

Minor Skin Surgery for Skin Lesions Commissioning Policy

Interventions	Minor Surgery for Skin Lesions
Policy Criteria	<p>Skin Lesions must meet at least ONE of the following criteria to be removed³:</p> <ul style="list-style-type: none"> • The lesion is unavoidably and significantly traumatised on a regular basis (e.g. causing regular bleeding or recurrent infections). There is repeat infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion is obstructing an orifice or impairing visual access. The lesion significantly impacts on function eg: restricts joint movement • If left untreated, more invasive intervention would be required for removal • Facial viral warts that have not resolved with an appropriate trial of topical treatment. • Facial spider naevi in children causing significant psychological impact
Background	<p>NHS Scarborough and Ryedale CCG and NHS Vale of York CCG are responsible for commissioning activity in secondary care, and this policy sets out the criteria for referral to secondary care for minor surgery, as this is not always routinely commissioned.</p> <p>As well as the lesions specifically detailed in the policy, the policy also applies to the benign lesions listed below³:</p> <p>Please note: This list is not exclusive:</p> <ul style="list-style-type: none"> • Solar comedones • Corn/callous • Dermatofibroma • Milia • Epidermoid & Pilar Cysts (sometimes incorrectly called sebaceous cysts) • Seborrheic keratosis (basal cell papillomata) • Spider naevi (telangiectasia) • Xanthelasmata • Neurofibromata

<p>Commissioning Position</p>	<p>Treatment of any condition for purely cosmetic reasons is not commissioned. NHS Scarborough and Ryedale CCG and NHS Vale of York CCG only commission referrals to secondary care dermatology / plastic surgery in the following circumstances:</p> <ul style="list-style-type: none"> • Where there is diagnostic uncertainty or a possibility of malignancy <p>OR</p> <ul style="list-style-type: none"> • A lesion has been excised in primary care and a re-excision has been subsequently recommended on clinical grounds by the histopathologist <p>OR</p> <ul style="list-style-type: none"> • After individual approval by the Individual Funding Request Panel (IFR) <p>The following conditions should always be referred direct to secondary care (dermatology, head and neck surgery or plastic surgery as appropriate) and IFR approval is not required for:</p> <ul style="list-style-type: none"> • Malignant Melanoma (2 week pathway) • Squamous Cell Carcinoma (SCC) including extensive premalignant changes to the lip (2 week pathway) • Basal Cell Carcinoma (refer as urgent and not via 2 week pathway. Where possible those <1cm and below the clavicle should be excised in Primary Care). <ul style="list-style-type: none"> ○ Removal by accredited GP Minor Surgeon (either in-house or through Practice-to-Practice referral via LES scheme) ○ Remove with 4mm margins, send for histology <ul style="list-style-type: none"> • Lentigo Maligna • Naevus Sebaceous
<p>Indications</p>	<p>Criteria for secondary care referral</p>
<p>Benign Skin Lesions</p>	<p>The removal of benign skin lesions is not routinely commissioned for cosmetic reasons.</p> <p>Where there is diagnostic uncertainty GPs should send three photos, (field, close-up and dermatoscopic) to the Dermatologists for advice on whether the patient needs to be seen in secondary care or whether primary care excision biopsy is appropriate (“permission to biopsy”)</p> <p>Under the Minor Surgery Directed Enhanced Service, GP practices may undertake:</p>

	<ul style="list-style-type: none"> • Incision and drainage of an abscess requiring local anaesthetic • Excision of sebaceous cysts where there is a history of more than one infection • Incision and Curettage of Meibomian Cysts (as per the Commissioning Statement Click Here) <p>Referral to Secondary Care services</p> <p>Indications for referral to an appropriate alternative provider include:</p> <ul style="list-style-type: none"> • lesions suspicious of being a basal cell carcinoma (BCC) that are > 1cm in size or above the clavicle or squamous cell carcinoma (SCC) and melanomas. • lesions of uncertain significance where a specialist opinion is that primary care treatment is appropriate or a histological diagnosis is required that should be seen and managed by an accredited clinician who has links with the local skin cancer MDT. This would include secondary care dermatologists and also (where commissioned) GPwSIs. • sebaceous cysts where there is a history of one or more episodes of infection and so which would be appropriate for removal under this enhanced service, but where the <ul style="list-style-type: none"> ○ patient has a history of keloid scarring or hypertrophic scarring and the lesion is in an area where the patient would not want to risk the development of such scarring <p>OR</p> <ul style="list-style-type: none"> ○ where the lesion lies in a position which is not appropriate for removal in primary care e.g. face or centre of spine <p>All other requests must have prior approval through Individual Funding request Panel.</p>
Molluscum contagiosum	<p>Patients need to be managed in primary care. Referral to the dermatology department should only be made if patients have either of the following:</p> <ul style="list-style-type: none"> • molluscum contagiosum in immunosuppressed patients

	<ul style="list-style-type: none"> • Diagnostic uncertainty of a solitary lesion. <p>All other requests for referral for secondary care should have prior approval from individual funding request panel. Funding for treatment will not normally be commissioned.</p> <p>Where molluscum contagiosum is causing significant problems in the management of atopic eczema, or other widespread conditions, specialised opinion should be sought in Advice & Guidance attaching clinical photographs.</p>
Viral warts	<p>Children found to have ano-genital warts should be referred to the York 'Child Sexual Assault Assessment Centre' for confirmation of diagnosis.</p> <p>Treatment for Viral Warts is restricted to the minimum eligibility criteria below. This is because most plantar warts can be managed with over the counter topical treatments or by treatments prescribed in Primary Care. Treatment for Viral Warts that do not meet the criteria below are deemed to be cosmetic and will not be funded. Referral to secondary care dermatology should only be made:</p> <ul style="list-style-type: none"> • for ano-genital warts in adults that have failed treatment in the Primary Care setting or Genito-Urinary (GUM) Clinic • for viral warts in immunosuppressed patients • if there is doubt about the diagnosis and concern about possible malignancy • Facial viral warts that have not resolved with an appropriate trial of topical treatment. <p>Where there are exceptional circumstances, referral should be made to the Individual Funding Request Panel. Viral warts on face where there are physical or mental sequelae should be referred to IFR for funding.</p>
Skin tags (including anal skin tags)	<p>Treatment is not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended. . Where exceptional clinical indications exist (e.g. intractable pruritus ani) then referral to the Individual Funding Request Panel is advised.</p>
Cyst of moll	<p>Not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended.</p>
Cyst of Zeis	<p>Not routinely commissioned. Where there is diagnostic uncertainty requesting a specialist opinion by sending photos via Advice and Guidance is recommended.</p>
Pingueculum	<p>Not routinely commissioned. Where there is diagnostic</p>










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Eyelid papillomas and skin tags	Not routinely commissioned. Where there is diagnostic uncertainty requesting an ophthalmologist opinion by sending photos via Advice and Guidance is recommended. See oculoplastic eye problems commissioning statement .
Actinic solar keratosis (AK)	<p>Referral to secondary care for Actinic Keratosis is not expected unless primary care treatments have failed, (guidance on primary care treatment is on the Referral Support Site website under Dermatology).</p> <p>Refer to secondary care for:</p> <ul style="list-style-type: none"> • severe AK when there may be a possibility of invasive malignancy: these are thicker and harder and may have an infiltrated base refer to secondary care where there is diagnostic uncertainty. • failure of 2 different treatments • Immuno-compromised patients
Pigmented Naevi (moles)	Refer if there is clinical suspicion of malignancy or diagnostic uncertainty.
Lipoma	<p>Surgery is NOT routinely funded for cosmetic reasons and concerns about cosmetic appearance should NOT be referred to secondary care unless there are clinically exceptional circumstances with IFR Panel approval or criteria below are met.</p> <p>Surgery is NOT routinely funded for excision of lipomas of any size that are confirmed as <u>benign</u> (clinically OR radiologically OR histologically following biopsy).</p> <p>Surgery is ONLY funded</p> <ul style="list-style-type: none"> • for lipomas that impair function such that the impaired function resulting from the lipoma could be harmful, e.g. restricts neck movements, unable to wear a safety helmet, restricting movement of a joint, obstructing an orifice. These examples are not meant to be exhaustive. Referring clinicians and/or surgeons will need to justify the prioritisation of NHS resources for such surgery. <p>OR</p> <ul style="list-style-type: none"> • where, if left untreated, more invasive intervention would be required for removal. Such cases may require secondary care surgeons opinion. <p>Surgery for excision out with these criteria needs IFR Panel</p>

	<p>approval</p> <p>See detailed clinical guidance, published on the RSS under General Surgery here. Diagnosis is usually clinical – USS is not routinely required to confirm the diagnosis.</p> <p>Where there is diagnostic uncertainty patients should be referred for imaging at York Teaching Hospitals Foundation Trust, not Yorkshire Health Solutions or other providers as per the pathway in the clinical guidance.</p>
Summary of evidence / rationale	<p>Minor surgery should only be carried out when clinically necessary and after weighing up the risks and benefits.</p> <p>The use of NHS resources to manage benign cosmetic lesions is not a current priority and expectations of such should be discouraged.</p> <p>The risks of carrying out minor surgery on skin lesions include damage to nerves, haemorrhage, failure to achieve wound closure, wound infection, wound dehiscence, over granulation, incomplete excision rate, unsatisfactory scar formation and distortion to local anatomy¹</p> <p>A comparison of minor surgery in primary and secondary care carried out in the South of England suggested that the quality of minor surgery carried out in general practice is not quite as high as that carried out in hospital, but patients prefer the convenience of treatment in General Practice. However, there</p>
	<p>may be clear deficiencies in GPs' ability to recognise malignant lesions, and there may be differences in completeness of excision when compared with hospital doctors²</p>
Date effective from	14 th April 2022
Review date	30 th April 2025
Approved by	Vale of York Executive Committee
Responsible officer	Michelle Carrington, Executive Director of Quality and Nursing

References:

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3. NHSE/I.(2018) Evidence-Based Interventions: Consultation Document. Available at: <https://www.england.nhs.uk/wp-content/uploads/2018/06/04-b-pb-04-07-2018-ebi-consultation-document.pdf>. Accessed:18/12/2018

Dermatology Referrals Commissioning Statement

<p>Background</p>	<p>NHS Scarborough and Ryedale CCG (SRCCG) & NHS Vale of York CCG (VOYCCG) are responsible for commissioning activity in secondary care and for enabling rapid review of patients with suspected cancer. This policy sets out the referral criteria for dermatology referrals.</p> <p>The CCGs want to support acute providers manage demand for dermatology services so that patients who need specialist support are not subject to longer waits. In particular the CCGs are keen that patients referred in to 2WW clinics only receive 2WW appointments if there is good evidence that they may have skin cancer. This should increase the identification of skin cancer in such clinics. To support these aims this commissioning statement defines the expectations of all primary care dermatology referrals into secondary care.</p> <p>In order to standardise the approach to dermatology referrals there is an expectation that three photographs should be attached with all dermatology referrals.</p>																										
<p>Definition</p>	<p>It is the policy of NHS Vale of York and NHS Scarborough and Ryedale CCG that three specific photograph views (an overview, a close up and a dermatoscopic picture as detailed below) must be attached to all dermatology referrals, unless exceptions apply.</p> <p>The three photograph technique with high quality images should enable accurate triage and diagnosis. This means that patients can be triaged to the right place at the right time and some of the benign lesions can be confidently diagnosed as such with advice provided to the GP, saving patients from unnecessary hospital visits and other patients waiting longer than necessary.</p>																										
<p>Essential Information to include with the referral letter</p>	<table border="1"> <tr> <td colspan="4" data-bbox="406 1366 1364 1400">All three photographs must be high-quality: Sharp and In-Focus</td> </tr> <tr> <td data-bbox="406 1400 550 1433">Device</td> <td colspan="2" data-bbox="550 1400 1061 1433">Camera</td> <td data-bbox="1061 1400 1364 1433">Dermatoscope</td> </tr> <tr> <td data-bbox="406 1433 550 1467">Views</td> <td data-bbox="550 1433 813 1467">1: Overview</td> <td data-bbox="813 1433 1061 1467">2: Close-up</td> <td data-bbox="1061 1433 1364 1467">3: Dermoscopy</td> </tr> <tr> <td data-bbox="406 1467 550 1668">Examples</td> <td data-bbox="550 1467 813 1668"></td> <td data-bbox="813 1467 1061 1668"></td> <td data-bbox="1061 1467 1364 1668"></td> </tr> <tr> <td data-bbox="406 1668 550 1769">Aim</td> <td data-bbox="550 1668 813 1769">Enables correct anatomical location</td> <td data-bbox="813 1668 1061 1769">Facilitate diagnosis by naked-eye</td> <td data-bbox="1061 1668 1364 1769">Facilitate diagnosis by Dermatoscope</td> </tr> <tr> <td data-bbox="406 1769 550 2004">Tips</td> <td data-bbox="550 1769 813 2004">Entire limb, Head or Torso should be visible</td> <td data-bbox="813 1769 1061 2004">Lesion centrally located & detail eg: scaling/crusting in focus</td> <td data-bbox="1061 1769 1364 2004">Use alcohol gel (or lubricating jelly if near eye or on mucosal surface). Vary pressure until vessels and pigment in sharp focus.</td> </tr> </table> <p>Dermoscopy helps to enable accurate diagnosis, but only if the image</p>			All three photographs must be high-quality: Sharp and In-Focus				Device	Camera		Dermatoscope	Views	1: Overview	2: Close-up	3: Dermoscopy	Examples				Aim	Enables correct anatomical location	Facilitate diagnosis by naked-eye	Facilitate diagnosis by Dermatoscope	Tips	Entire limb, Head or Torso should be visible	Lesion centrally located & detail eg: scaling/crusting in focus	Use alcohol gel (or lubricating jelly if near eye or on mucosal surface). Vary pressure until vessels and pigment in sharp focus.
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Responsible GP – Drs Shaun O’Connell and Dan Cottingham – York CCG	Approved: 05/06/2019 (VOY) 03/07/2019 (S&R)																										
Responsible Consultant – Drs Julia Stainforth and Kathryn Thompson	Review date: 04/06/2021																										
Responsible Pharmacist – n/a	NHS Scarborough & Ryedale Clinical Commissioning Group																										

	<p>is high quality and this requires the use of either alcohol gel or a lubricating jelly. A video on use of Schuco Handyscope dermatoscopes provided by York Against Cancer is here.</p> <p>Please note, rashes require only the first two photographs overview and close-up and exceptions are noted below.</p> <p>Where photos are not attached GPs should detail which exception applies or referrals will be returned to GPs to clarify.</p> <p>Further details of the requirements can be found here.</p>
Exceptions	<ul style="list-style-type: none"> • An area the patient deems too sensitive to photograph (e.g. genitalia, breasts) • Dermatoscopic equipment is broken (normal overview and close up photos should still be sent) • Dermatoscopic equipment is unavailable for other reason (normal photos should still be sent) <p>Patient declines to have photographs taken even when referrer has explained the benefits to them and other patients of doing so. A patient leaflet on medical photography is available here. (LINK NEEDS ADDING)</p> <p>Any exceptions and the reason for them must be included in the referral.</p>
Effective from	July 2019
Review Date	July 2021
Contact for this policy	Scarborough & Ryedale CCG: scrccg.rssifr@nhs.net Vale of York CCG: VOYCCG.RSS@nhs.net

Responsible GP – Drs Shaun O’Connell and Dan Cottingham – York CCG	Approved: 05/06/2019 (VOY) 03/07/2019 (S&R)
Responsible Consultant – Drs Julia Stainforth and Kathryn Thompson	Review date: 04/06/2021
Responsible Pharmacist – n/a	NHS Scarborough & Ryedale Clinical Commissioning Group

New Version	Created by	Nature of Amendment	Approved by	Date
1.0	S Bennett	Initial drafts		
1.2	S O'Connell	Amendments to initial draft		
2.0	S O'Connell	Consultation Draft		
3.0	S Bennett/S O'Connell	Near Final draft for Executive	Executive Committee	05/06/2019
4.0		Final draft for Governing Body		
5.0	S Bennett/S O'Connell	Final version for publication to providers	Scarborough & Ryedale Business Committee	03/07/2019

Responsible GP – Drs Shaun O'Connell and Dan Cottingham – York CCG	Approved: 05/06/2019 (VOY) 03/07/2019 (S&R)
Responsible Consultant – Drs Julia Stainforth and Kathryn Thompson	Review date: 04/06/2021
Responsible Pharmacist – n/a	NHS Scarborough & Ryedale Clinical Commissioning Group

Rhinoplasty Commissioning Statement

Statement number: 38

Treatment	Rhinoplasty / Septorhinoplasty
For the treatment of	Nasal deformities
Background	Rhinoplasty/septoplasty for nasal deformities is a surgical procedure performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image
Commissioning position	<p>All cases require prior approval. Consideration will not be given to cosmetic rhinoplasty.</p> <p>Rhinoplasty may be considered medically necessary only in limited circumstances and where the clinical rationale fits with the evidence base as follows:</p> <ol style="list-style-type: none"> 1. When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate; 2. Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when all of the following criteria are met: <ul style="list-style-type: none"> • Airway obstruction which will not respond to septoplasty and turbinectomy alone AND • Nasal airway obstruction is causing significant symptoms (e.g. chronic rhinosinusitis, difficulty breathing) AND • Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy AND • Photos demonstrate an external nasal deformity AND • There is an average 50% or greater obstruction of nostrils (e.g. 50% obstruction of both nostrils; or 75% one nostril and 25% of other; or 100% obstruction of one nostril), documented by endoscopy, CT scan or other appropriate imaging modality <p>There are, however, exclusions that need to be addressed such as:</p> <ul style="list-style-type: none"> • Unstable mental health • Unrealistic patient expectations • Previous rhinoplasty within the last 9-12 months (applies only to major rhinoplasties) • Poor perioperative risk profile • History of too many previous rhinoplasties, resulting in an atrophic skin–soft tissue envelope and significant scarring • Nasal cocaine users
Summary of evidence / rationale	<p>Rhinoplasty is an operation whereby the shape of the nose is changed by modifying the underlying bone and / or cartilage of the nose. In addition to altering the external appearance of the nose, the cartilage inside the nose can be straightened to improve the nasal airways. This procedure is called a septorhinoplasty.</p> <p>Guidance on commissioning is provided by the Modernisation Agency Document</p>

	'Information for Commissioners of Plastic Surgery Services', which was prepared by the British Association of Plastic and Reconstructive Surgery.
Date effective from	September 2016
Date published	September 2016
Review date	September 2018
Author	Dr Alison Forrester, Healthcare public health advisor, CYC and NYCC
Responsible officer	Dr Shaun O'Connell, GP Lead ValeofYork.contactus@nhs.net

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 prioritization in the NHS. Journal of Laryngology and Ontology 2004,118(1) :39- 45.

Haemorrhoidectomy (and Haemorrhoidopexy) Commissioning Policy

General Commissioning Policy

Treatment	Haemorrhoidectomy (and Haemorrhoidopexy)
<p>OPCS Codes</p>	<p>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</p> <p>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</p> <p>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</p>
<p>Background</p>	<p>Haemorrhoids are enlarged vascular cushions in the anal canal and may be external or internal. They are the commonest cause of rectal bleeding</p> <p>Definition of degrees of haemorrhoids:</p> <ul style="list-style-type: none"> • 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 • Fourth grade: the haemorrhoid is always outside
<p>Commissioning position</p>	<p>NHS Scarborough & Ryedale and Vale of York CCGs will only commission haemorrhoidectomy (and haemorrhoidopexy) in the following circumstances:</p> <ul style="list-style-type: none"> • 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) <p>Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionalism is demonstrated and approved by the Individual Funding Request</p>

	Panel prior to referral
Summary of evidence / rationale	<p>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.</p> <p>Treatment for Grade III and IV haemorrhoids include bipolar electrocoagulation using diathermy, stapled haemorrhoidopexy or haemorrhoidal artery ligation (IPG 525)</p> <p>There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure.</p> <p>Short term efficacy and cost effectiveness is similar.</p>
Date effective from	September 2018
Date published	September 2018
Review Date	2020

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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- BMJ Clinical Review – Management of haemorrhoids – BMJ2008; 336 doi; BMJ 2008;336:380 <http://www.bmj.com/content/336/7640/380>
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doi:10.1001/archsurg.2008.591.
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Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinician and Senior Service Improvement Manager	Initial draft of new policy and circulation to internal GP Leads	Lead Clinicians – VoY and SR CCGs	May 2018
2.0	Senior Service Improvement Manager	No requirement for consultation – no significant change in thresholds	Lead Clinicians – VoY and SR CCGs	June 2018
FINAL	Senior Service Improvement Manager	Approval of threshold	SRCCG Business Committee VoY Clinical Executive	04.07.18 04.07.18

22. Hernia Repair Commissioning Statement

Treatment	Hernia repair - inguinal (in men), umbilical, incisional
Background	<p>Hernia repair refers to a surgical operation for the correction of a hernia (a bulging of internal organs or tissues through the wall that contains it.) Hernias can occur in many places, including the abdomen, groin, diaphragm, brain, and at the site of a previous operation.</p> <p>This statement covers surgical treatment of inguinal hernias in adult men, and umbilical or incisional hernias in all adults</p> <p>It EXCLUDES suspected femoral hernias, inguinal hernias in women, and any irreducible hernias.</p>
Commissioning position	<p>Repair of suspected femoral hernias, inguinal hernias in women, or any irreducible hernias is commissioned and should be referred urgently due to the increased risk of incarceration/strangulation</p> <p>Hernia repair for cosmetic reasons or for asymptomatic or minimally symptomatic hernias in adults is NOT routinely commissioned. An approach of watchful waiting is recommended for small painless hernias and supported by the evidence base; delaying repair is considered safe. Conservative management should be encouraged first e.g. to lose weight or try support from surgical appliances or suitable underwear.</p> <p>Surgical treatment should only be offered when one of the following criteria are met:</p> <ul style="list-style-type: none"> • Pain/discomfort interfering significantly with activities of daily living <p>OR</p> <ul style="list-style-type: none"> • The hernia is difficult to reduce <p>OR</p> <ul style="list-style-type: none"> • Comorbidity which does not make the patient unfit for surgery at present but is like to significantly increase the risks associated with future surgery <p>AND</p> <p>Where patients are willing to undergo surgery and are aware of the risks and benefits of surgery. To meet professional standard expectations¹⁴ and ensure patients are fully informed about options for treatment it is recommended that the RightCare inguinal-hernia shared decision-making aid⁴ is discussed with patients prior to surgery.</p> <p>For referral please use the referral form</p> <p>Treatment in all other circumstances is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request Panel. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes</p>

	<p>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.</p> <ul style="list-style-type: none"> • Patient information leaflets – general NHS hernia advice; inguinal hernias inguinal hernias; NHS inguinal hernia repair inguinal hernia repair • RightCare shared decision-making aid RightCare inguinal-hernia
<p>Summary of evidence / rationale</p>	<p>Watchful waiting (WW) is regarded as an acceptable option for men with minimally symptomatic or asymptomatic inguinal hernias by the <i>European Hernia Society guidelines on the treatment of inguinal hernia in adult patients</i>¹ (Level 1B evidence) and by a number of RCTs, concluding that it is an acceptable option for men with minimally symptomatic inguinal hernias². Delaying surgical repair until symptoms increase is safe because acute hernia incarcerations occur rarely. More recently, the European Hernia Society has developed World Guidelines for Hernia Management which also supports this approach³.</p> <p>The RightCare shared decision-making aid for surgical repair of inguinal hernia⁴ states that</p> <ol style="list-style-type: none"> 1. Most people with inguinal hernia are free of symptoms by two weeks after surgical repair. But about 30% continue to feel pain and discomfort at the site of the repair. 2. The main short-term possible complications of surgical repair are bruising, swelling and numbness, difficulty passing urine and infection of the wound. Just over 22% of people get complications after surgery. 3. The main long-term possible health problems are: chronic pain that may last for several years, and recurrence of the hernia. 4. Quality of life after surgical repair depends on whether or not symptoms persist. People left with chronic pain and discomfort report a lower quality of life than those who are symptom-free. 5. Both types of surgery for inguinal hernia can be done as day surgery without needing to stay overnight in hospital. People who have complications may need to stay longer. It can take between three and four weeks to recover completely. 6. People usually need about seven days off work and 14 days before they can return to strenuous leisure activities. About 7% of people can't return to work and 17% can't go back to strenuous leisure activities after 30 days either because of pain or problems with the wound. <p>NICE CKS guidance⁵ (last revised in February 2010) states that, although European guidelines on the treatment of inguinal hernia in adults recommend that repair is not necessary for men with asymptomatic and reducible inguinal hernias, they recommend referral for repair where the hernia extends into the scrotum and the person is medically fit on the basis that:</p> <ul style="list-style-type: none"> ○ The risk of strangulation for all inguinal hernias is estimated to be 0.3–3.0% per year ○ If an inguinal hernia extends into the scrotum, it is almost always indirect. The risk of strangulation is thought to be 10 times higher for indirect hernias than for direct inguinal hernias

- An emergency operation to treat a strangulated inguinal hernia has a higher mortality (higher than 5%) compared with an elective operation for a non-strangulated inguinal hernia (lower than 0.5%)
- Repair is recommended in a narrative review for people with asymptomatic inguinal hernia if they are medically fit

The Royal College of Surgeons 2013 - High Value Care Pathway for groin hernia⁶ (which includes a useful flow chart) states that GPs should refer:

- all patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity **AND** do not want to have surgical repair (after appropriate information provided)^{7, 8}
- irreducible and partially reducible inguinal hernias, and all hernias in women as **'urgent referrals'**^{9, 10}
- patients with suspected strangulated or obstructed inguinal hernia as **'emergency referrals'**^{9, 10}
- all children <18 years with inguinal hernia to a paediatric surgical provider

Analysis of 336 patients randomised to watchful waiting in the American College of Surgeons Watchful Waiting Hernia Trial found readily identifiable patient characteristics can predict those patients with minimally symptomatic inguinal hernia who are likely to "fail" watchful waiting hernia management¹¹. These included pain with strenuous activities, chronic constipation and prostatism. Higher levels of activity reduced the risk of this combined outcome but there is no mention of BMI, although appropriate weight reduction is likely to help. Consideration of these factors will allow surgeons to tailor hernia management optimally.

Another study found that with follow up over 10 years, a total of 68% of men had had elective surgery, more commonly men older than 65 years, with pain¹². They conclude that, although WW is a reasonable and safe strategy, symptoms are likely to progress and an operation will be needed eventually.

More recently a study concluded that a commissioning policy restricting funding for elective hernia repairs (but notably across all types) had led to a significant increase in emergency hernia repairs¹³. They carried out a retrospective cohort study on around 2550 patients who underwent repair of inguinal, umbilical, incisional, femoral or ventral hernias over a 3 year period.

The number of elective hernia repairs reduced from 857 over 12 months before the funding restrictions to 606 in the same period afterwards ($p < 0.001$). Over the same time period, however, a significant rise in total emergency hernia repairs was demonstrated, increasing from 98 to 150 ($p < 0.001$). 30-day readmission rates also increased from 5.1 % before the policy introduction to 8.5 % afterwards ($p = 0.006$). They concluded that the funding restrictions introduced in 2011 were followed by a statistically significant and unintended increase in emergency hernia repairs in their trust, with associated increased risks to patient safety.

A "watchful waiting" approach is also supported by other CCGs, including the

	<p>Leeds CCGs. Their clinical guidelines commissioning position is that hernia repair is not routinely commissioned for:</p> <p>Men with an asymptomatic or a minimally symptomatic inguinal hernia (discomfort or pain that does not restrict daily activity - adopt watchful waiting)</p> <p>Men with groin pain and an ultrasound detected, but clinically impalpable, hernia (consider musculo-skeletal referral)</p> <p>Post-operative follow up for low risk cases (eg no evidence of clinically significant haematoma, injury to the bowel or major blood vessels, deep infection, ischaemic orchitis, recurrence) is not required.</p>
Date effective from	April 2017
Date published	April 2017
Review date	April 2019
Author	Dr Alison Forrester, Healthcare public health advisor, VOYCCG
Approved by	Clinical Research and Effectiveness Committee 07.03.17 / Clinical Executive 27.04.17
Responsible officer	Shaun O'Connell GP Lead valeofyork.contactus@nhs.net

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<http://www.europernherniasociety.eu/fileadmin/downloads/Rotterdam/HerniaSurgeGuidelinesPART1TREATMENT.pdf>
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<http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/697/CN-00962697/frame.html>
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14. GMC Good Medical Practice 2013, para 49a

Rhinoplasty Commissioning Statement

Statement number: 38

Treatment	Rhinoplasty / Septorhinoplasty
For the treatment of	Nasal deformities
Background	Rhinoplasty/septoplasty for nasal deformities is a surgical procedure performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image
Commissioning position	<p>All cases require prior approval. Consideration will not be given to cosmetic rhinoplasty.</p> <p>Rhinoplasty may be considered medically necessary only in limited circumstances and where the clinical rationale fits with the evidence base as follows:</p> <ol style="list-style-type: none"> 1. When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate; 2. Upon individual case review, to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect, when all of the following criteria are met: <ul style="list-style-type: none"> • Airway obstruction which will not respond to septoplasty and turbinectomy alone AND • Nasal airway obstruction is causing significant symptoms (e.g. chronic rhinosinusitis, difficulty breathing) AND • Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy AND • Photos demonstrate an external nasal deformity AND • There is an average 50% or greater obstruction of nostrils (e.g. 50% obstruction of both nostrils; or 75% one nostril and 25% of other; or 100% obstruction of one nostril), documented by endoscopy, CT scan or other appropriate imaging modality <p>There are, however, exclusions that need to be addressed such as:</p> <ul style="list-style-type: none"> • Unstable mental health • Unrealistic patient expectations • Previous rhinoplasty within the last 9-12 months (applies only to major rhinoplasties) • Poor perioperative risk profile • History of too many previous rhinoplasties, resulting in an atrophic skin–soft tissue envelope and significant scarring • Nasal cocaine users
Summary of evidence / rationale	<p>Rhinoplasty is an operation whereby the shape of the nose is changed by modifying the underlying bone and / or cartilage of the nose. In addition to altering the external appearance of the nose, the cartilage inside the nose can be straightened to improve the nasal airways. This procedure is called a septorhinoplasty.</p> <p>Guidance on commissioning is provided by the Modernisation Agency Document</p>

	'Information for Commissioners of Plastic Surgery Services', which was prepared by the British Association of Plastic and Reconstructive Surgery.
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Author	Dr Alison Forrester, Healthcare public health advisor, CYC and NYCC
Responsible officer	Dr Shaun O'Connell, GP Lead ValeofYork.contactus@nhs.net

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Gamete harvesting and storage (Cryopreservation) Commissioning Policy

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	<p>To date, Scarborough and Ryedale and Vale of York CCGs have not had a formal policy on gamete harvesting and preservation for patients undergoing medical treatments that may leave them infertile.</p> <p>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 CCGs have a comprehensive fertility policy available on their website which covers the commissioning of cryopreservation for routine infertility treatment.</p> <p>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.</p>
Commissioning position	<p>NHS Scarborough & Ryedale and Vale of York CCGs agree 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.</p> <p>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.</p> <p>Approval for harvesting and cryopreservation does not guarantee future funding of assisted conception or fertility treatment – in this instance the specific CCG policy for assisted conception should be applied.</p> <p>Prior to fertility preservation, the secondary care clinician at the organisation providing the fertility service must confirm:</p> <ul style="list-style-type: none"> • That the planned treatment is likely to affect future fertility (and document this for the commissioners’ 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 <p>Cryopreservation in males</p> <p>In general, it is recommended that at least two semen samples are collected over a period of one week. The CCGs will commission a maximum of three samples of semen; this is considered sufficient to</p>

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

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 CCGs.

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.

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.

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

	<p>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.</p>
<p>Summary of evidence / rationale</p>	<p>Following notification of a recent legal challenge¹ 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.</p> <p>The challenge relates to the commissioning and provision of gamete retrieval and storage services for transgender patients. The EHRC argues that:</p> <ul style="list-style-type: none"> • <i>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;</i> • <i>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;</i> • <i>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.</i> <p>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.</p> <p>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.</p>
<p>Date effective from</p>	<p>January 2019</p>
<p>Date published</p>	<p>January 2019</p>
<p>Review date</p>	<p>2021</p>

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

References:

- ¹NHE 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

Version	Created /actioned by	Nature of Amendment	Approved by	Date
V1	GP Clinical Lead	Draft of initial statement	n/a	n/a
FINAL	GP Clinical Lead and Senior Service Improvement Manager	Final statement for approval	SRCCG Business Committee (via email) VoYCCG Executive Committee	Dec 18 Jan 19

Invitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)
Commissioning Statement
Statement number: 28

<p>Treatment</p>	<p>Invitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)</p>
<p>Background</p>	<p>In December 2014 the CCG agreed to implement a policy of immediate access to one cycle of IVF for couples who met the agreed criteria.</p> <p>Following a review of its Access to Infertility Treatment Policy, in July 2020, the CCG updated the policy to reflect the recent review of the Yorkshire and Humber Fertility Policy. The changes to the NHS Vale of York CCG policy makes:</p> <ul style="list-style-type: none"> • One funded cycle of IVF available where the female is aged 40-43 (to 43rd birthday) • One funded cycle of IVF available where the female is aged 18 – 23yrs. <p>Subject to meeting existing eligibility criteria.</p>
<p>Commissioning position</p>	<p>The Executive Committee agreed to implement a policy of immediate access to one cycle of IVF for couples who meet the following criteria:</p> <ul style="list-style-type: none"> • Female age: 18 – 43rd birthday (at the time of treatment) • Female BMI: 19 to 29 female for six months prior to a referral • Smoking status: Non-smoking couple for six months prior to a referral • Existing children: To not have living or adopted children • Relationship: To be in a stable relationship for at least two years (including same sex couples) and currently cohabiting <p>Other criteria:</p> <ul style="list-style-type: none"> • For heterosexual couples: to have had regular unprotected intercourse (attempts to conceive) for at least two years prior to referral within the same stable relationship, in the absence of any known reproductive pathology • For same-sex couples and where a medical condition exists (such as physical disability, an infection requiring sperm washing, or a psychosexual disorder prevents natural conception), IUI for up to 6 cycles may be funded, followed by further assisted conception if required • Couples who have previously self-funded treatment are eligible for one NHS funded cycle as long as they have not received more than two self-funded cycles

Frequently Asked Questions

A copy of a list of Frequently Asked Questions can be found [here](#).

For Frequently Asked Questions specifically for same sex couples [click here](#).

Careful consideration will be given to previously eligible couples currently seeking IVF services. To ensure this process is fair and as effective as possible, the CCG is working closely with local Assisted Conception Units to develop a pathway into services.

Access Criteria

- Female age – years at the time of treatment
The age of women at the time of treatment must be less than 43rd birthday and over 18 years

- Female BMI 19 to 29 for 6 months prior to a referral
Body Mass Index within the range 19 to 29 kg/m² (this means that a BMI of 29.1 is outside the criteria). GPs should advise patients regarding weight loss support if they meet all other criteria. Assisted conception treatments will only be provided when BMI is within the range stipulated and has been maintained within 19 to 29 kg/m² for the previous 6 months.
- Partners: both must be:-
 - Non-smokers for 6 months prior to a referral
 - Both partners must be non-smokers for 6 months prior to a referral. Non-smoking status for both partners will be tested with a carbon monoxide breath test prior to commencement of any treatment. GPs should refer any smokers who meet all other criteria, to a smoking cessation programme to support their efforts in stopping smoking. Previous smokers must be non smoking for 6 months prior to being put forward for assisted conception treatment and register below 5 on the Carbon Monoxide test.
 - Existing children
 - Neither partner should have any living children from either current or any previous relationships. The adoption of children confers the legal status of parent to the adoptive parents; this will apply to both adoptions in and out of the family. If any fertility treatment results in a live birth (and the child is still alive), then the couple will

	<p>not be eligible for further fertility treatments, including the implantation of any stored frozen embryos.</p> <ul style="list-style-type: none"> ○ Stable 2 year relationship <ul style="list-style-type: none"> ▪ To be in a stable relationship for at least two years (including same sex couples) and currently cohabiting. ○ Having regular unprotected intercourse for the 2 years prior to referral within the same stable relationship <ul style="list-style-type: none"> ▪ Couples must have been having regular unprotected intercourse for a 2 year period, reported to and documented by GP. Attempts to conceive should be based upon using recognised ovulation indicators at the appropriate time in the cycle. Couples who conceive naturally and who subsequently miscarry up to twice within 2 years will be investigated for recurrent miscarriages. These women will not automatically received assisted conception treatment unless clinically appropriate as they are able to conceive naturally. ○ Previous treatment history <ul style="list-style-type: none"> ▪ Any previous NHS funded IVF treatment will be an exclusion criterion. Couples who have previously self-funded treatment are eligible for 1 NHS funded cycle as long as they have not received more than 2 self-funded cycles.
Summary evidence rationale	of / The CCG Access to Infertility Treatment Commissioning Policy reflects the latest guidelines from the National Institute for Clinical Excellence (https://www.nice.org.uk/guidance/cg156).
Date effective from	July 2020
Date published	October 2020
Review date	July 2022
Author	Dr Emma Broughton Clinical Lead Women’s & Children NHS Vale of York Clinical Commissioning Group, Sarah Kocinski Commissioning & Transformation Manager, NHS Vale of York Clinical Commissioning Group
Approved by	CCG Executive Committee, July 2020
Responsible officer	Dr Shaun O’Connell GP Lead valeofyork.contactus@nhs.net

43. Labiaplasty /vaginoplasty Commissioning Statement

Treatment	Labiaplasty /vaginoplasty
Background	<p>This commissioning policy is needed as cosmetic procedures are not routinely commissioned.</p> <p>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</p> <p>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 Health².</p> <p>Patients who have undergone female genital mutilation should be referred to a specialist female genital mutilation clinic via NHS England.</p>
Commissioning position	<p>The CCG will ONLY routinely commission reconstructive labiaplasty/vaginoplasty:</p> <ul style="list-style-type: none"> • 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 <p>NHS Vale of York 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 England³.</p> <p>Requests for labiaplasty will be considered, via a request to the IFR Panel, for the following indication:</p> <ul style="list-style-type: none"> • Where the labia are directly contributing to recurrent disease or infection <p>Requests for vaginoplasty will be considered, via a request to the IFR Panel, for the following indication:</p> <ul style="list-style-type: none"> • Congenital absence or significant developmental/endocrine abnormalities of the vaginal canal, <p>The clinician needs to submit an application to the CCG's Individual Funding Request Panel (IFR)</p>

Summary of evidence /rationale	<p>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^{4,5}. 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 surgery⁴.</p> <p>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 commissioned⁶. In one large multicentre study, the author noted that although over 90% of patients were satisfied with the results of their surgery in the short-term, sexual dysfunction before surgery and enhancement after surgery is highly subjective and difficult to quantify⁷.</p> <p>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.</p>
Date effective from	March 2017
Date published	March 2017
Review date	March 2019
Author	Dr Emma Broughton, GP Lead for Women’s Health VOYCCG
Approved by	Clinical Research & Effectiveness Committee 07.03.17 / VOYCCG Clinical Executive 16.03.17
Responsible officer	Shaun O’Connell, GP Lead valeofyork.contactus@nhs.net

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2. Female genital mutilation: multi-agency practice guidelines. Dept of Health, February 2011 <https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practice-guidelines>
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Vale of York
Clinical Commissioning Group

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Dupuytren's Contracture Commissioning Policy

Intervention	Surgical Treatment for Dupuytren's Contracture
For the treatment of:	Dupuytren's contracture
Background	<p>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 required¹.</p> <p>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 others¹. 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</p>
Commissioning position	<p>Treatment is not indicated where there is no contracture or it is mild (less than 20°) or not progressing and does not impair function¹</p> <p>NHS Scarborough & Ryedale and Vale of York CCG's will commission surgical treatment for Dupuytren's Contracture only in the following circumstances.</p> <p>An intervention (collagenase injections; needle fasciotomy; fasciectomy and dermatofasciectomy) should only be considered (and IFR approval is not required), when the patient meets at least one of the following functional difficulties.</p> <ul style="list-style-type: none"> • 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 <p>OR</p> <ul style="list-style-type: none"> • thumb contractures which interfere with function <p>AND</p> <ul style="list-style-type: none"> • There is a current material impairment of hand function <p>AND</p> <ul style="list-style-type: none"> • Surgery is likely to restore function <p>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.</p>

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	<p>NICE concluded that collagenase treatment (Xiapex) should only be used for²:</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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.
<p>Summary of evidence / rationale</p>	<p>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 fingers³. 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.</p> <p>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.</p> <p>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.</p> <p>Recurrence following treatment is more likely in younger patients if the original contracture was severe or if there is a strong family history</p>

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	<p>of the condition.</p> <p>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 fasciotomy³ 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.</p> <p>Recent developments have been towards outpatient procedures, percutaneous needle fasciotomy (PNF) and collagenase injection (CCH) (more experimental, but supported by NICE TA459²). NICE guidance for PNF only exists as an IPG from 2004⁴. 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.</p> <p>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 treatment⁵. 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.</p> <p>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 years⁶.</p> <p>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.</p>
OPCS codes	T521, T522, T525, T526, T528, T529, T541, T549, T561 T562 ICD code: M720
Date effective from	22 nd February 2020
Review date	2022

Dupuytren's Contracture Commissioning Policy

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Version	Created /actioned by	Nature of Amendment	Approved by	Date
FINAL	Senior Service Improvement Manager	Approval of threshold	NY Joint Business Executive VoY Executive Committee	Jan 20 Dec 19

16. Exogen Ultrasound Bone Healing Commissioning Statement

Treatment	Exogen® Ultrasound Bone Healing
Background	<p>From April 2013, NHS England took over responsibility for commissioning activity in primary care, where initial conservative treatment takes place. NHS Vale of York CCG is responsible for commissioning activity in secondary care.</p> <p>The Exogen® ultrasound bone healing system delivers ultrasound waves with the aim of stimulating bone healing. Long bone fractures with non-union (most commonly tibia) are suitable for treatment if the fracture is stable and well aligned. Tibial fractures also appear to have the best healing rates and outcomes. Exogen® is not indicated for use in fractures of the skull or vertebrae or in children or adolescents because of their skeletal immaturity.</p>
Commissioning position	<p>This commissioning policy is needed to provide a commissioning position for the use of Exogen.</p> <p>The use of the Exogen® system to treat long bone fractures with delayed union or any other indications is NOT commissioned.</p> <p>NHS Vale of York Clinical Commissioning Group will fund the use of the Exogen® system to treat long bone fractures with non-union, in accordance with defined clinical criteria as follows:</p> <ul style="list-style-type: none"> • Patient age > 18 years • Non-union of fracture > 9 months • Not to be used in cases of unstable surgical fixation, not well aligned or where inter-fragment gap is > 10mm • Not to be used in cases with infection • Not to be used in pregnancy, patients with pacemakers or vertebral/skull fractures • Only when lifestyle factors addressed** <p>**Note: patients with lifestyle factors which are known to delay fracture healing rates e.g. smoking and excess alcohol intake (i.e. men and women should not drink more than <u>14 units</u> of alcohol each week¹), will be appropriately counselled and required to eliminate these risks before determining non-union status and ultimately eligibility for Exogen®. Where appropriate, referrals to specific support services should be arranged e.g. smoking cessation service.</p> <p>NHS Vale of York Clinical Commissioning Group will NOT fund the use of the Exogen® system to treat long bone fractures with delayed union or any other indications for use of Exogen®.</p> <p>These criteria will be reviewed on publication of new evidence in the form of relevant trial data, updated national guidance, or national or local audit outcomes.</p>

	<p>Any identified new indications for use of the Exogen® system requiring additional funding will only be considered in exceptional circumstances through the Individual Funding Request Panel.</p>
<p>Summary of evidence / rationale</p>	<p>The Exogen® device consists of a main operating unit with a permanently connected transducer and a separate fixture strap. The strap is placed around the fractured bone and the transducer is secured directly over the fracture site. The transducer generates an acoustic wave pattern specific to Exogen®. If the patient's limb is immobilised in a cast then a hole is cut to allow access to the skin. It is thought that healing is promoted by stimulating the production of growth factors and proteins that increase the removal of old bone, increase the production of new bone and increase the rate at which fibrous matrix at a fracture site is converted to mineralised bone².</p> <p>The device is programmed to deliver ultrasound in 20-minute sessions and these are self-administered by the patient each day, generally over several months. It is intended to be used in the patient's home. The only type of device shown to be cost-effective in treating non-union (one can deliver more than 6 months' treatment) is the Exogen 4000+, cost around £2500 (price 2013; excludes VAT)².</p> <p>NICE published guidance for Exogen® in January 2013². This states that the technique is cost-saving over traditional surgery when used for treatment of long bone fractures with non-union.</p> <p>The NICE MTG states that:</p> <ul style="list-style-type: none"> • The case for adopting the Exogen® system to treat long bone fractures with non-union (failure to heal after 9 months) is supported by the clinical evidence, which shows high rates of fracture healing. • About one third of non-union tibial fractures might be suitable for treatment with Exogen and thereby avoid surgery • The Exogen® 4000+ system to treat long bone fractures with non-union is associated with an estimated cost saving of £1164 per patient compared with current management, through avoiding surgery. (Note: this level of cost-saving has not been established locally) • There is some radiological evidence of improved healing when the Exogen® system is used for long bone fractures with delayed healing (no evidence of healing after about 3 months). There are substantial uncertainties, however, about the rate at which bone healing progresses without adjunctive treatment between 3 and 9 months after fracture, and about whether or not surgery would still be necessary. These uncertainties result in a range of cost consequences, some cost-saving and others that are more costly than current management. <p>It should be noted that all the evidence associated with Exogen® when used for long-bone fracture with non-union is from observational studies with limited outcomes but with good clinical results, with healing rates ranging from 75% to 100% (depending on the long bone involved and duration of non-healing) over a period of 4.6 to 7.3 months. This is the reason for support from NICE.</p> <p>Comparative evidence with surgery is limited. Healing rates from surgical intervention as identified in case series/cohort studies range from 62 to 100% over a period of 9 to 24 weeks.</p>

	<p>The evidence for use of Exogen® when used for long bone fracture and delayed healing is more limited and the outcomes varied. Uncertainties about the rate at which healing progresses after fracture, both with and without Exogen®, and about whether surgery would still be required, are outlined in the MTG as mentioned above. This therefore raises many uncertainties about the cost savings. . Some of the delayed healing studies include a significant number of patients (50%) considered to be non-union, with no sub-group analysis.</p> <p>Adverse events associated with use of Exogen® appear to be minimal. None of the clinical studies reported device-related events and no safety concerns were identified by the external assessment centre in relation to Exogen®.</p> <p>Reports on surgical treatment of non-union and delayed healing fractures documented adverse events including postoperative wound infection, osteomyelitis and pain.</p>
Date effective from	November 2016
Date published	November 2016
Review date	November 2018
Author	Dr Alison Forrester, Healthcare Public Health Advisor CYC & NYCC
Approved by	Clinical Research & Effectiveness Committee 22.11.16
Responsible officer	Dr Shaun O'Connell, GP Lead valeofyork.contactus@nhs.net

Reference:

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<https://www.nice.org.uk/guidance/mtg12>

Bunions and Hallux Valgus Commissioning Policy

<p>Intervention</p> <p>OPCS codes</p>	<p>Bunion Surgery</p> <p>W79 Soft tissue operations on joint of toe W791 Soft tissue correction of hallux valgus W792 Excision of bunion NEC W793 Syndactylisation of lesser toes W798 Other specified soft tissue operations on joint of toe W799 Unspecified soft tissue operations on joint of toe</p> <p>W15 Division of bone of foot W151 Osteotomy of neck of first metatarsal bone W152 Osteotomy of base of first metatarsal bone W153 Osteotomy of first metatarsal bone NEC W154 Osteotomy of head of metatarsal bone W155 Osteotomy of midfoot tarsal bone W156 Cuneiform osteotomy of proximal phalanx with resection of head of first metatarsal W157 Osteotomy of bone of foot and fixation HFQ W158 Other specified division of bone of foot W159 Unspecified division of bone of foot</p> <p>W59 Fusion of joint of toe W591 Fusion of first metatarsophalangeal joint and replacement of lesser metatarsophalangeal joint W592 Fusion of first metatarsophalangeal joint and excision of lesser metatarsophalangeal joint W593 Fusion of first metatarsophalangeal joint NEC W594 Fusion of interphalangeal joint of great toe W595 Fusion of interphalangeal joint of toe NEC W596 Revision of fusion of joint of toe W598 Other specified fusion of joint of toe W599 Unspecified fusion of joint of toe</p>
<p>For the treatment of:</p>	<p>Hallux valgus (bunion) surgery for the treatment of a deformity of the joint connecting the big toe to the foot</p>
<p>Commissioning position</p>	<p>NHS Scarborough & Ryedale and Vale of York CCGs do not routinely commission surgery for asymptomatic hallux valgus (bunion), regardless of cosmetic appearance. Concerns about cosmetic appearance should not be referred to secondary care. These procedures will not be funded.</p> <p>All patients should be referred to local podiatry services prior to referral to secondary care. (This does not affect the existing diabetic foot pathway) URGENT referral to Podiatry required if patient has a skin ulcer not healing.</p> <p>Requests for the removal of symptomatic bunions will ONLY be considered where:</p> <ul style="list-style-type: none"> • Appropriate conservative measures have been trialled for 3 months and have failed⁽²⁾ (these include trying accommodative footwear, considering orthoses as advised by podiatry and using appropriate analgesia). OR • In the view of the podiatrist, three months of conservative treatment is futile <p>AND the patient suffers from either</p> <ul style="list-style-type: none"> • Pain on walking (not relieved by appropriate analgesia) that causes significant functional impairment OR • Deformity (with or without lesser toe deformity) that causes significant functional impairment or prevents them from finding adequate footwear OR

Bunions and Hallux Valgus Commissioning Policy

	<ul style="list-style-type: none"> • Recurrent or chronic ulceration or infection <p>The clinician needs to ensure that the patient fulfils all the criteria before they are referred to secondary care.</p> <p>Before referral patients must be informed that</p> <ul style="list-style-type: none"> • 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⁽²⁾ <p>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.</p>
<p>Patient Information Leaflets</p>	<p>NHS Bunion patient advice</p> <p>Patient information leaflet</p>
<p>Summary of evidence / rationale</p>	<p>NICE CKS makes clear that referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes⁽¹⁾</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Untreated Hallux valgus in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even amputation⁽²⁾</p>
<p>Date effective from</p>	<p>September 2018</p>
<p>Date published</p>	<p>September 2018</p>

Bunions and Hallux Valgus Commissioning Policy

Review date	2020
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Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinician and Commissioning & Transformation Manager	Re-drafting of STP and SR/VoY policies No changes to previous commissioning positions highlighted. No consultation required.	n/a	27.04.18
2.0	Senior Service Improvement Manager	Share of new draft internally	Lead Clinicians – VoY and SR CCGs	May 18
3.0	Senior Service Improvement Manager	Minor changes following feedback from Clinical Director	Lead Clinician – VoY	June 18
FINAL	Senior Service Improvement Manager	Approval of threshold	SRCCG Business Committee VoY Clinical Executive	04.07.18 04.07.18

24. Hip and Knee Replacement Commissioning Statement

Treatment	Hip and knee replacement for hip & knee arthritis - referral to secondary care
Background	<p>This commissioning policy is needed in order to clarify the criteria for referral to secondary care for hip and knee replacement.</p> <p>The Prevention and Better Health strategy¹ has been developed to demonstrate how focusing our efforts on prevention, self-care and shared decision making can support a shift in the way health care resources are valued, and to empower patients in the Vale of York to become more active participants in shaping their health outcomes</p>
Commissioning position	<p>Funding will ONLY be considered where criteria are met (see section 3). The clinician needs to ensure that the patient fulfils all the criteria and provides evidence of any of the clinical indications before they are referred to secondary care.</p>

All other cases need to be referred for consideration by the Individual Funding request panel (IFR). For further information see [IFR policies and guidance](#) (including the referral form)

In line with NICE CG177 Care and Management in Osteoarthritis³, patients should be offered advice on the following core treatments. (All conservative options should have been tried for at least 3 months.)

1. Non pharmacological management

- Agree individualised self-management strategies. Ensure that positive behavioural changes, such as paced activity / exercise, weight loss, use of suitable footwear and, are appropriately targeted
- Activity and exercise should be encouraged, irrespective of age, comorbidity, pain severity or disability. Exercise should include local muscle strengthening **and** general aerobic fitness.
- All patients must have taken part in regular tier 2 exercise, with support as available from any appropriate service eg local authority exercise trainers, NHS services where available or private gyms and personal coaches
- All patients must have undertaken a programme of physiotherapy, including manipulation and stretching as an adjunct to core treatments.
- Interventions to achieve weight loss must be offered if the person is overweight or obese (see NICE CG 43⁴).
- People with osteoarthritis who have biomechanical joint pain or instability should be considered for assessment for bracing/joint supports/insoles. Assistive devices (e.g. walking sticks) should be considered for people who have specific problems with activities of daily living. Referral to occupational therapy or podiatry may be appropriate
- TENS should be considered as option for pain relief
- DO NOT offer glucosamine or chondroitin products, or acupuncture, for the management of osteoarthritis

2. Pharmacological management

Arthritic pain is chronic nociceptive pain and drug management is covered in the [RSS pathway guidance](#) for pain relief.

This includes:

- Oral analgesia (eg regular paracetamol, cocodamol)
- Topical NSAIDs
- Oral NSAIDs eg ibuprofen 400mg tds or naproxen 500mg bd, with PPI cover.

At least three different types should be tried. Diclofenac and Cox2 inhibitors are not recommended because of the increased cardiovascular risk

- Intra-articular corticosteroid injections can be considered as an adjunct to core treatments, if appropriate, for the relief of moderate to severe pain in people with osteoarthritis³

3. Before any referral for surgery, patients also have to meet the following criteria:

- Experiencing moderate-to-severe persistent pain not adequately relieved by an extended course of non-surgical management. Pain is at a level at which it interferes with activities of daily living e.g. washing, dressing, lifestyle and sleep

AND

- Troubled by clinically significant functional limitation resulting in diminished quality of life AND
- Patients with a BMI range that is >30 but <35 meet the criteria covered by the Optimising Outcomes from All Elective Surgery commissioning statement² AND
- The patient has been a non-smoker for at least 8 weeks

AND

- Evidence that regular paced tier 2 activity/exercise has been undertaken, with physiotherapy support if appropriate

AND

- A simple x-ray to confirm diagnosis has been carried out

AND

- Evidence that PROMS data have been explained and discussed (see link <http://www.valeofyorkccg.nhs.uk/rss/index.php?id=proms>)
- Evidence that the patient has had their options discussed via a shared decision-making tool

Patient Information

Further information for patients can be found the following website <http://www.valeofyorkccg.nhs.uk/rss/index.php?id=prevention>

4. Referring Clinician

Therefore the referring clinician must:

- Ensure patients are signposted to the most appropriate support required for their lifestyle changes
- Ensure that patients are advised to seek review by their GP or other appropriate health care professional should their condition change during the period for lifestyle changes
- Ensure patients who continue to smoke and are not able to reduce their BMI must be allowed to access clinically appropriate elective care after specified periods of time.
- Ensure patients who receive interventions contrary to this policy statement may still be able to access support post procedure to improve their lifestyles to minimise any disadvantage to their health.
- Vulnerable patients / patients with mental illness, learning

	<p>disabilities or cognitive impairment will need to be clinically assessed to ensure that where they may be able to benefit from opportunities to improve lifestyle that 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.)</p> <p>5. The MSK service must refer all requests via the RSS and demonstrate that</p> <ul style="list-style-type: none"> • Patients with clinically urgent need do not experience avoidable delay • The recommended hierarchy of management within NICE CG177 Care and Management in Osteoarthritis⁴ has been followed: non-pharmacological treatments first, then drugs, for at least 3 months • Adherence to the Optimising Outcomes from All Elective Surgery commissioning statement² for those patients within a BMI range that is >30 but <35 • Confirmation that patients have been made aware of the options available as an alternative to surgery and the risks associated with surgery, and have considered the PROMs data and used shared decision-making tools during the patient care pathway • Patients' fitness for surgery has been properly assessed and this is evidenced AND • Ensure that patients with significant co-morbidities [systemic or local] have appropriate investigations and treatment to optimise their condition before referral
<p>Summary of evidence / rationale</p>	<p>Around 450 patients per 100,000 population will present to primary care with hip pain each year. Of these, 25% will improve within three months and 35% at twelve months; this improvement is sustained⁵.</p> <p>20% of adults over 50 and 40% over 80 years report disability from knee pain secondary to osteoarthritis⁶. 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.</p> <p>Osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures, as outlined by NICE³. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years⁵.</p> <p>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</p>

	<p>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 knee osteoarthritis⁶.</p> <p>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, IHD, HT and sleep apnoea. Some years ago, an Arthritis Research Campaign Report⁷ stated that joint surgery is less successful in obese patients because</p> <ol style="list-style-type: none"> 1. Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (eg longer operations, excess blood loss requiring transfusions, DVT, wound complications including infection). 2. The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (eg they are less likely to regain normal functioning or reduction in pain and stiffness) 3. The implant is likely to fail more quickly, requiring further surgery (eg within 7 years, obese patients are more than 10 times as likely to have an implant failure); 4. 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) <p>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 life⁸.</p> <p>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.</p>
Date effective from	November 2018
Date published	November 2018
Review date	November 2020
Author	Dr Alison Forrester, Healthcare Public Health Advisor VOYCCG Andrew Bucklee, Head of Commissioning & Delivery, VoYCCG
Approved by	

Responsible Officer	Dr Shaun O'Connell, GP Lead Valeofyork.contactus@nhs.net
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29. Knee Arthroscopy Commissioning Statement

Treatment	Knee arthroscopy for diagnostic or therapeutic reasons
Background	<p>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.</p> <p>Recent analysis of the RightCare Commissioning for Value Focus Pack for Vale of York CCG shows that the CCG appears to have a much higher rate of elective knee arthroscopy than demographically similar CCGs.</p> <p>One of the main measures of knee arthroscopy* is the third commonest procedure carried out on the CCG population under elective MSK, after knee and hip joint replacement. The CCG is identified as an outlier, with over 60% more procedures than age and sex matched populations in similar CCGs, involving around £5M expenditure. The reasons for this are being explored (see RightCare data)</p> <p>With such a common procedure, it is all the more 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.</p> <p>The most recent Royal College of Surgeons commissioning guide states that knee arthroscopy, lavage and debridement should NOT be offered to patients with non-mechanical symptoms of pain and stiffness¹. This approach is supported by many CCGs in England, including ones local to Vale of York, which do not support the routine funding of diagnostic knee arthroscopy.</p> <p>* (W822 Endoscopic resection of semilunar cartilage - not elsewhere classified)</p>
Commissioning position	<p>NHS Vale of York CCG does NOT routinely commission referral to secondary care for knee arthroscopy.</p> <p>In particular, both diagnostic and therapeutic arthroscopy are NOT routinely commissioned:</p> <ul style="list-style-type: none"> • for diagnostic purposes for investigation of knee pain • to provide washout treatment (lavage) or debridement as a treatment for knee pain or arthritis (in line with NICE guidance, this should not be offered as part of a treatment for osteoarthritis unless the person has a clear documented history of mechanical locking)^{2, 3}

	<ul style="list-style-type: none"> • for symptoms of ‘giving way’ or X-ray evidence of loose bodies without true locking <p>NB If clinical assessment suggests the patient might have a red flag condition (e.g.trauma, infection, carcinoma, bony fracture, avascular necrosis, or constant progressive non-mechanical pain, particularly at night), refer without delay OR if there has been knee trauma causing fracture or ligament avulsion and arthroscopy is needed urgently.</p> <p>The CCG will ONLY commission therapeutic knee arthroscopy in adults where:</p> <ul style="list-style-type: none"> • the patient has clear mechanical features of true locking, or symptoms that worsen with conservative treatment, <p>AND</p> <ul style="list-style-type: none"> • conservative treatment has been tried over a 3 month period (This needs to include exercise, weight loss where appropriate, physiotherapy and maximal analgesic medication) <p>OR</p> <ul style="list-style-type: none"> • for patients with chronic knee pain, up to 6 months of comprehensive conservative treatment should be tried, including <ul style="list-style-type: none"> ○ efforts to lose weight if BMI over 25, (as outlined in NICE guidance³), ○ lifestyle advice, including exercise or rest ○ optimum pharmacological treatments ○ self or physiotherapy guided mobilisation and strengthening exercises. <p>NB: Referral for MRI scans should only be made by secondary care consultants or specialists working in CCG commissioned MSK services.</p> <p>Investigation of knee pain with locking within the MSK service (tier 2) should start with less invasive MRI scanning to identify meniscal tears and loose bodies, in line with RSS guidance Radiology for knee pain with locking. The only exception is when there are contraindications to MRI (eg a pacemaker) or diagnostic uncertainty following a MRI scan OR if the patient has an anterior cruciate ligament reconstruction with metal screws affecting the MRI image quality.</p> <p>Treatment in all other circumstances is not normally funded and should not be referred unless there is prior approval by the Individual Funding Request Panel.</p> <p>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 (IFR request)</p> <p>Providers will not be reimbursed for procedures on patients that do not have IFR approval.</p>
<p>Summary of evidence / rationale</p>	<p>For patients with non-traumatic knee injury, evidence shows that, on average, conservative treatment is as effective as arthroscopic knee surgery for some</p>

procedures. As long ago as 2002, a controlled trial addressing knee arthroscopy, using placebo or “sham” surgery as a comparator, showed no benefit⁴.

Partial meniscectomy surgery showed no advantage over sham in one RCT of patients aged 35-65 years with degenerative meniscal tears without osteoarthritis⁵ 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 treatments⁸. In an RCT of patients with patellarfemoral pain syndrome (18-40 years), mixed arthroscopic procedures and exercise resulted in equivalent improvements compared with exercise alone⁹.

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 death¹⁴. 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 osteoarthritis¹⁴.”

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 non-surgical measures as outlined by NICE¹.”

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^{16, 17}. 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, 18}.

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 tear¹⁹. 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 symptoms²⁰.

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^{17, 21}. 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”.

Rationale for up to 12 months of conservative treatment in chronic knee pain

This policy therefore specifies that conservative treatment should primarily be used but, when this fails, referral for surgery is an option. In the trial of meniscal surgery compared with conservative treatment in patients without osteoarthritis, at earlier time points, outcomes favoured surgery, but by 12 months of conservative treatment, outcomes were equivalent⁵. Therefore, to allow sufficient time for benefits of conservative treatment to be gained, and to allow for any potential natural healing of joint derangements, a minimum 12 months restriction has been selected for which conservative treatment should be attempted before any referral.

In this trial, cross-over from the conservative group to surgery over 12 months was low (7%). However, in other trials cross-over has been higher (around 30%)^{5,6} suggesting that some patients will require more urgent surgery. There may be some cases where symptoms re-occur on conservative management and these patients may benefit from surgery¹⁵. Therefore, this policy allows for patients with mechanical locking or worsening symptoms to be referred before the 12 month period of conservative management.

Restricted procedures

For some interventions, the evidence identifies a lack of effect or there is insufficient evidence to warrant their use. There is currently no NICE guidance on the use of many procedures but, for the procedures that have been assessed, those not recommended by NICE will not be funded without IFR

	<p>approval.</p> <p>There is evidence (including from a Cochrane systematic review) that lavage does not improve patient outcome compared to sham^{2, 3, 24-26} and NICE does not recommend lavage². NICE recommends knee meniscus replacement with biodegradable scaffold only with special arrangements for clinical governance, consent and audit or research²⁷. NICE currently recommends that mosaicplasty should not be used without special arrangements for consent and audit or research²⁸.</p> <p>NICE does not currently recommend autologous chondrocyte implantation for the treatment of articular cartilage defects of the knee joint except in the context of on-going or new clinical studies²⁹. NICE recommends that arthroscopic trochleoplasty for patellar instability should only be used with special arrangements for clinical governance, consent and audit or research³⁰. There is some evidence that debridement is ineffective^{3, 24, 25}, but NICE recommends that debridement may be appropriate in cases where there is mechanical locking³.</p> <p>Restricted use of MRI</p> <p>MRI is a good diagnostic tool²², but may be inaccurate when used by less experienced staff²³ and its use is, therefore, restricted to secondary care or specialists working in CCG commissioned MSK services for this indication.</p> <p><i>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</i></p> <p>Shared decision-making</p> <p>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 making³². 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 progression³³. 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 overdiagnosis of meniscal tears and subsequent overtreatment.</p> <p>"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."</p> <p>Deciding what to do about osteoarthritis of the knee; SDM guide - OA knee</p> <p>Patient information leaflets available Arthroscopy Knee cartilage injuries</p>
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Approved by	NHS VOYCCG Clinical Executive 09/02/2017
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Cataract Commissioning Policy

Treatment	Cataract Surgery
Background	<p>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:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>First Eye</p> <p>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.</p> <p>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.</p> <p>Referral of patients with cataracts to Ophthalmologists should be based on the following indications:</p> <ul style="list-style-type: none"> • 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). <p>AND</p> <ul style="list-style-type: none"> • There has been a discussion on the risks and benefits of cataract surgery. <p>AND</p>

	<ul style="list-style-type: none"> • The patient has understood what a cataract surgical procedure involves and wishes to have surgery. <p>Second Eye</p> <p>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.</p> <p>Exclusions</p> <p>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:</p> <ul style="list-style-type: none"> • 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; <p>Exceptionality</p> <p>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.</p>
<p>Summary of evidence / rationale</p>	<p>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.</p> <p>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 benefit⁷. Cataract surgery does not always result in an improvement in visual acuity or patient satisfaction with visual function⁸.</p>

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 them⁶.

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 location²."

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 VAs⁵.

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 essential⁶.

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Responsible officer	

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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

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 <u> </u> / <u> </u> / <u> </u> Address Telephone NHS Number GP Name and Surgery	Practice Stamp
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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:
RE										Date:
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:

Endoscopic Thoracic Sympathectomy for Hyperhidrosis Commissioning Policy

Intervention	Endoscopic Thoracic Sympathectomy
OPCS codes	R61*
For the treatment of:	Primary hyperhidrosis of the upper limb
Background	Endoscopic thoracic Sympathectomy (ETS) is a surgical procedure in which a portion of the sympathetic nerve trunk in the thoracic region is destroyed. ETS is used to treat focal hyperhidrosis, facial blushing, Raynaud’s disease and reflex sympathetic dystrophy. By far the most common complaint treated with ETS is palmar hyperhidrosis, colloquially known as ‘sweaty palms’. The intervention is controversial and illegal in some jurisdictions. Like any surgical procedure, it has risks; the endoscopic sympathetic block (ESB) procedure and those procedures that affect fewer nerves have lower risks.
Commissioning position	<p>NHS Scarborough & Ryedale and Vale of York CCGs do not routinely commission Endoscopic Thoracic Sympathectomy.</p> <p>Applications will only be considered by the individual Funding Request Panel (IFR) where exceptional clinical circumstances are demonstrated. All cases require prior approval.</p> <p>In view of the risk of side effects, this procedure should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been refractory to other treatments. (These may include topical agents, oral medication, botulinum toxin injections and iontophoresis.)</p> <p>Endoscopic Thoracic Sympathectomy does not work as well for those with excessive axillary (armpit) sweating.</p>
Summary of evidence / rationale	<p>Recent NICE guidance (IPG 487 May 2014) indicates that the evidence base for the efficacy and safety of this procedure is “adequate” but there is a risk of serious complications (including death from major intrathoracic bleeding); it is not always effective; and it can cause hyperhidrosis (“compensatory”) elsewhere on the body (in around 80% of cases, of whom 33% reported symptoms that were “severe” or “incapacitating”).</p> <p>The primary indication is palmar hyperhidrosis because it is less effective for axillary symptoms. It should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been refractory to other treatments.</p> <p>Further research is required to establish good patient selection and to identify which patient characteristics might predict severe side-effects.</p>
Date effective from	26 th March 2018
Date published	March 2018
Review date	March 2020

References

1. NICE Clinical Knowledge Summary – Hyperhidrosis
2. NICE IPG 487 (May 2014) Endoscopic Thoracic Sympathectomy for primary hyperhidrosis of the upper limb: guidance

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinician and Senior Service Imp Manager	Re-drafting of STP and SR/VoY policies. No changes to previous commissioning	n/a	01.02.18
2.0	Senior Service Improvement Manager	Share of new draft internally	Lead Clinicians – VoY and SR CCGs	01.02.18
FINAL	Senior Service Improvement Manager	Approval of threshold	SRCCG Business Committee VoY Clinical Executive	07.03.18 21.03.18

10. Circumcision for Adults and Children

Treatment	Circumcision for adults and children for medical conditions
Background	<p>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.</p> <p>This commissioning policy is needed because male circumcision (defined as the surgical removal of all or part of the foreskin of the penis) may be done for certain medical reasons.</p> <p>NB Female circumcision has no medical benefits and is illegal under the Female Genital Mutilation Act (2003)</p>
Commissioning position	<p>NHS Vale of York CCG does NOT routinely commission male circumcision for cultural or religious reasons; the procedure will only be considered where medically necessary.</p> <p>NHS Vale of York CCG routinely commission circumcision IF there is evidence of one of the following clinical indications:</p> <ul style="list-style-type: none"> • Lichen sclerosus (chronic inflammation leading to a rigid fibrous foreskin) in males aged 9 years and over • Potentially malignant lesions of the prepuce or those causing diagnostic uncertainty • Congenital abnormalities with functional impairment • Distal scarring of the preputial orifice (a short course of topical corticosteroids might help with mild scarring) • Painful erections secondary to a tight foreskin • Recurrent bouts of infection (balanitis/balanoposthitis) • Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepuce ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin) • Traumatic injury eg zipper damage • Congenital urological abnormalities when skin is required for grafting <p>Otherwise, funding will ONLY be considered where criteria are met. In children ensure physiological phimosis has been excluded and consider a trial of topical steroids for up to 3 months.</p> <p>The clinician needs to submit an application to the CCG's Individual Funding Request Panel (IFR), using the referral form to provide evidence of any of the following clinical indications :</p> <ul style="list-style-type: none"> • Interference with normal sexual activity in adult males • Dermatological disorders unresponsive to treatment <p>Patient information leaflet Circumcision</p>
Summary of evidence / rationale	<p>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</p>

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.

In children up to and including 18 years of age, pathological phimosis (non-retraction) must be distinguished from physiological adherence of the foreskin to the glans, which is normal¹. Non-retractile ballooning of the foreskin and spraying of urine do not routinely need to be referred for circumcision although not all ballooning is related to physiological phimosis and spraying can be due to lichen sclerosus¹.

Parents and patients should be made aware of the risks and benefits of circumcision. Referrals from primary care for physiological phimosis account for a significant clinical workload in consultation time that could be avoided¹. Conservative management of the non-retractile foreskin is under-recognised and practised in some regions. This is of particular importance in the paediatric population where too many circumcisions are undertaken for physiological phimosis thereby incurring avoidable morbidity¹.

When physiological phimosis is diagnosed in a primary care assessment of foreskin condition, consultation should focus on reassurance and education of parents and child. If there is concern that any pathology is evident, or if there is diagnostic uncertainty, referral to a regional centre undertaking paediatric surgery is indicated¹.

Discrepancy between regional UK circumcision rates suggest a significant number of circumcisions are being unnecessarily performed and commissioning guidance is intended to provide the necessary information to identify and introduce conformity in the frequency of procedures undertaken though better understanding, and differentiation between disease and physiological change in the foreskin¹.

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 has stated 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 inappropriate².

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 cyst³. 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)⁴. 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 effective from	November 2016
Date published	November 2016
Review date	November 2018
Author	Catherine Lightfoot, Clinical Triage Lead, Yorkshire and Humber CSU and Dr Alison Forrester, Healthcare Public Health Advisor CYC and NYCC
Approved by	Clinical Research & Effectiveness Committee 22.11.16
Responsible Officer	Shaun O'Connell, GP Lead Valeofyork.contactus@nhs.net

References:

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<http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions>
2. 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>
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4. Siegfried N, Muller M, Deeks J, Volmink J. Male circumcision for prevention of heterosexual acquisition of HIV in men. Cochrane Database of Systematic Reviews 2009, Issue 2.
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003362/pdf_fs.html
5. NHS Choices – Information on Circumcision and medical reasons why it may be necessary.
<http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx>

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

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	<p>To date, Scarborough and Ryedale and Vale of York CCGs have not had a formal policy on gamete harvesting and preservation for patients undergoing medical treatments that may leave them infertile.</p> <p>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 CCGs have a comprehensive fertility policy available on their website which covers the commissioning of cryopreservation for routine infertility treatment.</p> <p>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.</p>
Commissioning position	<p>NHS Scarborough & Ryedale and Vale of York CCGs agree 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.</p> <p>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.</p> <p>Approval for harvesting and cryopreservation does not guarantee future funding of assisted conception or fertility treatment – in this instance the specific CCG policy for assisted conception should be applied.</p> <p>Prior to fertility preservation, the secondary care clinician at the organisation providing the fertility service must confirm:</p> <ul style="list-style-type: none"> • That the planned treatment is likely to affect future fertility (and document this for the commissioners’ 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 <p>Cryopreservation in males</p> <p>In general, it is recommended that at least two semen samples are collected over a period of one week. The CCGs will commission a maximum of three samples of semen; this is considered sufficient to</p>

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

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 CCGs.

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.

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.

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

	<p>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.</p>
<p>Summary of evidence / rationale</p>	<p>Following notification of a recent legal challenge¹ 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.</p> <p>The challenge relates to the commissioning and provision of gamete retrieval and storage services for transgender patients. The EHRC argues that:</p> <ul style="list-style-type: none"> • <i>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;</i> • <i>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;</i> • <i>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.</i> <p>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.</p> <p>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.</p>
<p>Date effective from</p>	<p>January 2019</p>
<p>Date published</p>	<p>January 2019</p>
<p>Review date</p>	<p>2021</p>

Gamete harvesting and storage (Cryopreservation) Commissioning Policy

References:

- ¹NHE 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

Version	Created /actioned by	Nature of Amendment	Approved by	Date
V1	GP Clinical Lead	Draft of initial statement	n/a	n/a
FINAL	GP Clinical Lead and Senior Service Improvement Manager	Final statement for approval	SRCCG Business Committee (via email) VoYCCG Executive Committee	Dec 18 Jan 19

Vasectomy Commissioning Policy

Intervention	Vasectomy under General (GA) anaesthetic
For the treatment of:	Male Fertility
Exclusions to policy	Not applicable
Background	Vasectomy is a surgical procedure for male sterilisation or permanent contraception. During the procedure, the male vas deferens are severed and then tied or sealed in a manner so as to prevent sperm from entering into the seminal stream (ejaculate) and thereby prevent fertilisation.
Commissioning position	<p>Vasectomy under General Anaesthetic (GA) NHS Scarborough & Ryedale and Vale of York CCGs do commission vasectomies under General Anaesthetic in secondary care only in the following circumstances:</p> <ul style="list-style-type: none"> • Previous documented adverse reaction to LA • Scarring or deformity from previous scrotal surgery or trauma that makes vasectomy under LA difficult to achieve • History of coagulation disorder, inguinal scrotal hernia or cryptorchidism • Large varicocele or hydrocele • Where patients have previously had vasectomy on the NHS, have subsequently had a reversal of vasectomy (privately or on the NHS) and again wish to undergo vasectomy <p>Fear of the procedure, or patient choice are not adequate reasons for requesting vasectomy under GA, unless supporting mitigating factors are submitted to the IFR panel by the requesting clinician.</p> <p>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</p>
Summary of evidence / rationale	<p>It is recommended 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.</p> <p>Men should be counselled about the permanency of the procedure and variable success rates for reversal. Additional counselling is recommended for men under 30 years¹. Advice should also be provided to men about the possibility of chronic testicular or scrotal pain after vasectomy.</p> <p>Most vasectomies are carried out under local anaesthetic. This means only the scrotum and testicles will be numbed and the patient will be awake for the procedure. The procedure should not be painful but may feel slightly uncomfortable. Most men will only need a local anaesthetic.</p> <p>The RCOG guidelines⁴ recommend a general anaesthetic is used where:</p> <ul style="list-style-type: none"> • There is a history of allergy to local anaesthetic

Vasectomy Commissioning Policy

	<ul style="list-style-type: none"> • Surgery has been carried out before on the scrotum or genital area <p>The RCOG guidelines also recommend:</p> <ul style="list-style-type: none"> • A 'no-scalpel' approach, as there are lower levels of complications such as bleeding, pain and infection; • The use of fascial interposition or diathermy; • That clips are not used, due to high failure rates; • That local anaesthesia is used wherever possible; • Effective contraception be used before the operation and until follow-up tests show that the vasectomy has been successful; • Practitioners must be trained to the level of the FSRHC requirement⁵
OPCS codes	N17 Excision of vas deferens N171 Bilateral vasectomy N172 Ligation of vas deferens NEC N178 Other specified excision of vas deferens N179 Unspecified excision of vas deferens
Date effective from	August 2019
Review date	2021

References:

1. RCOG Faculty of Sexual & Reproduction Health Care. UK Medical Eligibility Criteria for Contraceptive Use. 2009. (section on male surgical sterilisation pp101-104)
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<https://www.aspc-uk.net/wp-content/uploads/2014/03/VasectomyLogbook.pdf>
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<http://www.fpa.org.uk/sites/default/files/male-and-female-sterilisation-your-guide.pdf>

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinicians and Senior Service Imp Manager	Re-drafting of STP and SR/VoY policies	n/a	Mar 19
2.0	Senior Service Improvement Manager	Share of new draft internally and circulation for consultation	Lead Clinicians – VoY and SR CCGs	Mar 19
2.1 – 2.5	Senior Service Improvement Manager	Update of statement following comments from consultation	Lead Clinicians – VoY and SR CCGs	
3.0	Senior Service Improvement Manager	Approval by CCG Committees	SRCCG Business Committee VoYCCG Executive Committee	July 19 July 19