination by a specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, chondral flap, ligament rupture or loose body) with symptomatic and functional impairment **and** conservative treatment (including exercise, weight loss where appropriate,

	physiotherapy and maximal analgesic medication) has been tried over a **3-month** period and failed **or** where it is clear that conservative treatment will not be effective. Summary to support criteria listed above from the ESSKA Meniscus Consensus Project can be found in Appendix A and in the link below: 2016-meniscus-consensus-proj.pdf (ymaws.com) Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes there is an exceptional clinical need that justifies deviation from the rule of this policy. Individual cases will be considered by the individual funding request panel NB: NHS North Yorkshire CCG also does NOT routinely commission a routine elective intervention on patients who have a BMI of 30 or above (classified as obese) or patients who are recorded as a current smoker – see Health Optimisation commissioning statement.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1st July 2021
Summary of evidence/ rationale:	For patients with non-traumatic knee injury, evidence shows that, on average, conservative treatment is as effective as arthroscopic knee surgery for some procedures. As long ago as 2002, a controlled trial addressing knee arthroscopy, using placebo or "sham" surgery as a comparator, showed no benefit (4). Partial meniscectomy surgery showed no advantage over sham in one RCT of patients aged 35-65 years with degenerative meniscal tears without osteoarthritis (5) and no advantage over physical therapy in two RCTs of older patients (>45 years) with osteoarthritis (6, 7). In a systematic review of RCTs of young patients (mean age ~20 years) with a first occurrence of patellar dislocation, there was no conclusive advantage of surgical treatments compared with non-surgical treatments (8). In an RCT of patients with patellofemoral

	pain syndrome (18-40 years), mixed arthroscopic procedures and exercise resulted in equivalent improvements compared with exercise alone (9). Although rates of post-operative complications are generally low higher rates have been observed in children and young people (10,11). There may also be future knee damage associated with arthroscopic procedures (12, 13) and a recent meta-analysis showed that the small benefit from arthroscopic knee surgery seen in middle aged or older patients with knee pain and degenerative knee disease was absent one to two years after surgery and was associated with an increase in significant harms such as deep vein thrombosis, pulmonary embolism, infection and death (14). The paper concludes "The small inconsequential benefit seen from interventions that include arthroscopy for the degenerative knee is limited in time and absent at one to two years after surgery. Knee arthroscopy is associated with harms. Taken together, these findings do not support the practice of arthroscopic surgery for middle aged or older patients with knee pain with or without signs of osteoarthritis (14). The Royal College of Surgeons/British Orthopaedic Association commissioning guide points out that "osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by nonsurgical measures as outlined by NICE (1)." Regarding knee arthroscopy, it states that lavage and debridement should be considered in patients: - With clear history of mechanical symptoms e.g. locking that have not responded to at least 3 months of non-surgical treatment - Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy) The RCS/BOA guidance also states (in line with NICE guidance) that "Knee arthroscopy, lavage and debridement should NOT be offered for patient with non-mechanical symptoms of pain and stiffness." More recently, the BMJ has published two editorials about arthroscopic surgery for degenerative knee or knee pain (15, 16). They both explore the evidence for benefit and harm and point out that, although this is one of the most common surgical procedures,

there is no convincing evidence for the procedure being beneficial beyond the placebo effect.

A series of rigorous trials summarised in two recent systematic reviews and meta-analyses provide clear evidence that arthroscopic knee surgery offers little benefit for most patients with knee pain (14, 17).

The most recent linked paper is a comparison between exercise therapy alone and arthroscopic partial meniscectomy alone (without any postoperative rehabilitation) in adults with a degenerative meniscal tear (18). The authors found no between group differences in patient reported knee function at the two-year follow-up, but greater muscle strength in the exercise group at three months.

Over time, the indications have extended from locked knees in young patients to all patients of all ages with knee pain and meniscus tears of any sort; tears which, on magnetic resonance imaging, have proved poorly associated with symptoms (19).

Essentially, the editorials say, good evidence has been widely ignored. The most recent editorial comments that arthroscopic surgery for knee pain continues unabated, as disinvestments in ineffective treatments are generally slow (16, 20). It calls for local commissioners to respond appropriately to the evidence, because "system level measures that result in more appropriate use of scarce medical resources are urgently required". In addition, it says that "in a world of increasing awareness of constrained resources and epidemic medical waste, what we should not do is ignore the results of rigorous trials and allow continuing widespread use of procedures for which there has never been compelling evidence".

Restricted use of MRI
MRI is a good diagnostic tool (21) but may be inaccurate when used by less experienced staff (22) and its use is, therefore, restricted to secondary care or specialists working in locally commissioned MSK pathways.

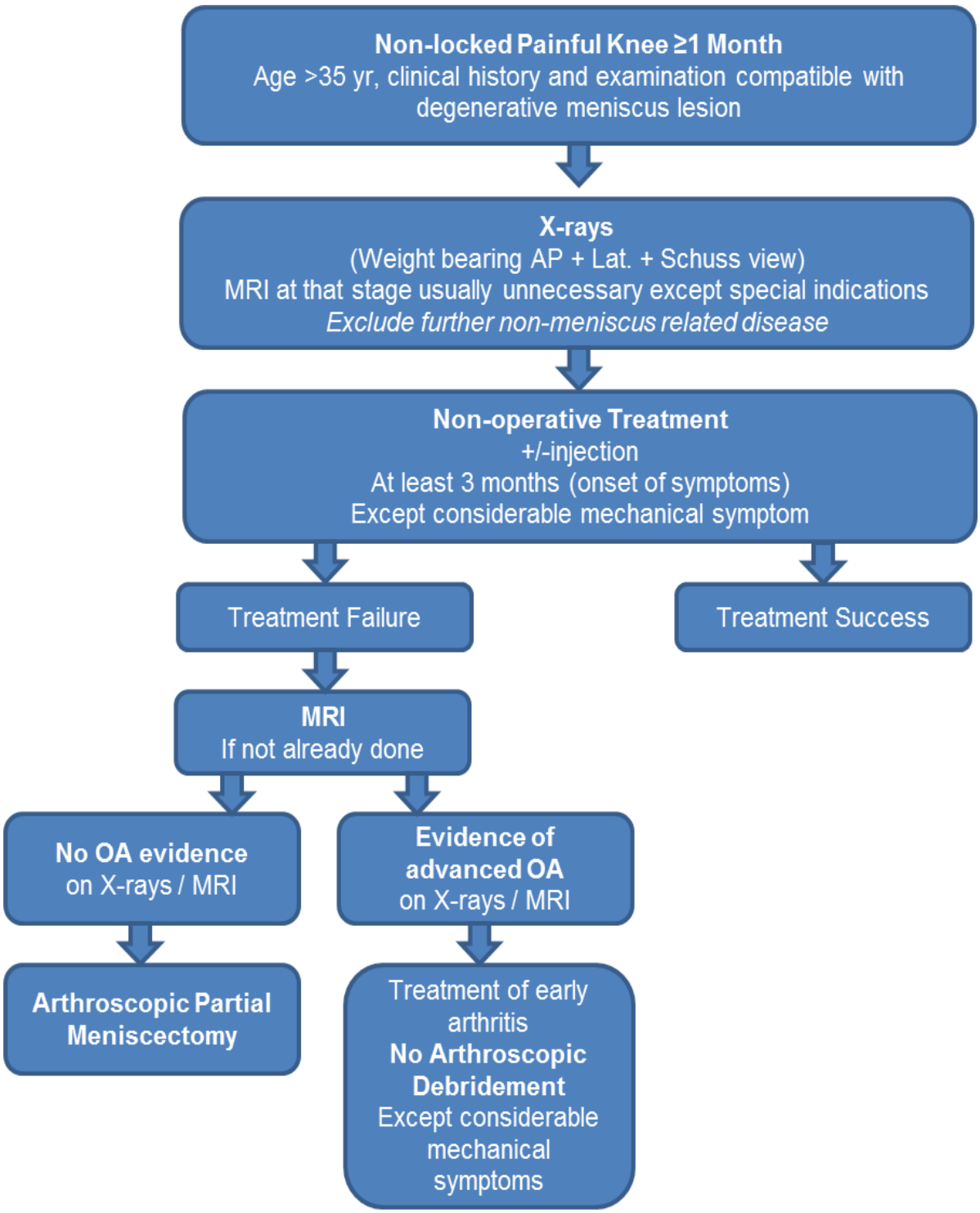
Adapted (and updated) from evidence review in Knee arthroscopy for chronic knee pain Cambridgeshire and Peterborough CCG31, with thanks to Dr Raj Lakshman, Consultant Lead in Healthcare

Shared decision-making
A letter following the recent BMJ editorial suggests that the overtreatment of knee pain with arthroscopy could be solved through the use of shared decision making (31). The NHS/BMJ aid

	for knee arthritis clearly states that arthroscopy for lavage and/or debridement doesn't make much difference to pain, increase mobility around or stop symptom progression (32). The British Orthopaedic Association recently claimed that GPs were over-diagnosing patients with non-arthritic complaints and referring them on for surgery (instead of prescribing exercise) with the expectation that the keyhole procedure would "cure" the problem, so that too many patients were undergoing needless arthroscopy. Easy access to MRI is also likely to be leading to over diagnosis of meniscal tears and subsequent overtreatment. "Shared decision making for the management of knee pain should begin in the GP surgery and continue through the patient's treatment. Given the research findings, it would be difficult to see why patients who are adequately supported in the decision-making process would be choosing surgery over physiotherapy." Patient information leaflets available Arthroscopy Knee cartilage injuries
Date:	April 2021
Review Date:	July 2023
Contact:	Dr Christopher Ives, Governing Body GP/Acute Commissioning lead

Additional Information/References:

Appendix A: ESSKA Meniscus Consensus Algorithm (34)



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32. Osteoarthritis of the knee shared decision-making tool
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https://www.aomrc.org.uk/evidence-based-interventions/

34. ESSKA Meniscus Consensus Project
2016-meniscus-consensus-proj.pdf (ymaws.com)

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	**Knee Replacement for knee Arthritis**
Summary of Intervention:	Many people with knee osteoarthritis do not require joint surgery and can adequately manage their symptoms with compliance to a comprehensive non-surgical programme including appropriate use of analgesia, lifestyle modification, weight reduction and exercise therapy. Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery, should ensure that the person has been offered the recommended non-surgical treatment options (NICE CG177) and meet the criteria listed in this policy. Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should share in the decision for referral for surgical assessment. This should include: • Confirmation of willingness to undergo surgery • The benefits and risks of surgery • The potential consequences of not having surgery • Recovery timescales and rehabilitation requirements after surgery
Policy Exclusions:	This policy does not apply to: • Children under 16 • Knee replacements required due to acute trauma • Cancer
Commissioning Position:	**Referrals for surgical opinion should be made if patients present with one of the following:** • Patient complains of intense or severe pain (please refer to the classification of symptomology table below) **OR** • Patient has radiological features of severe degenerative change or bone loss **OR** • Has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental). **OR** • Patient has radiological features of moderate disease **AND** is troubled by limited joint mobility

AND
limited stability of the knee joint
OR

- Patients who have demonstrated good compliance to a comprehensive non-operative programme including NSAID's and analgesics, weight reduction, lifestyle modification and participation in therapy programmes
  AND
  continue to present with moderate to intense symptomology (please refer to the classification of symptomology table below)
  AND
  are troubled by limited mobility and/or stability of the knee

Classification of pain levels and functional limitations are described in the table below:

For Knee Replacement: Classification of Symptoms

Variable	Definition
Mobility and Stability	
Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range from 0° to 90°. Stable or not lax is equivalent to an slackness of more than 5mm in the extended joint.
Limited mobility and/or stable joint	Limited mobility is equivalent to a range of moveme to 90o unstable or lax is equivalent to the presence more than 5mm in the extended joint.
Symptomology	
Mild	Sporadic pain. Able to carry out daily activities (those requiring great physical activity may be limited). Analgesia medication controls pain with no/few side effects.
Moderate	Occasional pain. Pain walking on level surfaces (half an hour or standing). Some limitation of daily activities. Analgesia medication controls pain with no/few side effects.
Intense	Pain of almost continuous nature. Pain walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of analgesia medication to take effect. Requires the sporadic use of walking aid
Severe	Continuous pain. Pain at rest. Daily activities significantly limited constantly. Continuous use of analgesia medication with adverse effects or poor response. Requires more constant use of walking aid

	Rapid joint deformity / leg shortening

Oxford Knee Score
The Oxford knee score provides a single summed score which reflects the severity of problems that the respondent has with their knee and can be used when considering referral.

It may help a clinician assess the severity of knee disease but should **not** be used as an arbitrary threshold. A score below 20 may indicate severe knee arthritis and it is highly likely that these patients may well require some form of surgical intervention and therefore may benefit from a surgical opinion.

The Oxford Knee Score can be found at:

http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html

Further guidance available at:

http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full

NICE Guidance:
https://www.nice.org.uk/guidance/cg177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-2

https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations#identification-and-classification-of-overweight-and-obesity

Conservative Management

- Patients with knee pain, without red flag or acute trauma indications, should be managed in line with the North Yorkshire CCG pathways and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective or are judged likely to be ineffective.
- Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted / failed.
- Conservative measures include weight reduction, analgesia, education on OA and the management of symptoms, referral to physiotherapy if required, lifestyle modification such as increased physical activity, exercise, and introducing a walking aid.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.

	Shared Decision Making • Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment. • This should include an understanding of rehabilitation requirements and likely duration of recovery and confirmation of willingness to undergo surgery. • The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. • The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention. **Lifestyle Factors** • All patients being referred for knee pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services. • All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment. • Patients with a BMI of >40 (the super-obese) are at increased risk of surgical complications and careful consideration should be given for surgery • If there are specific indications where delay would increase bone loss and prolong suffering, the individual decision should be made by the clinician, with the patient, balancing the clinical risk against the perceived benefits.
Effective From:	1 July 2021
Summary of evidence/ rationale:	20% of adults over 50 and 40% over 80 years report disability from knee pain secondary to osteoarthritis9. The majority of patients present to primary care with symptoms of pain and stiffness which reduces mobility and with associated reduction in quality of life. Osteoarthritis may not be progressive and most patients will not need surgery with their symptoms adequately controlled by non-surgical measures as outlined by NICE [1] .

	When patient's symptoms are not controlled by up to 3 months of non-operative treatment they become candidates for assessment for joint surgery. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support such as the NHS Decision Aid for managing osteoarthritis https://musculoskeletal.cochrane.org/sites/musculoskeletal.cochrane.org/files/public/uploads/What%20are%20my%20options%20for%20managing%20hip%20or%20knee%20osteoarthritis%20%20June%2015.pdf Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischemic heart disease (IHD), hypertension (HT) and sleep apnoea. Some years ago, an Arthritis Research Campaign Report [7] stated that joint surgery is less successful in obese patients because: • Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (e.g. longer operations, excess blood loss requiring transfusions, deep vein thrombosis (DVT) and wound complications including infection). • The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (e.g. they are less likely to regain normal functioning or reduction in pain and stiffness). • The implant is likely to fail more quickly, requiring further surgery (e.g. within 7 years, obese patients are more than ten times as likely to have an implant failure). • People who have joint replacement surgery because of obesity related osteoarthritis are more likely to gain weight post operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels). It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". A study of obese patients with knee osteoarthritis found that those who dropped their weight by 10% after a combination of diet and exercise reported less pain, better knee function, improved mobility and enhanced quality of life [8] . A recent extensive literature review advises assessment of "timely weight loss as a part of conservative care"[9]. It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.
Date:	October 2020

North Yorkshire
Clinical Commissioning Group

Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. .Care and Management of Osteoarthritis NICE Clinical Guidelines CG177 Feb 2014 http://www.nice.org.uk/guidance/CG177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-
2. .Optimising Outcomes from Elective Surgery Commissioning Statement
3. .Obesity prevention NICE CG 43 Dec 2006; last amended March 2015 https://www.nice.org.uk/guidance/cg43
4. .RightCare shared decision-making tools
5. NHS Choices: http://www.nhs.uk/chq/Pages/849.aspx?CategoryID=51&SubCategoryID=165
6. Royal College of Surgeons Commissioning Guides: Painful osteoarthritis of the knee November 2013

   https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/osteoarthritis-knee-guide/
7. Arthritis Research Campaign: “Osteoarthritis and Obesity” (2009) http://www.arthritisresearchuk.org/external-resources/2012/09/17/15/29/osteoarthritis-and-obesity-a-report-by-the-arthritis-research-campaign.aspx
8. Effects of intensive diet and exercise on knee joint loads, inflammation, and clinical outcomes among overweight and obese adults with knee osteoarthritis: the IDEA randomised controlled trial Messier et al JAMA 310(12) 1263-73 (2013) http://www.ncbi.nlm.nih.gov/pubmed/2406501
9. Obesity and total joint arthroplasty: a literature based review. Journal of Arthroplasty May 2013

   http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

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Commissioning Statement:

Condition or Treatment:	Labiaplasty / Vaginoplasty
Background:	This commissioning policy is needed as cosmetic procedures are not routinely commissioned. Labiaplasty is a surgical procedure where the folds of the labia minora are partially removed, usually for cosmetic reasons alone to change appearance. Non-reconstructive vaginoplasty or "vaginal rejuvenation" is another cosmetic procedure used to restore vaginal tone and appearance **Note**: Female circumcision is prohibited in law by the Female Genital Mutilation Act 20031 and is the subject of multi-agency guidelines from the Department of Health. Patients who have undergone female genital mutilation should be referred to a specialist female genital mutilation clinic via NHS England.
Commissioning position:	The CCG will ONLY routinely commission reconstructive labiaplasty/ vaginoplasty: • Following surgery for cancer; • vaginal repair following delivery; • for dyspareunia caused by scarring from vaginal delivery (including Fenton"s procedure); • for scarring caused by underlying dermatology condition such as Lichen Sclerosis NHS North Yorkshire CCG does not routinely commission labiaplasty/ vaginoplasty, for cosmetic reasons, as these procedures are considered to be of limited clinical value. This is in line with the Interim Clinical Commissioning Policy produced by NHS England. Requests for labiaplasty will be considered, via a request to the IFR Panel, for the following indication: • Where the labia are directly contributing to recurrent disease or infection Requests for vaginoplasty will be considered, via a request to the IFR Panel, for the following indication: • Congenital absence or significant developmental/endocrine abnormalities of the vaginal canal,

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North Yorkshire
Clinical Commissioning Group

	The clinician needs to submit an application to the CCG"s Individual Funding Request Panel (IFR)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	The number of requests for this procedure and the number of surgeons offering it has dramatically increased in recent years. Reasons for requesting labiaplasty are often to alleviate functional discomfort, improve appearance and increase self-esteem. Many women seeking labial reduction opt for the procedure because they feel stigmatised by social norms about how they should look and may have unrealistic expectations of the surgery. Recent work has demonstrated there is a wide range of what is regarded as "normal" and satisfaction at the cosmetic outcome of surgical attempts to create normative feminine genital appearance tends to be poor, with up to 80% requiring further reconstructive surgery. Surgery to the labia minora is being promoted as an effective treatment for complaints such as recurrent urinary tract infections (UTIs) or to enhance sexual functioning. There is no good evidence for clinical effectiveness so it can be considered as medically non-essential surgery and thus not routinely commissioned. In one large multicentre study, the author noted that although over 90% of patients were satisfied with the results of their surgery in the shortterm, sexual dysfunction before surgery and enhancement after surgery is highly subjective and difficult to quantify. Some case series also point to re-operation rates following labiaplasty of up to 7% for reasons such as wound dehiscence, infection and dissatisfaction with appearance. None of the studies found in a literature review looked at the potential for long-term obstetric complications after such surgery.
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

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North Yorkshire
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Additional Information/References:

Female Genital Mutilation Act 2003 http://www.legislation.gov.uk/ukpga/2003/31

Female genital mutilation: multi-agency practice guidelines. July 2020

https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Interim Clinical Commissioning Policy: Labiaplasty, vaginoplasty and hymenorrhaphy Nov 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC023.pdf

Lloyd J, et al (2005) Female genital appearance: „normality" „unfolds". BJOG - An International Journal of Obstetrics and Gynaecology 2005; 112:643-646. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2004.00517.x/pdf

Bramwell R, et al (2007) Expectations and experience of labial reduction: a qualitative study. BJOG An International Journal of Obstetrics and Gynaecology 114:1493-1499. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01509.x/pdf

Liao LM, et al (2010) Labial surgery for well women: a review of the literature. BJOG An international Journal of Obstetrics and Gynaecology 2010;117: 20-25

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Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Liposuction
Background:	Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures.
Commissioning position:	Liposuction simply to correct the distribution of fat will not be funded. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	It is the responsibility of NHS North Yorkshire CCG to commission the most clinically and cost effective treatments for its local population within the resources available to it. Treatments which are primarily cosmetic in nature are, therefore, considered a low priority.
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Lycra dynamic splinting for children with neurological impairment
Commissioning position:	Requests for funding will only be considered on an individual patient basis by the CCG IFR Panel. The referral needs to come from a local lead specialist physiotherapist or occupational therapist. The expected benefits for that patient over other treatments must be clearly quantified. Expert opinion suggests that younger children with athetoid disorders (involuntary movements), those with quadriplegic palsy and those with neuromuscular disorders benefit the most. Lycra dynamic splinting is not suitable for clients who have fixed deformities of a bony nature which are not amenable to change. Compliance has a significant role to play in determining outcome, as it does for all therapy and medical interventions. The client and family or carers, who may be assisting them to apply the splints, are made fully aware of the commitment required to ensure success. Provision of subsequent garments will depend on clear, quantifiable demonstration of benefit for the individual patient which has been set upfront. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy. Investigations prior to referral • None
Referral Guidance:	The referral letter should contain: • Details of how the patient meets the above criteria OR demonstrates clinical exceptionality • Impact on activities of daily living • Treatments and interventions tried including the results • Drug history (prescribed and non-prescribed) • Relevant past medical/surgical history • Current regular medication • BMI Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form

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Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Referral for Nerve Conduction Studies from Primary Care
Commissioning position:	These investigations are not commissioned for access from Primary Care. If in doubt, advice and guidance from neurology may be sought.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

Bady, B. and Vial, C. (1996) Critical study of electrophysiologic techniques for exploration of carpal tunnel syndrome Neurophysiol Clin. 1996;26(4):183-201.

Carter, T, Jordan, R and Cummins, C (2000) Electrodiagnostic techniques in the pre-surgical assessment of patients with carpal tunnel syndrome. West Midlands Development and Evaluation Service Report.

Chapell R, Bruening W, Mitchell M D, Reston J T, Treadwell J R. Diagnosis and treatment of worker-related musculoskeletal disorders of the upper extremity. 2002:714. Rockville, MD, USA: Agency for Healthcare Research and Quality.

D'Arcy C A, McGee S. Does this patient have carpal tunnel syndrome?. JAMA. 2000;283(23):3110-3117.

Jablecki, C.K.; Andary, M.T.; So, Y.T.; Wilkins, D.E. and Williams, F.H. (1993)

Literature review of the usefulness of nerve conduction studies and electromyography for the evaluation of patients with carpal tunnel syndrome. AAEM Quality Assurance Committee. Muscle Nerve. 1993 Dec;16(12):1392-414.

Jarvik, Jeffrey G.; Yuen, Eric and Kliet, Michael (2004) Diagnosis of carpal tunnel syndrome: electrodiagnostic and MR imaging evaluation. Neuroimaging Clin N Am. 2004 Feb;14(1):93-102, viii.

Kilmer, D.D and Davis, B.A. (2002) Electrodiagnosis in carpal tunnel syndrome. Hand Clin. 2002 May;18(2):243-55.

Wilder-Smith, Einar P.; Seet, Raymond C.S. and Lim, Erle C.H. (2006)

Diagnosing carpal tunnel syndrome--clinical criteria and ancillary tests. Nat Clin Pract Neurol. 2006 Jul;2(7):366-74.

www.gp-training.net - on right hand side ‘Doctors’ click ‘protocols’ then ‘orthopaedics’ then ‘orthopaedic referral guidelines’

NHS Scotland National Patient Pathways 2005: Orthopaedics; Hand conditions.

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

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Commissioning Statement:

Condition or Treatment:	Oculoplastic Eye Problems
Background and Commissioning position	**Blepharitis:** Blepharitis is a common condition where the edges of the eyelids (eyelid margins) become red and swollen (inflamed). This condition often runs a protracted course and its containment will largely depend on the patient understanding the nature of the problem and what the management issues are. Lid hygiene is the mainstay of treatment and may be sufficient to control simple low-grade blepharitis. **Policy: Referral to secondary care for Blepharitis is NOT routinely commissioned. Referral will only be funded in accordance with criteria below:** • Associated cellulitis OR • Corneal involvement OR • There is well documented evidence of significant pain OR • There is significant impact on vision affecting functionality Consider referring patients with persistent unilateral blepharitis which may be a presentation of Meibomian gland carcinoma **Ectropion** Ectropion is a condition, typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball. **Policy: Surgery for Ectropia will only be funded in accordance with the criteria below:** • Conservative management has been exhausted and there is evidence of significant impairment of the punctum AND • There is recurrent infection in surrounding skin OR • There is significant impact on vision affecting functionality OR • In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure. **Entropion** An entropion occurs where an eyelid turns inwards towards the eye. This causes the eyelashes to rub against the front of the eye (the cornea). The lower eyelid is most commonly affected. **Policy: Surgery for Entropia will only be funded in accordance with the criteria below:**

- There entropion is symptomatic causing ocular irritation, foreign body sensation, blepharospasm, tearing and redness and there is risk of corneal damage

OR

- There is significant impact on vision affecting functionality

OR

- In order to have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Epiphora (watery eyes)

Conservative management comprises:

• Daily massage of lacrimal sac
• Warm Compresses
• Massage
• Referral to Optometry for Syringing of the nasolacrimal duct (for adults only)
• Chloramphenicol for recurrent conjunctivitis in young children.
• Systemic antibiotics for dacryocystitis but requires relief of obstruction to prevent recurrence.

Referral to Secondary Care for Surgical intervention for epiphora secondary to lacrimal sac or nasolacrimal duct obstruction.

Referral to secondary care may be made for diagnostic purposes or tear duct syringing, however surgery is not routinely commissioned therefore prior approval must be obtained from the CCG's Individual Funding Request panel.

Refer to the IFR Panel for watery eyes surgery when, despite undergoing conservative management, the patient is experiencing a daily impact of significant watering of the eyes affecting visual function and / or interfering markedly with quality of life. The watering should occur both in outdoor and indoor settings.

Surgery for Minor Eyelid Lesions

Minor eyelid lesions include eyelid papilloma's or skin tags, cysts of moll, cysts of zeis, Meibomium cysts (see separate commissioning statement)

Policy: Surgery or treatment for minor eyelid lesions will only be funded in accordance with criteria below:

- There is well documented evidence of significant pain

OR

- Recurrent infection

OR

- Recurrent bleeding

OR

	• Is subject to unavoidable recurrent trauma leading to bleeding OR • There is significant impact on vision affecting functionality Where the lump is rapidly growing, abnormally located and / or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2 week wait pathway. **Surgery for primarily cosmetic reasons is not eligible for NHS funding** See separate commissioning statements for Chalazion and Meibomium Cysts.
Effective From:	1st July 2021
Summary of evidence/ rationale:	Ectropion and entropion are common maladies of the eyelid margin that can directly affect ocular function and patient comfort; surgical repair is commonly performed. Ectropion (out-turning of the eyelid) can present with keratoconjunctivopathy, infection, and dermatitis, among other signs and symptoms. Tearing is a common presentation, whether the punctum is everted (resulting in a tear outflow problem) or not (as in reflex tearing from irritation and exposure kerato-conjunctivopathy). Combined-mechanism tearing is not unusual in these cases. Entropion (in-turning of the eyelid) presents as an irritated eye with foreign-body sensation caused by inwardly rotated eyelashes and eyelid skin. The eye is red from kerato-conjunctivopathy. Affected individuals often devise home remedies, such as taping the lid down to the cheek to rotate it away from the globe for comfort.
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

Additional Information/References:

Entropion and Ectropion Christopher DeBacker: http://emedicine.medscape.com/article/1844045-overview

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:
Optimising Outcomes from All Elective Surgery (Health Optimisation)

Background

North Yorkshire CCG has a statutory responsibility for improving the health of the local population as well as providing individual patient-centred care for health promotion, prevention, diagnosis, treatment and rehabilitation. Maximising health is a critical element in achieving a sustainable health service into the future.

This commissioning statement enables a systematic approach to addressing the lifestyle risk factors of smoking and obesity in pre-operative patients. It enables appropriate support to be given to patients, with the aim of helping them to experience the best possible post-operative outcome. In supporting best practice, this statement will therefore ensure that the appropriate management of lifestyle risk is a routine part of surgical care pathways.

This statement applies to adults over age 18.

Obesity

Obesity is a global problem and in the UK 23% of adults are obese (Body Mass Index > 30) and. Obesity contributes to many illnesses. The development of diabetes as a result of obesity is said to be one of the largest 'time bombs' for the NHS with potentially one in ten people having Type 2 diabetes by 2034. Type 2 diabetes itself is a major cause of illness; preventable sight loss, heart disease, strokes, peripheral circulatory problems and renal failure

Obesity is defined as a Body Mass Index (BMI) (weight in kg / height in m^2) of more than 30.

BMI ranges	Weight status
18 to 24	Normal
25 to 29	Overweight
30 to 39	Obese
40 to 49	Morbidly obese

BMI is an established measure of weight though it is recognised that muscular people will have a higher BMI that is not thought to be a risk to health (muscle is denser than fat) and adults of Asian origin may have a higher risk of health problems at BMI levels below 25.

Waist circumference

Obesity can be measured by waist measurements but it is not yet established in UK clinical practice. NHS Choices website[1] states individuals have a higher risk of health problems if waist size is:

- more than 94cm (37 inches) if male
- more than 80cm (31.5 inches) if female

Risk of health problems is even higher if your waist size is:

- more than 102cm (40 inches) if male
- more than 88cm (34.5 inches) if female

	Smoking Smoking causes a range of diseases including cancer, cardiovascular disease and respiratory diseases. It causes many other debilitating conditions such as age-related macular degeneration, gastric ulcers, impotence and osteoporosis. Further, it can cause complications in pregnancy and after surgery is associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated post operative admissions.
Commissioning position	NHS North Yorkshire CCG does NOT routinely commission an elective surgical intervention under general anaesthetic or with spinal or epidural anaesthesia on patients who have a BMI of 30 or above or patients who are recorded as a current smoker unless they have under gone a twelve month period of optimisation as described below or **fit specific exclusion criteria (see appendix A)** The 12 month period will commence from the first documented conversation between GP and patient around weight management and smoking cessation prior to referral. Funding will ONLY be considered where criteria are met. The clinician needs to ensure that the patient fulfills all the criteria and provides evidence of any of the clinical indications before they are listed for surgery following referral for opinion. All other cases need to be referred for consideration by the Individual Funding request panel (IFR), with evidence about clinical exceptionality. For further information on the IFR policies and guidance (including the referral form) please visit: North Yorkshire: https://www.northyorkshireccg.nhs.uk/ **Weight Management Principles** Anyone to be listed for an elective surgical intervention under general anaesthetic or with spinal or epidural anaesthesia that has • a BMI of 30-35 **AND** • a waist circumference more than 94cm (37 inches) - males, more than 80cm (31.5 inches) - female **Must** reduce their weight by 10%, or their BMI to below 30, prior to being put on the waiting list. Patients with a BMI of 30-35 due to high muscle bulk must have a waist measurement below the above figures. The patient can be placed on the waiting list as soon as the target loss has been achieved, or following a year of trying to achieve their target weight loss. The patient should be clinically reassessed to determine whether they still would benefit from the elective procedure as the lifestyle change may have improved their condition.

In summary, listing for surgery* for patients will be via the following process:

- BMI 30–35, Health Optimisation for 12 months, if >10% weight loss or BMI goes below 30, patient can be listed
- BMI 35-40. Health Optimisation for 12 months, if 10% weight loss managed patient can be listed. If less than 10% weight reduction in 12 months – IFR required before proceeding to listing. If BMI is <35 at 12 months, patient can be listed (IFR not required)
- BMI 40+ IFR required before listing

*Surgery under general anesthetic, epidural or spinal anesthesia.

Patients may be offered locally commissioned weight management services prior to referral.

Smoking
Anyone to be listed for an elective surgical intervention under general anaesthetic or with spinal or epidural anaesthesia that is recorded as a smoker must stop smoking prior to being put on the waiting list. The patient can be placed on the waiting list once they have successfully stopped smoking for 8 weeks, or following a twelve month period after being advised to stop smoking.

Please note that a decision to treat will be the responsibility of the clinician and patient. Some surgeons may not wish to risk surgery on patients who smoke."

For the purposes of this policy, vaping is not classed as smoking.

Therefore the referring clinician must:
1. Ensure patients are given up to date patient information leaflet(s) and signposted to the most appropriate support required for their lifestyle changes.
2. Ensure that the shared decision making aids are discussed with patients.
3. Ensure that PROMS are discussed with patients.
4. Ensure patients are advised of their options including non-surgical options and the risks / benefits associated with them.
5. Ensure that arrangements are made for any necessary review while patients are on the pathway for elective care.
6. Advise patients to seek review by their GP or other appropriate health professional should their condition change during the period for lifestyle changes.

<u>Supporting Patient Information</u>

Weight Management
Information and a range of support materials/services which will assist patients in managing their weight loss can be found as follows:

Patient information leaflet: https://www.northyorkshireccg.nhs.uk/wp-content/uploads/2021/03/Smoking-and-BMI-Patient-Information.pdf

Hambleton Richmondshire and Whitby registered patients:
Tier 2 Weight Management
Hambleton:

	https://www.hambleton.gov.uk/zest/homepage/72/weight_management_scheme Richmondshire: https://www.richmondshire.gov.uk/leisure-and-tourism/health-and-wellbeing/choose-to-lose-adult-weight-management-programme/ Whitby: https://www.nhs-health-trainers.co.uk/services/north-yorkshire/scarborough-whitby/ **Harrogate and Rural District** registered patients: **Tier 2 Weight Management**: https://www.harrogate.gov.uk/fit4life **Scarborough and Ryedale** registered patients: **Tier 2 Weight Management** https://www.nhs-health-trainers.co.uk/services/north-yorkshire/scarborough-whitby/ **North Yorkshire County Council** https://www.northyorks.gov.uk/healthy-weight-and-eating-well ***Smoking*** There is a free stop smoking service commissioned by North Yorkshire County Council. Contact the Living Well Smokefree team for advice about giving up smoking for good. https://www.northyorks.gov.uk/stopping-smoking NHS Smoke Free App The NHS Smoke Free App can help patients to stop smoking by providing daily support and motivation. If a patient stays smoke free for the four week programme they are up to five times more likely to stay a lifelong non-smoker. There is free support on offer including a Quit Kit, emails and texts at https://www.nhs.uk/smokefree
Exclusions	Exclusions apply to enable access to urgent care, but all patients must be offered access to smoking cessation and/or weight management concurrently regardless of urgency. Please see Appendix A for details of the exclusions. **(NB: this list is regularly updated)**
Summary of evidence / rationale	**Obesity** Obesity is a recognised risk factor for a wide variety of per-operative complications. Research highlights that obese patients are likely to experience: • a nearly 12-fold increased risk of a post-operative complication after elective cosmetic breast procedures[2] NB obesity not defined • a 5-fold increased risk of surgical site infection (SSI)[3]

- an increased risk of SSI as much as 60% when undergoing major abdominal surgery [4]
- a higher incidence of SSI (up to 45%) when undergoing elective colon and rectal surgery [4]
- an increased risk of bleeding and infections after abdominal hysterectomy [5]
- a higher incidence of peri-operative deep venous thrombosis and pulmonary embolism [6, 7]
- increased risk of complication after elective lumbar spine surgery [8]
- an increased risk of restrictive pulmonary syndrome, including decreased functional residual capacity (for morbidly obese patients [9]

Additionally, it is understood that around 50% of obese patients have a poor outcome following joint replacement surgery compared to less that 10% of patients with a healthy body mass index (BMI).

Reasons include:

- a significantly higher risk of a range of short-term complications [10]
- a less likely outcome of surgery improving symptoms [11]
- a higher risk of implant failing, requiring further surgery
- a higher incidence of weight gain following joint replacement surgery

This weight management peri-operative intervention should be seen as a basic component of evidenced based commissioning for elective surgery.

Smoking

Smoking is a well-known risk factor for complications after surgery and there is good evidence that smokers undergoing induction of general anaesthesia and surgery are at a higher risk of intra and post-operative complications including adverse airway events thereby reducing the benefit of operative treatment in those who continue to smoke. In addition, after surgery, compared with non-smokers and ex-smokers, smokers are more likely to: [12]

- stay longer in hospital - increasing use of hospital beds and associated costs means less opportunity to treat other patients
- be admitted to an intensive care unit
- die in hospital

There is conclusive evidence that smoking causes:

- impaired pulmonary function such as increased mucus production, and damage to the tracheal cilia which impedes the clearance of the mucus leading to post-operative respiratory complications such as chest infection [13]
- impaired wound healing leading to increased risk of wound infection after surgery [14]

Substantial evidence [12] that smoking causes:

- an increase in the risk of cardiovascular complications such angina pectoris, strokes, graft failures and DVT after surgery

Suggestive evidence [12] that smoking causes:

- post-operative complications relating to the gastrointestinal system
- post-operative impairment of antimicrobial and pro-inflammatory functions

	• post-operative complications relating to the musculoskeletal system such as reduction in bone fusion after fracture and operative treatment **Evidence to support preoperative smoking cessation** A 2010 Cochrane review [14] on the interventions for preoperative smoking cessation suggests that stopping smoking four to eight weeks before surgery may reduce the risk of: • wound-related complications • lung and heart complications • prolonged bone fusion time after fracture repair • prolonged stay in hospital after surgery In addition, the National Institute for Health and Clinical Excellence (NICE) guidance on smoking cessation services recommends that patients who are waiting for elective surgery should be encouraged to stop smoking before the operation [15]
Date effective from	1 July 2021
Date published	1 July 2021
Date of Review	July 2023
Author	Suzanne Savage, Service Improvement Manager
Responsible officer	Dr Christopher Ives, Governing Body GP

References:

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11. Foran J, Mont M, Etienne G, Jones L and Hungerford D. (2004) the outcome of total knee arthroplasty in obese patients. J Bone Joint Surg Am. 2004;86:1609-1615
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http://ash.org.uk/files/documents/ASH_1023.pdf
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15. National Institute for Health and Clinical Excellence https://www.nice.org.uk/guidance/ng92/

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Clinical Commissioning Group

Appendix A
Exclusion criteria for Optimising Outcomes from all Elective Surgery

Exclusions apply to enable access to urgent care, but all patients must be offered access to smoking cessation and/or weight management concurrently regardless of urgency.

Exclusions include:

- Patients receiving surgery for the treatment of **cancer or the suspicion of cancer**
- Patients requiring **emergency surgery** or with a clinically urgent need where a delay would cause clinical risk: Some examples are:
    1. Cholecystectomy
    2. Surgery for arterial disease
    3. Anal fissure
    4. Hernias that are at high risk of obstruction
    5. Anal fistula surgery
    6. Revision hip surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, recurrent dislocations, impending peri-prosthetic fracture, gross implant loosening or implant migration.
    7. Revision knee surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, impending peri-prosthetic fracture, gross implant loosening/migration, severe ligamentous instability.
    8. Primary hip or knee surgery which is clinically urgent because there is rapidly progressive or severe bone loss that would render reconstruction more complex.
    9. Nerve compression where delay will compromise potential functional recovery of nerve.
    10. Surgery to foot/ankle in patients with diabetes or other neuropathies that will reduce risk of ulceration/infection or severe deformity.
    11. Orthopaedic procedures for chronic infection.
    12. Acute knee injuries that may benefit from early surgical intervention (complex ligamentous injuries, repairable bucket handle meniscal tears, ACL tears that are suitable for repair).
- The destruction of the patient's joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure or there is impending loss of independence
- Referrals for opinion or interventions of a diagnostic nature such as:
    - Gastroscopy
    - Colonoscopy
    - Nasopharyngolaryngoscopy
    - Laparoscopy
    - Hysteroscopy
    - Cystoscopy
- Patients who despite having a BMI >30 have a waist circumference of:
    - Less than 94cm (37 inches) male
    - Less than 80cm (31.5 inches) female
- Children under 18 years of age
- Any surgical interventions that may be required as a result of pregnancy
- Vulnerable patients who will need to be clinically assessed to ensure that, where they may be able to benefit from opportunities to improve lifestyle, that these are offered. (Please note that deferring elective interventions may be appropriate for some vulnerable patients based on clinical assessment of their ability to benefit from an opportunity to stop smoking/reduce their BMI/improve pre-operative fitness). This includes patients with the following:

- learning disabilities
- significant cognitive impairment
- severe mental illness**

**Adults with a serious mental illness are persons who currently or at any time during the past year, have a diagnosable mental, behavioural, or emotional disorder of sufficient duration that has resulted in functional impairment which substantially interferes with or limits one

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North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Penile Implants for the treatment of Erectile Dysfunction
Background:	A penile prosthesis is another treatment option for men with erectile dysfunction (ED). These devices are either malleable or inflatable. The simplest type of prosthesis consists of a pair of malleable (bendable) rods surgically implanted within the erection chambers of the penis.
Commissioning position:	NHS North Yorkshire CCG does not routinely commission penile implants (prostheses) for treating erectile dysfunction (ED). Funding will only be considered by NHS North Yorkshire CCG Individual Funding Request Panel (IFR) where exceptional clinical circumstances are demonstrated. These might include men with sexual dysfunction after radical treatment for prostate cancer[i].
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Erectile dysfunction (ED) is defined as the persistent inability to attain and maintain an erection sufficient to permit satisfactory sexual performance. It is more common in older men, affecting about half the male population of 40–70 years of age. There is considerable evidence that adequate levels of testosterone are required for ED therapies, especially phosphodiesterase type 5 (PDE5) inhibitors, to achieve maximal response and in many cases normalisation of testosterone levels can restore erectile function. PDE5 inhibitors are effective in approximately 75% of patients, but for nonresponders alternative therapies are available including vacuum erection devices, intracavernous or intraurethral injections, or as a possible third line therapy, a penile implant. NICE CG 175[ii] includes the following advice on managing sexual dysfunction following radical treatment for prostate cancer: 1.3.31 Ensure that men have early and ongoing access to specialist erectile dysfunction services 1.3.32 Offer men with prostate cancer who experience loss of erectile function phosphodiesterase type 5 (PDE5) inhibitors to improve their chance of spontaneous erections 1.3.33 If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer men vacuum devices, intraurethral inserts penile

	injections, penile prostheses as an alternative or approved topical treatments. A Cochrane Review from 2007[iii] mainly covered the effectiveness of PDE5 and did not mention penile implants.
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

[i] NHS Evidence - Clinical Knowledge Summaries ; Erectile Dysfunction http://cks.nice.org.uk/erectile-dysfunction

[ii] NICE CG 175 Prostate cancer: diagnosis and treatment January 2014
http://www.nice.org.uk/guidance/cg175/chapter/1-recommendations

[iii] Interventions for sexual dysfunction following treatments for cancer. Cochrane Review 2007
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005540.pub2/abstract

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Commissioning Statement:

Condition or Treatment:	Pinnaplasty (Otoplasty)
Background:	Pinnaplasty is performed for the correction of prominent ears or bat ears. Prominent ears are a condition where one's ears stick out more than normal.
Commissioning position:	Correction is considered to be a primarily a cosmetic procedure. Surgery for primarily cosmetic reasons is not eligible for NHS funding. The exception to this policy is procedures (remodelling of external ear lobe) in children with congenital abnormalities of the ear to improve hearing as this is covered by Specialised commissioning and should be managed through the specialised commissioning route.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Thigh Lift, Buttock Lift and Arm Lift, Exclusion of Redundant Skin or Fat
Background:	These surgical procedures are performed to remove loose skin or excess fat to reshape body contours. As the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance, in which case it should not be available on the NHS.
Commissioning position:	These procedures will not be routinely funded. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Resurfacing Procedures; Dermabrasion, Chemical Peels and laser treatment
Background:	Dermabrasion involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications. This policy includes all laser skin treatments, for example for Rhinophyma or Rosacea.
Commissioning position:	Resurfacing procedures will not be routinely funded. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	**Reversal of sterilisation in men & women**
Background:	Reversal of female sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens
Commissioning position:	NHS North Yorkshire CCG does not routinely commission the Reversal of sterilisation for men or women **Reversal of female sterilisation**: Sterilisation procedure is available on NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent. **Policy: Reversal of female sterilisation will not be routinely funded.** **Reversal of male sterilisation** Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent. **Policy: Reversal of male sterilisation will not be routinely funded.**
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	The Faculty of Sexual & Reproductive Healthcare Clinical Guidance Male and Female Sterilisation Clinical Effectiveness Unit, September 2014 provides evidence-based recommendations and good practice points for health professionals on elective male sterilisation (vasectomy) and female sterilisation (tubal occlusion) in the UK. It is intended for any health care professional or service that undertakes or refers individuals for either procedure. This guidance has been jointly developed with the Royal College of Obstetricians and Gynaecologists (RCOG). On the reversals of both male and female sterilization it states the following: It is important to note that at present female sterilisation reversal and vasectomy reversal is not routinely offered by the NHS. • Reversal of female sterilisation (pg 45) Fallopian tube re-anastomosis following sterilisation can result in high postoperative patency rates, but may not result in pregnancy or a return to fertility

	• Reversal of male sterilisation (pg 22) Vasectomy reversal involves complex surgery that can result in high postoperative patency rates, but may not result in pregnancy or a return to fertility
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Rhinitis (Adult)

Background:	**Definition**
	Inflammation of the lining of the nose causing: blockage, rhinorrhoea (anterior or posterior), sneezing or itch.
	Classification
	• Infective
	• Irritant
	  Temperature, Chemicals
	• Allergic
	  Seasonal, Perennial, Occupational
	• Non-allergic
	  Drug induced (B-blockers, Topical decongestants, NSAIDs, ACEI)
	  Hormones (Pregnancy, OCP, Hypothyroidism)
	  Eosinophilic
	  Systemic disorders (Cystic fibrosis, Granulomatous disease)
	  Structural
	
	Primary care management
	Not greatly affected by diagnostic classification
	Regular prophylactic medication (even when asymptomatic) is more effective
	Starting treatment two weeks before known allergen improves efficacy
	For Detailed Management Refer to CKS guidelines:
	https://cks.nice.org.uk/topics/allergic-rhinitis/management/
	General Principles Include:
	1. Trigger avoidance
	2. Smoking cessation
	3. Nasal douching with high volume saline rinses see Appendix 1 for additional advice.
	4. Pharmacotherapy – See **(see Appendix 1 for additional advice)**
	  ○ Mild Rhinitis

	Intranasal or Oral Antihistamines ○ Moderate Rhinitis Intranasal Steroids ○ Severe Rhinitis Intranasal or Oral Antihistamines and Intranasal Steroids ○ Watery Rhinorrhoea (eg Senile Rhinitis) Intranasal Steroids or Ipratropium Bromide ○ Asthmatic patients Consider adding Oral Leukotriene Receptor Antagonist ○ In the case of treatment failure with nasal steroid sprays consider using nasal steroid drops instead. ○ In the case of very severe symptoms or symptoms not responding to maximal treatment refer to CKS and consider oral steroids and short term nasal decongestents. (Correct use of Nasal Drops and Sprays – see Appendix 2)
Referral Guidance:	**2WW** • Unexplained nasal obstruction **Routine** • Recurrent unexplained epistaxis • Nasal perforation, ulceration or collapse • Inadequate control of symptoms despite three months of compliant treatment. For management of Sinusitis please see CKS and the EBI2 statement https://cks.nice.org.uk/topics/sinusitis/management/chronic-sinusitis/ https://www.aomrc.org.uk/search/?archive_search=evidence+based+interventions
Effective From:	1 July 2021
Summary of evidence/ rationale:	"BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised Edition 2017; First edition 2007)" https://www.bsaci.org/wp-content/uploads/2020/01/Scadding_et_al-2017-Clinical_amp_Experimental_Allergy.pdf https://cks.nice.org.uk/topics/allergic-rhinitis/ www.evidence.nhs.uk/formulary/bnf/current

North Yorkshire
Clinical Commissioning Group

	www.nhs.uk/Conditions/Rhinitis---non-allergic/Pages/Treatment.aspx
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

North Yorkshire
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Appendix 1.

Regimens

Saline douching

- 1 pint of boiled, cooled water
- 1 tablespoon of rock salt
- 1 teaspoon of bicarbonate of soda

Sniff the solution up into each nostril in turn from the palm of the hand although a 20ml syringe provides a higher volume. Best treatment is obtained with a sinus rinse bottle such as “NeilMed” or “Netipot”.

Antihistamines – See CKS

Steroids – See CKS

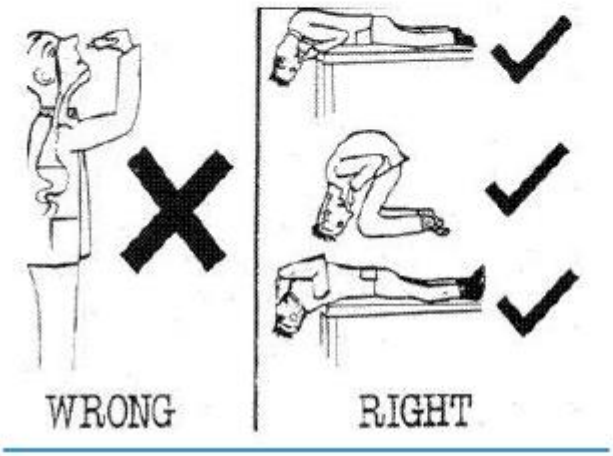
Intranasal Decongestants

Maximum 7/7 due to risk of rebound congestion (rhinitis medicamentosa), ephedrine nasal drops have the least risk.

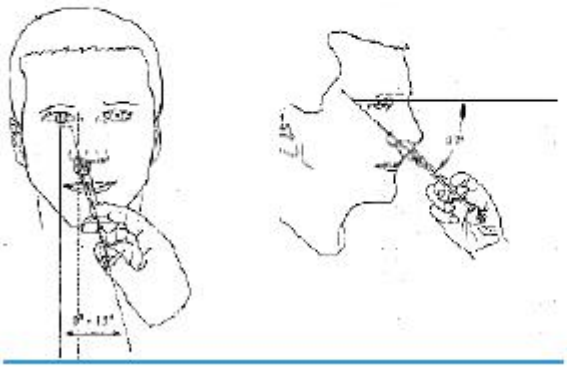
Appendix 2.

Correct way to use nasal drops and sprays

Nasal Drops should be inserted in the head down position and patient should remain in that position for 2 minutes



Nasal sprays should be directed away from the nasal septum and should be followed by a gentle sniff in with the other nostril held closed



North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities
Background:	Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities are surgical procedures performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image. The policy applies to all three procedures of Septorhinoplasty, Rhinoplasty, and Septoplasty.
Commissioning Position:	Rhinoplasty, Septoplasty, or Septorhinoplasty for nasal deformities will only be funded in accordance with the criteria specified below: • Where conservative treatment has been exhausted; AND • Problems caused by obstruction of the nasal airway OR • Objective nasal deformity caused by direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred. OR • Correction of complex congenital conditions to improve function e.g. cleft lip and palate. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Effective From:	1 July 2021
Date:	December 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

References:

1. A Policy To Make Best Use of Resources in Plastic Surgery and Related Specialities November 2006 Northern, Eastern, Southern and Western Health and Social Services Board

2. NHS Modernisation Agency: Action on Plastic, Information for Commissioners of Plastic Surgery Services: Referrals and Guidelines in Plastic Surgery 2004

3. Prasa, S., Kappor, P.K.D., Kumar, A., Reddy, V., Kumar, B.N. Waiting list priorisation in the NHS. Journal of Laryngology and Ontology 2004, 118(1) :39-45

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Commissioning Statement:

Condition or Treatment:	Sacral Nerve Stimulation for Bladder Symptoms
Background:	Sacral nerve stimulation, also termed sacral neuromodulation, is a type of medical electrical stimulation therapy. It typically involves the implantation of a programmable stimulator subcutaneously, which delivers low amplitude electrical stimulation via a lead to the sacral nerve, usually accessed via the S3 foramen. In line with NICE recommendations this policy has separate eligibility criteria and care pathways for men and women.
Commissioning position:	**Policy: Women** SNS for urinary incontinence or urgency-frequency syndrome in women will only be funded in accordance with the criteria below: • Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if BMI >30) AND • Symptoms are refractory to behavioural interventions: a minimum of 6 weeks of bladder retraining OR 3 months of pelvic floor muscle training (in mixed UI only, where there is some stress incontinence as well as OAB) AND • Symptoms are refractory to 4 weeks of anticholinergic medication to a maximal tolerated dose (a number of drugs may be tried in accordance with NICE CG171) (OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects (NICE TA290)) AND • The woman has been referred to secondary care, reviewed by an MDT and a diagnosis of detrusor over activity has been confirmed by urodynamic assessment AND • Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation. **Policy: Men** SNS for men with overactive bladder (OAB) caused by detrusor over activity will only be funded in accordance with the criteria below:

	• Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.) AND • Symptoms are refractory to 4-6 weeks of anticholinergic medication (OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290)) AND • The man has been referred to secondary care for specialist assessment and a diagnosis of detrusor over activity has been confirmed AND • Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation. Before a permanent SNS device is fitted, ALL prospective patients must have been approved for and have undergone a positive trial period (2-3 weeks) of temporary stimulation resulting in a 50% or greater improvement in voiding function based on the results of a voiding diary. **SNS will not be funded for patients with**: • Stress incontinence, the most common type of urinary dysfunction • Urinary retention due to obstruction (e.g. from benign prostatic hypertrophy, cancer, or urethral stricture) • Urge incontinence due to psychological or neurological conditions, such as diabetes with peripheral nerve involvement, MS, stroke or spinal cord injury (see NICE CG 148).
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	May 2020

North Yorkshire
Clinical Commissioning Group

Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Scar Revision Surgery
Commissioning position:	NHS North Yorkshire CCG does not routinely commission scar revision surgery
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS North Yorkshire Clinical Commissioning Group

Arthroscopic Sub acromial Decompression surgery

Treatment	**Arthroscopic Sub acromial Decompression of Shoulder**
OPCS Codes	029.1 Sub acromial decompression W84.4 Endoscopic decompression of joint + Shoulder W88.9 Unspecified diagnostic endoscopic examination of other Joint + shoulder
For the treatment of	Sub acromial shoulder pain
Background	Evidence published suggests that arthroscopic sub acromial decompression for sub acromial shoulder pain offers little benefit over a non-operative approach. **This statement does not apply to those with any of the following:** • Acute rotator cuff tears • Sub acromial impingement pain for whom a combined rotator cuff repair and sub acromial decompression may be appropriate • Calcific tendonitis • Large Sub acromial spur • Post fracture complications • Post traumatic sub acromial bursitis **OR** • Those with any clinical suspicion of infection, malignancy, unreduced dislocation or inflammatory arthritis, for whom appropriate local urgent pathways should be followed North Yorkshire CCGs commissioning statement is a modified version of the national Evidence Based Commissioning (EBI) policy thresholds
Commissioning position	NHS North Yorkshire CCG **DO NOT** routinely commission arthroscopic sub acromial decompression shoulder surgery for the treatment of sub acromial impingement pain. Patients should be managed conservatively as outlined in the MSK pathway for conservative management: • Rest/activity modification • Appropriate oral analgesia including NSAIDs • Lifestyle factors considered, such as BMI/smoking/exercise status, and discussed as risk factors for MSK ill health/tendon pain • At least six months active physiotherapy including, rotator cuff and scapular muscle strengthening, manual therapy and motor control retraining including class based

	exercise. If appropriate, six month programme can include patient self-directed continuation of exercises. • No more than two sub acromial steroid injections, if appropriate and only considered in conjunction with physiotherapy as high recurrence rates in cases managed with injection alone **Treatment is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request panel**
Summary of evidence / rationale	The benefits of surgery are unclear, however, with some conflicting evidence. A recent randomised, placebo-controlled study compared outcomes following sub acromial decompression surgery, arthroscopy only, and no treatment for patients with sub acromial shoulder pain[2]. It concluded that "surgical groups had better outcomes for shoulder pain and function compared with no treatment, but this difference was not clinically important and decompression appeared to offer no advantage over arthroscopy only… The findings question the value of this operation for these indications." In response to these results, the British Elbow and Shoulder Society (BESS) and the British Orthopaedic Association (BOA) have issued a position statement announcing that they will be recruiting a multidisciplinary group to update the 2014 BOA commissioning guidelines for sub acromial pain [3]. Wider questions have since also been raised about distinguishing between the effects of elective surgery and those of time, rest, graduated rehabilitation and the placebo effect – "the reported outcomes of many elective orthopaedic surgical procedures may be attributed to these responses"[4]. The condition is a long-term one and fluctuations in symptoms are to be expected. Further studies are being carried out. This statement has a review date and future publications will be taken into account upon review.
Date effective from	1 July 2021
Review date	July 2023
Author	Dr Alison Forrester (Public Health England Advisor), Annette Wardman (Commissioning & Transformation manager), Vale of York CCG. Adopted by North Yorkshire CCG: Suzanne Savage
Approved by	Executive Committee and Quality and Clinical Governance Committee
Responsible officer	Dr Christopher Ives (GP Lead for Acute Commissioning)

References:

1. Beard et al Lancet 391: 329-338 January 2018 Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multi-centre, pragmatic parallel group, placebo-controlled, three-group, randomised surgical trial CSAW Trial

2. Statement in response to recent studies regarding subacromial decompression BESS (2017) Bess/boa statement

3. Lewis J Journal of Orthopaedic and sports physical therapy 48:127-129 March 2018 The end of an era?

Version	Created /actioned by	Nature of Amendment	Approved by	Date
0.1	Lead Clinician and Service Improvement Manager	Draft of aligned policy and circulation to internal GP Leads	QCGC – NY CCG	5.11.20

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Commissioning Statement:

Condition or Treatment:	Surgery for minor foot problems
Commissioning position:	Referral for surgery for minor foot problems which include (but not limited to): claw toe, hammer toes, inner growing toenails, metatarsalgia, Morton's neuroma, plantar fasciitis, will only be considered when the following criteria are met: • The patient has been referred to a podiatrist and/or physiotherapist where appropriate and conservative management has failed (including avoiding high heels, exercises, applying ice, appropriate analgesia, non-surgical treatment) AND • the patient suffers from severe deformity that causes significant functional impairment OR • the patient suffers from severe pain that causes significant functional impairment OR • there is recurrent or chronic ulceration (or infection) due to the deformity **Metatarsus Varus:** Refer to secondary care if: • After the child reaches the age of 5 years the in-toeing is still evident as surgery may necessary All patients to be referred to local podiatry services prior to referral to secondary care **Hallux Valgus and Paediatric Curly Toes:** Please see separate NY policy **Exclusions:** If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not affect the existing diabetic foot pathway This policy does not apply to surgery to correct deformity due to acute trauma.

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Effective From:	1 July 2021
Date:	April 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

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Commissioning Statement:

Condition or Treatment:	Surgical Fillers
Background:	Surgical fillers are widely used in cosmetic surgery, for the treatment of wrinkles and skin aging, to improve the appearance of scars and for augmenting the volume of soft tissue such as in the lips.
Commissioning position:	Surgical fillers for the treatment of wrinkles and skin ageing will not be routinely funded
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Tattoo Removal
Background:	A tattoo is defined as a form of body modification, made by inserting indelible ink into the dermis layer of the skin to change the pigment.
Commissioning position:	Tattoo removal will not be routinely funded. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Clinical Commissioning Group

Intervention	**Therapeutic and diagnostic injections for the treatment of spinal pain**
For the treatment of:	Spinal pain - Cervical, Thoracic & Lumbar.
Background	This policy sets out the commissioning position and threshold for therapeutic and diagnostic injections for the treatment of spinal pain. This commissioning policy is needed because the clinical and cost effectiveness of therapeutic injections for back pain is not proven. There is a threshold in place for diagnostic injections for back pain prior to surgery and also for patients who are on an acute back pain pathway.
Commissioning position	NHS North Yorkshire CCG **DOES NOT** routinely commission therapeutic spinal injections for cervical, thoracic or Lumbar spine pain. This includes: • Spinal Epidural Injections (transforaminal/interlaminar) and nerve root blocks • Spinal Facet Joint Injections (FJI)/Medial branch blocks • Spinal Radiofrequency Nerve Denervation (rhizolysis/medial branch block/nerve root pulsed denervation) • Therapeutic trigger point injections for the management of spinal pain **There are five exceptions which <u>are</u> commissioned**: 1. **During the acute episode of severe spinal pain with radicular pain,** as part of the acute/subacute back pain pathway, to help with mobilisation, **one** epidural <u>or</u> trans-foraminal <u>or</u> medial branch block injection will be commissioned within an acute back pain service. 2. **For the treatment of chronic severe spinal pain with radicular pain for diagnostic purposes, to guide surgical decision making only,** up to two independent episodes of trans-foraminal injections are commissioned to guide surgical decision making in patients. 3. **Facet joint medial branch block injections for diagnostic purposes:** For patients with spinal pain AND/OR radicular pain <u>up to 2</u> diagnostic facet medial branch block injections will be commissioned for diagnostic purposes to help define further management in line with the National Back Pain Pathway[1] (NBPP).

	4. **Facet nerve radiofrequency denervation** – can be offered at no less than 16 month intervals to those with chronic low back pain who have (in the opinion of the specialist pain team), engaged in an MDT approach and have a positive response to a diagnostic facet joint medial nerve block (in line with National Back and Radicular Pain Pathway). 5. **Spinal injections required to treat spinal pain caused by cancer.** ALL OTHER requests now must be made via an Individual Funding Request (IFR) application: • HRW/SR GP practices https://ifryh.necsu.nhs.uk/ • HaRD GP practices Referral Form All patients with low back pain and/or sciatica should be assessed and managed in line with NICE guidance NG59[1]. This MUST initially include: • Consider alternative diagnoses e.g. injury, malignancy • Risk assessment and risk stratification (e.g. STarTBack risk assessment tool at first point of contact with a healthcare professional). Based on risk stratification, consider simpler support (e.g. self-management - exercise, weight loss etc.) or more complex intensive support (e.g. pain management programmes with physical and psychological elements), optimised pharmacological interventions.
Summary of evidence / rationale	**History of evidence base** The previous NICE clinical guideline on low back pain (CG88; May 2009[2]) recommended that injection therapy should not be offered for back pain lasting greater than 6 weeks and less than 1 year. It specifically states “Do not offer injections of therapeutic substances into the back for non-specific low back pain”. **Current evidence base** The new NICE guidance NG59[3] maintains the current position not to offer spinal injections for managing low back pain and to consider epidurals only in people with acute and severe sciatica. It does however include a new recommendation to “consider” referral for assessment for radiofrequency denervation (RFD) for people with chronic low back pain when: • non-surgical treatment has not worked for them and • the main source of pain is thought to come from structures supplied by the medial branch nerve and • they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or

	equivalent) at the time of referral. Only to be performed in people with chronic low back pain (i.e. over 12 weeks) and after a positive response to a diagnostic medial branch block. The most commonly used injection for the management of sciatica is corticosteroid, with or without local anaesthetic. Although performed widely since the 1950s, the administration of steroids into the epidural space remains unlicensed. Currently there are areas of uncertainty beyond the effectiveness of epidural injections to be considered, including the ideal route of administration, the use of imaging to improve accuracy, the timing of injection and the safety profile. The fuller NICE guideline (methods, evidence and recommendations) covers the evidence base in detail[4]. The quality of evidence is low to moderate in strength and comes from populations with chronic pain for more than 2 years who had failed to respond to conservative treatment[5]. It comments that the duration of pain relief following RFD is uncertain. Data from randomised controlled trials suggests relief is maintained for at least 6-12 months but no study has reported longer term outcomes. Some trials show adverse event (allodynia) rates higher than expected with RFD. The economic model built for the guideline showed that RFD is "cost effective" but the results were sensitive to the duration of the intervention; it suggested that the treatment is likely to be cost effective provided the duration of effect exceeds 16 months. When this was less than 16 months, RFD was not cost effective as the ICER would go above the £20,000 per QALY threshold. This is, in itself, the upper limit of what is considered an acceptable threshold and takes no account of affordability. Given the relatively low cost of RFD (around £750 per procedure) it also suggests the impact is rather limited. The guideline development group considered the various limitations of the model together with the main results and concluded that although RFD is a cost effective intervention, there was not enough confidence for a strong ('offer') recommendation for this intervention. In addition, if RFD is repeated, there is no evidence to show whether the outcomes and duration of these outcomes are similar to the initial treatment. **What NICE mean by the terms 'Offer' and 'Consider'** Some NICE recommendations are made with more certainty than others. NICE word their recommendations to reflect this.

For example NICE use 'offer' to reflect a strong recommendation, usually where there is clear evidence of benefit. NICE use 'consider' to reflect a recommendation for which the evidence of benefit is less certain. See Making decisions using NICE guidelines: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/making-decisions-using-nice-guidelines

Back pain injections glossary

Spinal injections include all of the following:

Facet joint injections (FJI).
These involve injection of substances (local anaesthetic, steroid or other agents) into the facet joint itself. Facet joints are small stabilizing joints located between and behind adjacent vertebrae in the spine and are believed to contribute to spinal pain in some cases. Facet joint injections can be used as a diagnostic procedure intended to establish whether the pain originates entirely or largely from the facet joint and may also be used as a therapeutic procedure for short-term pain relief in patients who have such significant degenerative change it is difficult to identify the location of the medial branch nerve

Facet Medial branch Blocks
Injection of the same substances as above around the primary nerve innervating the facet joint (the medial branch of the posterior primary ramus) is termed a medial branch block. It can be used as a more specific diagnostic procedure for considering future radiofrequency and is intended to establish whether pain originates from the facet joint. It can also sometimes be used as a therapeutic procedure.

Radiofrequency denervation (RFD) (requires a positive response to a diagnostic medial branch block
For people with low back pain who experience significant but short term relief with facet joint nerve block, this can be followed by a neurodestructive procedure called radiofrequency denervation (RFD) in an attempt to achieve longer term pain relief. RFD has evolved as a treatment for spinal pain over the last 40 years and is a minimally invasive and percutaneous procedure. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves and denatures them. This process may allow axons to regenerate with time requiring the repetition of the radiofrequency procedure. Radiofrequency denervation is not an appropriate treatment of people who have sciatica without back pain.

	Trans-foraminal Epidurals/ Nerve root injections/ Dorsal root ganglion block The epidural space lies within the spinal canal, outside the dura mater, and contains the spinal nerve roots. A trans-foraminal epidural injection is an injection of a therapeutic substance into this canal around a single nerve root with the aim of a more regional response. **Inter-laminar Epidurals** This may be a caudal injection at the base of the spine or in the midline between the vertebral laminae (NICE recommends against use of epidural injections for patients with central spinal canal stenosis). This is usually only the injection of steroid with no local anaesthetic component to prevent the chance of accidental spinal injection. **Trigger point injections** Trigger points are specific sites in a muscle that cause pain. In back pain this can occur either locally or refer more widely throughout the back. For the purpose of this policy Trigger point injections refers to those into painful muscles causing spinal pain.

Date effective from	1 July 2021
Review date	July 2023
Author	Suzanne Savage, Service Improvement Manager
Responsible officer	Dr Christopher Ives, Governing Body GP

References

1. National Back Pain and Radicular Pain Pathway (Third edition) 2017 national back pain and radicular pain pathway
2. Low back pain: Early management of persistent non-specific low back pain NICE CG88 May 2009 https://www.nice.org.uk/guidance/cg88
3. NICE NG59 (November 2016) Low back pain and sciatica in over 16s: assessment and management https://www.nice.org.uk/guidance/ng59
4. NG59 full guidance; invasive treatments: methods, evidence and recommendations https://www.nice.org.uk/guidance/ng59/evidence/full-guideline-invasive-treatments-2726157998
5. Bedfordshire and Hertfordshire interim priorities forum statement 55 (Nov 2016): Back injections: the elective use of epidural and facet joint injections and denervation of facet joints in management of back pain.

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Commissioning Statement:

Condition or Treatment:	**Tier 3 Weight Management**
Background:	The Adult Tier 3 Weight Management Service, also referred to as the Specialist Weight Management Service (SWMS), is a multi-disciplinary, intensive, secondary-care based programme, designed to support adults with severe obesity and complex needs who require a more individualised approach than the Tier 2 service has previously been able to offer them. The programme is typically 6-12 months and will potentially include input from a physician (either consultant or GP with a specialist interest), specialist nurse, specialist dietitian, psychologist, psychiatrist and physiotherapist.
Commissioning position:	Referral Criteria The service is available to patients aged 18 years of age and over, who are registered with a North Yorkshire CCG GP practice, have a BMI of ≥40, or a BMI ≥ 35 with significant co-morbidities AND Who have maximised primary care and community conservative management including: • Receiving healthy weight and lifestyle advice in primary care • Evidence of active participation in modification to exercise and diet, which is patient- or GP-led, or delivered by an independent commercial service or Tier 2 service, depending on local availability • Have been offered a trial of pharmacological interventions where there are no contra-indications • Understanding of the commitment required for the Tier 3 programme and willingness to engage
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval.
Effective From:	2nd March 2022
Summary of evidence/ rationale:	NICE Clinical Guideline CG189: https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations Report of the Working Group into Joined Up Clinical Pathways for Obesity: https://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf

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Date:	February 2022
Review Date:	January 2024
Contact:	Dr Emma O'Neill, Clinical Advisor, North Yorkshire CCG

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention for Tonsillectomy for Recurrent Tonsillitis
Background:	This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children. Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person's ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.
Commissioning Position:	Surgery for treatment of recurrent severe episodes of sore throat is commissioned 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: https://www.sign.ac.uk/our-guidelines/management-of-sore-throat-and-indications-for-tonsillectomy/

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	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 • 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. Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Recurrent sore throats are a very common condition that presents a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the Scottish Intercollegiate Guidelines Network criteria are met. The surgery carries a small risk of bleeding requiring readmission to hospital (3.5%). A previous national audit quoted a 0.9% risk of requiring emergency surgery to treat bleeding after surgery but in a more recent study of 267, 159 tonsillectomies, 1.88% of patients required a return to theatre. Pain after surgery can be severe (especially in adults) for up to two weeks after surgery; this requires regular painkillers and can cause temporary difficulty swallowing. In addition to bleeding; pain or infection after surgery can require readmission to hospital for treatment. The Getting it Right First Time ENT report published in 2019 presented updated figures on readmission rates in relation to tonsillectomy. There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation.
Date:	September 2020

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Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun 6;16:263.

https://www.ncbi.nlm.nih.gov/pubmed/26047934

2. https://www.sign.ac.uk/our-guidelines/management-of-sore-throat-and-indications-for-tonsillectomy/

3. Osbourne MS, Clark MPA. The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018. May (100) 5: 406-408

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Condition or Treatment	**2019 NHSE Evidence Based Intervention (EBI) for Trigger finger release***
Summary of intervention	Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.
Commissioning Threshold	Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously. Cases interfering with activities or causing pain should first be treated with: a) one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics; Surgery should be considered if: a) the triggering persists or recurs after 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 nonoperative methods; **or** d) the patient has diabetes. 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).
Referral guidance	Referrals for exceptional circumstances are to be submitted by way of an Individual Funding Request (IFR) referral form for decision by the IFR panel. The referral form is available through the following link: • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form

Effective from	1 July 2021
Summary of evidence / Rationale	Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%). This policy is a modified version of the national EBI policy.
Review Date	July 2023
Contact for this policy	Dr Christopher Ives GP/Governing Body Member christopherives@nhs.net

References:

1. https://www.nhs.uk/conditions/trigger-finger/treatment/
2. Amirfeyz R, McNinch R, Watts A, Rodrigues J, Davis TRC, Glassey N, Bullock J. Evidence-based management of adult trigger digits. J Hand Surg Eur Vol. 2017 Jun;42(5):473-480. doi: 10.1177/1753193416682917. Epub 2016 Dec 21.
3. British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST). https://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/trigger_digit_leaflet_2016.pdf
4. Chang CJ, Chang SP, Kao LT, Tai TW, Jou IM. A meta-analysis of corticosteroid injection for trigger digits among patients with diabetes. Orthopedics. 2018, 41: e8-e14.
5. Everding NG, Bishop GB, Belyea CM, Soong MC. Risk factors for complications of open trigger finger release. Hand (N Y). 2015, 10: 297-300.
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7. Hansen RL, Sondergaard M, Lange J. Open Surgery Versus Ultrasound-Guided Corticosteroid Injection for Trigger Finger: A Randomized Controlled Trial With 1-Year Follow-up. J Hand Surg Am. 2017;42(5):359-66.
8. Lunsford D, Valdes K, Hengy S. Conservative management of trigger finger: A systematic review. J Hand Ther. 2017.
9. Peters-Veluthamaningal C, Winters JC, Groenier KH, Jong BM. Corticosteroid injections effective for trigger finger in adults in general practice: a double-blinded randomised placebo controlled trial. Ann Rheum Dis. 2008 Sep;67(9):1262-6. Epub 2008 Jan 7.

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Commissioning Statement:

Condition or Treatment:	Urinary Incontinence Surgery (Female)
Commissioning position:	**Patients should be seen and assessed in a Local Continence Service prior to a secondary care referral** Threshold for referral for surgery: 1. The following assessment should be undertaken in primary care prior to referral (refer to local Continence Services): • UTI excluded or treated • Initial assessment and categorisation of incontinence • Voiding dysfunction excluded (refer to secondary care if this is confirmed/suspected) In addition patients should have been given advice on: • Advice on weight loss if BMI over 30 • Advice on fluid intake including effect of caffeine/alcohol 2. First-line conservative management to be undertaken in primary care as follows: • A trial of supervised pelvic floor muscle training for at least 3 months (stress/mixed incontinence) AND/OR • Bladder retraining lasting for a minimum of 6 weeks +/- antimuscarinic (urge/mixed incontinence) In addition, if appropriate: topical vaginal oestrogens in post-menopausal women with urogenital atrophy
Effective From:	1 July 2021
Summary of evidence/ rationale:	NICE guidance advocates the use of conservative measures before surgical treatments. NICE CG123: Urinary incontinence and pelvic organ prolapse in women, June 2019
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

Additional Information/References:

NICE CG123: Urinary incontinence and pelvic organ prolapse in women, June 2019
https://www.nice.org.uk/guidance/ng123

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Intervention	**Interventional treatments in the management of Varicose Veins**
OPCS Codes	L832 – Subfascial ligation of perforating vein of leg L841 – Combined operations on primary long saphenous vein L842 – Combined operations on primary short saphenous vein L843 – Combined operations on primary long and short saphenous vein L844 – Combined operations on recurrent long saphenous vein L845 – Combined operations on recurrent short saphenous vein L846 – Combined operations on recurrent long and short saphenous vein L858 – Other specified ligation of varicose vein of leg L859 – Unspecified ligation of varicose vein of leg L875 – Local excision of varicose vein of leg L876 – Incision of varicose vein of leg L883 – Percutaneous transluminal laser ablation of varicose vein of leg NEC L888 – Other specified transluminal operations on varicose vein of leg L889 – Unspecified transluminal operations on varicose vein of leg L882 - Radiofrequency Ablation of Varicose Vein of Leg L862 - Ultrasound guided foam sclerotherapy for varicose vein of leg L881 - Percutaneous transluminal laser ablation of long saphenous vein L849 - Unspecified combined operations on varicose vein of leg L848 - Other specified combined operations on varicose vein of leg L871 - Stripping of long saphenous vein L873 - Stripping of varicose vein of leg NEC L851 - Ligation of long saphenous vein L861 - Injection of sclerosing substance into varicose vein of leg NEC L874 - Avulsion of varicose vein of leg L853 - Ligation of recurrent varicose vein of leg
For the treatment of	**Varicose Veins**
Background	This commissioning policy clarifies the care pathway and the criteria that must be met before interventional treatment or surgery is commissioned. The policy takes into account NICE Clinical Guideline CG168 (July 2013) *Varicose Veins in the legs – Diagnosis and Management*[1] and *NICE Surveillance report 2016 – Varicose veins in the legs (2013) NICE guideline CG168*[2] The NICE Clinical Guideline is only a recommendation and in this statement the CCG has defined the grading / severity of varicose veins for what is felt to be an appropriate use of NHS resources. Requests for surgical treatment outside the criteria outlined below and outside the pathway must be considered via the Individual Funding Request (IFR) Panel.
Commissioning position	**The NHS does not routinely commission treatment in secondary care for varicose veins.** **The NHS does not commission treatment for** • **telangiectasia,**

- **reticular veins,**
- **asymptomatic varicose veins,**
- **varicose veins without other clinical skin signs**
- **treatment for cosmetic or aesthetic reasons**
- **surgical treatment for varicose veins in pregnancy**

Clinicians should exclude Red Flag Symptoms which are not covered by this statement

- **Deep vein thrombosis** (DVT) should be excluded in any patient presenting with a red, hot swollen leg with use of the Well's criteria and d-dimer testing.
- **Superficial vein thrombosis** above the knee should be discussed with the vascular team as admission is sometimes indicated for high tie and/or anticoagulation as there is a significant potential for clot migration and pulmonary embolism.
- **Bleeding varicose vein** which has caused significant blood loss and/or will not stop with direct pressure may require admission.

NICE detail symptoms from varicose veins as pain, aching, discomfort, swelling, heaviness and itching. Patients along with their primary care clinicians and surgeons should be aware that these symptoms are subjective and not specific just to varicose veins. Other causes should be considered and excluded prior to referral to the secondary care vascular services.

Clinical signs of varicose veins that <u>may</u> justify surgical treatment include

- oedema,
- changes in skin and subcutaneous tissue such as eczema, lipodermatosclerosis or atrophie blanche,
- healed or active ulceration of the skin in the absence of other causes of ulceration.

The severity of varicose vein induced skin damage or imminent risk to skin integrity and any subjective symptoms should be a guide for general practitioners and vascular surgeons in prioritizing patients for NHS surgery. Conservative management should still be encouraged to prevent or delay the need for, or support the success of, subsequent surgery.

In the **absence of** skin damage or an imminent risk to skin integrity, primary care clinicians should only refer for an opinion, and surgeons should only undertake surgery, where there is a clear justification for clinical benefit and use of NHS resources.[3]

In light of financial position and capacity issues within the local health economy referral for, and surgery for, symptomatic varicose veins without skin damage is not regarded as a priority for use of NHS resources.

Where **clinical signs are mild, conservative management should**

be undertaken prior to referral for specialist opinion.

Conservative management in primary care should include advice on

- the causes of varicose veins,
- the likelihood of progression and possible complications (NICE in 2013 stated "the evidence review for the guideline showed a *lack of high-quality evidence on the progression of varicose veins* from [mild] (CEAP[9] stage C2 or C3) to more serious varicose veins disease[1])
- Patient Reported Outcome Measures for Varicose Vein Surgery. In 2013/14 nationally only 52% of patients reported an improvement in their health status as measured by the EQ5D tool; although 84% reported improvement using the Aberdeen Varicose Vein Questionnaire, only 40% reported improvement using the EQ-VAS score.
- The following should be recommended for those who do not have signs of skin damage or those who do not wish to undergo surgery.
    - Increasing activity such as walking and more vigorous exercise when possible
    - Weight loss where needed, aiming to achieve a BMI of 20-25
    - Avoidance of activities that exacerbate symptoms e.g. prolonged sitting or standing
    - Elevation of the legs when sitting down to increase venous return
    - A trial of compression hosiery to relieve oedema (leg swelling) associated with varicose veins (especially in pregnancy). In 2013 NICE recommended research was needed to ascertain the clinical and cost effectiveness of compression hosiery versus no compression for the management of symptomatic varicose veins[1].

NHS North Yorkshire CCG commissions referral to a secondary care vascular service for patients with

- Symptomatic primary or recurrent varicose veins **and** clinical signs such as oedema (in the absence of other causes), changes in skin and subcutaneous tissue: eczema, lipodermatosclerosis or atrophie blanche, healed or active venous ulcers

NHS North Yorkshire CCG does not routinely commission Transilluminated Powered Phlebectomy or Endovenous Mechanochemical Ablation (NICE IPG37 and IPG435) to treat varicose veins, due to inadequate evidence on the safety and efficacy of these techniques[4, 5].

NHS North Yorkshire CCG commissions surgical treatment for varicose veins as detailed above if

- the pathway has been clinically evidenced as being followed and

there is justification for prioritising NHS resources for treatment and

- after clinical assessment including duplex ultrasound confirmation of the diagnosis of varicose veins and presence of truncal reflux (venous blood flowing backwards due to valves not working properly),

NHS North Yorkshire CCG only commissions the following surgical treatment:

1. First line: endothermal (radiofrequency) ablation **without** removal of varicosities[6, 7].
2. Second line: Ultrasound guided foam sclerotherapy **without** removal of varicosities[8].

Surgery to remove superficial varicosities (phlebectomies) is NOT routinely commissioned. NICE stated in 2013 'There is limited evidence on the use and timing of tributary treatments after truncal endothermal ablation. There is a need for practice to be based on empirical evidence from a large and sufficiently powered RCT comparing all 3 main intervention options (no tributary treatment, concurrent tributary treatment and delayed tributary treatment). NICE reviewed studies published between 2013 and 2016 and reported that none of the new evidence considered in surveillance of [the 2013] guideline was thought to have an effect on current recommendations[1, 2].

Removal of varicosities (phlebectomies) are commissioned when:

- there has been a history of significant bleeding from the varicosities **OR**
- there is anterior thigh vein incompetence and the incompetent trunk is too tortuous for endothelial ablation. Where possible patients should have proximal ablation and sequential avulsions if skin complications are present **OR**
- large (>1cm) varicosities are present in association with truncal incompetence and perforator disease in the calf or thigh. Ultrasound measurement of varicosities, demonstration of truncal incompetence, and presence of perforators needs to be recorded and stored for medico-legal and audit purposes.

All patients are expected to be treated under **local anaesthetic** unless there are clinical reasons why this is not appropriate, e.g.

- Three or more truncal veins require treatment
- For high tie and stripping of a Saphena Varix or a large (>2cm) Greater Saphenous Vein where radiofrequency ablation and foam

	sclerotherapy are not suitable. • Patients in whom a large number of phlebectomies are needed AND the phlebectomies are commissioned (as defined above) AND the use of local anaesthesia would risk toxicity. **Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request panel.** Patient preference for general anaesthesia without exceptional factors, as agreed by IFR, is not an appropriate use of NHS resources
Summary of evidence / rationale	Varicose veins are dilated superficial veins in the leg caused by incompetent venous valves. About a third of the population are affected by visible varicose veins in the legs; prevalence increases with age and they often develop during pregnancy. Asymptomatic ones present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes. Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated pain or discomfort and slight ankle swelling. Severe varicose veins may present with phlebitis, ulceration and haemorrhage. About 3-6% of people who have varicose veins will go on to develop ulcers. There is some evidence that the clinical severity of venous disease is worse in obese persons so advice on weight loss may help reduce symptoms and would make any intervention safer. Because most varicose veins do not cause serious health problems, treatment is not usually needed on medical grounds.
Date effective from	1 July 2021
Date published	1 July 2021
Review Date	July 2023

References:

1. NICE Clinical Guideline 168 (July 2013) Varicose veins in the legs: the diagnosis and management of varicose veins

2. Surveillance report 2016 – Varicose veins in the legs (2013) NICE Guideline CG168 (published 4/2/16)

3. Paragraph 18 GMC Good Medical Practice, 2013

4. NICE IPG 37 (2004) Transilluminated powered phlebectomy for varicose veins
5. NICE IPG 435 (2013) Endovenous mechanochemical ablation for varicose veins
6. NICE IPG 8 (2003) Radiofrequency ablation of varicose veins
7. NICE IPG 52. (2004) Endovenous laser treatment of the long saphenous vein.
8. NICE IPG 440. (2013) Ultrasound-guided foam sclerotherapy for varicose veins
9. HG.Beebe,J.J.Bergan,D.Bergqvist,B.Eklöf,I.Eriksson,M.P.Goldman*et al.* Classification and grading of chronic venous disease in the lower limbs: a consensus statement

Version	Created by	Nature of Amendment	Approved by	Date
1.0	CCG GP Lead	Adoption of VoY policy approved	NYCCG QCGC	

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Vasectomy under General Anaesthetic
Commissioning position:	The CCG commissions vasectomy services under local anaesthetic in a number of settings. Vasectomy under general anaesthetic is not routinely commissioned.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	The purpose of vasectomy is to provide permanent birth control. A vasectomy is a male surgical procedure to cut or tie the vas deferens as a reliable method of contraception, usually done under local anaesthetic. The vas deferens is a tube that carries sperm from the testicles. NHS North Yorkshire CCG recommends that men who request a vasectomy are fully assessed and counselled before the procedure is given, including taking the medical history of both partners to ascertain if the procedure is, indeed, the most appropriate intervention. Most vasectomies are carried out under local anaesthetic. This means only the scrotum and testicles will be numbed. The Faculty of Sexual and Reproductive Healthcare Clinical Guidance for Male and Female Sterilisation recommends that Vasectomy should be performed under local anaesthesia wherever possible.
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

References:

1. NICE Clinical Knowledge Summaries. Contraception -management. Male sterilization

http://cks.nice.org.uk/contraception-sterilization

2. World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Geneva: WHO; 5th edition 2015.

https://www.who.int/publications/i/item/9789241549158

3. Cook LA, Pun A, van Vliet H, Gallo MF, Lopez LM. Scalpel versus no-scalpel incision for vasectomy. Cochrane Database Syst Rev. 2007 Apr 18;(2):CD004112

https://www.researchgate.net/publication/292183447_Scalpel_versus_no_scalpel_incision_for_vasectomy

4. FPA Factsheet on male and female sterilisation.

https://www.fpa.org.uk/sites/default/files/male-and-female-sterilisation-your-guide.pdf

5. Faculty of Sexual and Reproductive Healthcare Clinical Guidance, Male and Female Sterilisation Summary of Recommendations (2014) https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-summary-sep-2014/