Health and care working together
in South Yorkshire and Bassetlaw

South Yorkshire and Bassetlaw - Commissioning for Outcomes Policy

FINAL (v21)

Version Control

Version	Date	Author	Changes
V1.0	01/04/2015	Dr Sarah Lever	
V1.1	19/06/2015	Hilary Porter	Added wording specifically excluding tonsillectomy as part of cancer treatment/management
V1.2	24/08/2015	Rebecca Chadburn	Change of email address
V2	28/07/16	Dr Sarah Lever	Renamed Clinical thresholds policy with 7 additional clinical thresholds added. Changes to process for referral and approval for treatment. Prior approval only required when deemed exceptional
V3		Dr Sarah Lever	Renamed South Yorkshire and Bassetlaw Commissioning for Value policy. Additional clinical thresholds added and commissioning policy made expressly clear for all procedures including, cosmetic, plastic and fertility procedures.
V8	4/9/17	Jack Harding	Formatting
V14			
V15	20/12/17	Jack Harding	Includes updated links to IFR policies and ACS website
V16	13/02/2018	Adele Spence	Includes previous omission regarding BMI for Doncaster breast augmentation
V17	16/02/18	Abigail Tebbs	Includes changes for Sheffield position on Orthopaedic and cataract procedures
V18	07/08/18	Debbie Stovin	Indicates the elements where Sheffield have opted out
V19	16/11/18	Julie Shaw	Includes changes to Cataracts policy and checklist and the Varicose Veins checklist
V20	01/02/19	David Lautman	Updated to incorporate National Evidence Based Interventions Guidance. Local evidence based interventions and specialist plastics policies also reviewed and updated as part of annual review.
V21	01/05/19	David Lautman	To incorporate EBI mobilisation feedback and Governing Body feedback.

This policy is hosted on the South Yorkshire and Bassetlaw Integrated Care System website and can be accessed at: https://www.healthandcaretogethersyb.co.uk/about-us/useful-documents

Contents

1. Executive Summary

Now more than ever, it is important for the NHS to demonstrate that it is making the most effective use of public monies to maximise the health and wellbeing of the people of South Yorkshire and Bassetlaw (SY&B). We need to ensure that our resources are used wisely to maximise the impact of the services we commission to improve health, reduce health inequalities and ensure our population receives appropriate high quality evidence based clinical care.

We seek to ensure that our commissioning decisions are fully informed and based on the best evidence available and provide best value for money. To fulfil these aims, SY&B Commissioners have agreed a regional wide Commissioning for Outcomes (CFO) Policy. The Policy sets out our approach and governance arrangements to ensure that as far as possible, our decisions are robust, rational and justifiable.

2. Introduction

The purpose of this Policy is to establish a system for transparent and coherent prioritisation for the commissioning of health and wellbeing services. It provides a framework for making decisions about relative priorities at a strategic and planning/commissioning level and facilitates rational and reasonable decisions about which services are commissioned in accordance with the SY&B Integrated Care System (ICS).

The Policy applies to all commissioning decisions made by SY&B CCGs and should be applied when healthcare interventions can no longer be prioritised on the basis of clinical evidence, outcomes and value for money.

This policy links with our strategic plan and commissioning intentions available at the ICS Plan.

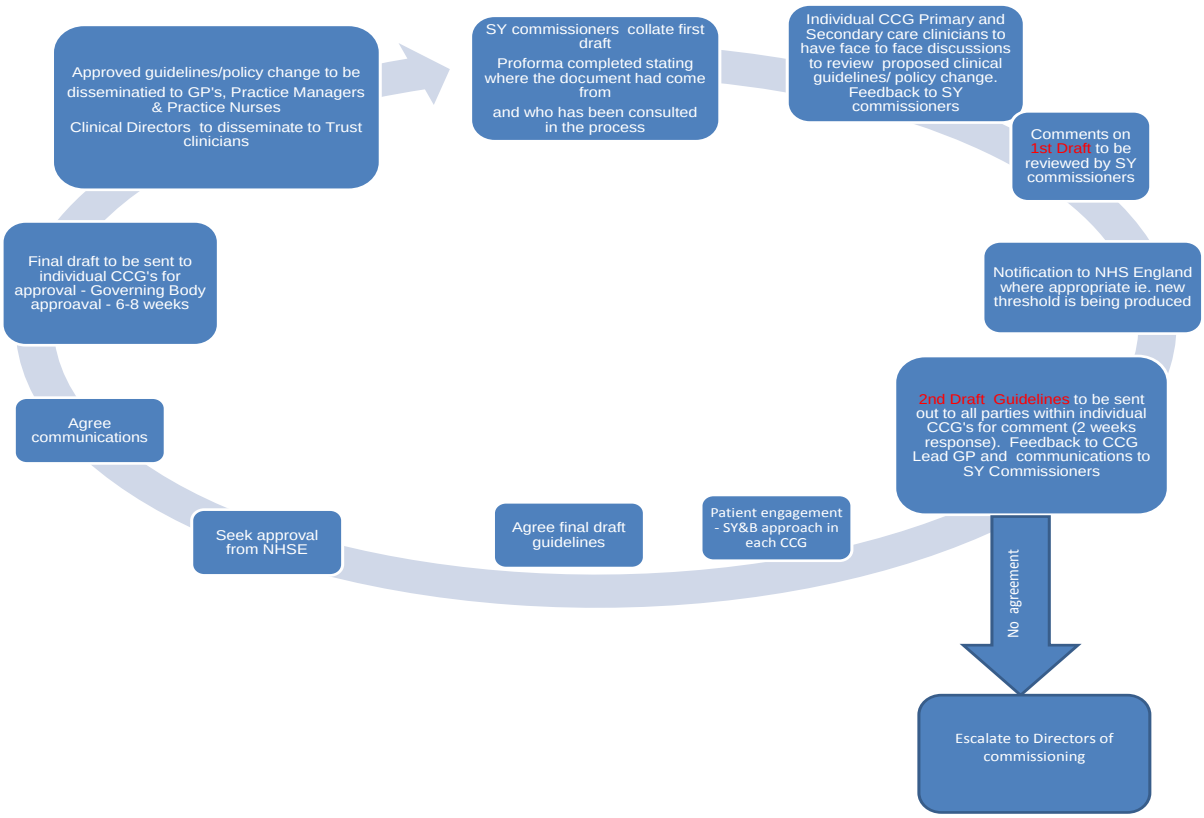
3. Decision Making and Prioritisation Approach

SY&B CCGs are required to make decisions about strategic and operational priorities for annual resource allocation. These may arise from:

- Business cases for investment in services
- Value for money reviews
- Performance monitoring of services or specific treatments where they no longer provide evidenced clinical value, outcomes and best value for money or are a lower priority than services we need to fund within our affordability envelope (including proposal for new Individual Funding Request (IFR) policies)
- Decisions required outside of our planning process on funding outside existing commissioned services and exceptionality for individual cases. This may apply in the following circumstances:
    - A new intervention is made available that is of significant importance
    - A new treatment or service is made available that provides such significant health or financial benefits
    - A proposal is submitted by an external body that provides benefits

SY&B CCGs work together to agree a common approach where decisions are not specific to individual CCGs and their providers. As legal entities, decisions are required by individual CCGs prior to implementation at a SY&B level. Accordingly, the decision making approach within individual CCGs is set out in Figure 1

Figure 1 SY&B process for decision making



4. Priorities for Annual Resource Allocation

SY&B CCGs will prioritise existing resources, reconsider commissioned services that are not considered to be delivering the expected health benefit, and consider any new services or business cases to ensure that we are utilising our resources effectively. Local needs and national benchmarking information, where appropriate, will guide CCGs in this prioritisation of expenditure at a local level between commissioning programmes. The following criteria will be used for consideration:

- Alignment with the SY&B Integrated Care System
- Alignment with the CCGs' strategic objectives or national mandatory priorities
- Benefits and outcomes are identified and evidenced/measurable
- Compliance with any legal and clinical frameworks or guidance and procurement processes
- Response to a need that has been assessed
- Clinical effectiveness, outcomes including assessment by NICE or other evidence-based review
- Impact on health inequalities and protected characteristics
- Will improve patient safety and experience
- Accessibility to service users
- Affordability and value for money

5. Service Developments

SY&B commission services in line with NICE Guidance. There is a contractual requirement for providers to treat in line with NICE guidance.

The CCGs will not introduce new drugs/technologies on an ad hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCGs.

The CCGs expect consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

The CCGs have a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the CCGs or an individual CCG has not previously been asked to fund an intervention that has the potential to affect a number of patients, applications should be made by clinicians for the CCGs/CCG to consider the intervention through its general commissioning policy and not by way of an IFR application.

Interventional Procedure Guidance issued by NICE will be deemed by the CCGs as a Service Development and will not be routinely funded by the CCGs unless agreed in advance.

6. Scope of Document

SY&B Commissioning for Outcomes Policy covers the following:

- National Evidence Based Interventions (Section 8)
  - Category 1 Interventions – Procedures not routinely commissioned
  - Category 2 Interventions – Criteria Led
- Local Evidence Based Interventions (Section 9)
- Not Routinely Commissioned
- Criteria Led
- The SY&B Commissioning Guidelines for Plastic Surgery Procedures which have been incorporated into this document
- The Y&H Fertility Policy which has been incorporated into this document

Age Range: This policy applies to both adults and children unless specified otherwise.

This document sets out:

- The procedures covered by this policy
- The referrals process including the use of the IFR process where prior approval is required or there is a case for exceptionality.
  Note: Procedures which are not routinely commissioned require prior approval through the Individual Funding Request Panel (Section 11).
- The interventions and threshold for treatment
- Monitoring arrangements
- Rules around payment
- Referral checklists
- Patient information sheet

7. Review

This policy will be reviewed on an annual basis.

Date of next Review: March 2020

Part 2
Interventions and Process for Referral

8. National Evidence Based Interventions

8.1 Category 1 Interventions - Procedures not routinely commissioned

Table 1 below lists the Category 1 interventions to which the national Evidence Based Interventions Policy applies. These interventions are not routinely commissioned or performed.

Table 1: Procedures not routinely commissioned

Intervention		Commissioning Position
A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))	Not routinely commissioned. If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).
B	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women	
C	Knee arthroscopy for patients with osteoarthritis	
D	Injection for non-specific low back pain	

8.2 Category 2 Interventions – Criteria Led

Table 2 below lists the Category 2 interventions to which the national Evidence Based Interventions Policy applies and the responsibilities of referring and receiving clinician. These interventions should be only performed when specific criteria are met and are only routinely commissioned in these circumstances.

Please refer to table below for referral process. Note the following interventions require prior approval via the IFR panel:

- Breast Reduction / asymmetry and gynaecomastia
- Tonsillectomy

Table 2: Responsibilities of referring and receiving clinician in the operation of the National Evidence Based Intervention Policy (Category 2 interventions)

Intervention		Referring clinician responsibility	Receiving clinician responsibility
E	Breast reduction / asymmetry and gynaecomastia *	Prior Approval via IFR (Clinical Letter and Questionnaire)	Ensure Prior Approval in place prior to listing patient
F	Removal of Benign Skin Lesions	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
G	Grommets in children	Complete the checklist and attach to referral letter	Complete relevant secondary care section of checklist & check and electronically sign/accept the checklist
H	Tonsillectomy *	Prior Approval via IFR (Clinical Letter and Checklist)	Ensure Prior Approval in place prior to listing patient
I	Haemorrhoid surgery	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
J	Hysterectomy for heavy menstrual bleeding	Checklist from GP not required	Complete and sign checklist
K	Chalazia removal	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist

L	Arthroscopic shoulder decompression for sub-acromial shoulder pain *	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
M	Carpal tunnel release	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
N	Dupuytren's surgery	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
O	Ganglion surgery	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
P	Trigger finger release	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Q	Varicose vein surgery *	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist

**Subject to additional local guidance*

9. Local Evidence Based Interventions

9.1 Local Evidence Based Interventions - Not Routinely Commissioned

These interventions are not routinely commissioned or performed:

- Vasectomy under General Anaesthetic
- Acupuncture (except for those conditions which are NICE approved)

If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (see section 11).

9.2 Local Evidence Based Interventions – Criteria Led

Table 3 below lists the interventions to which local evidence based clinical threshold apply and the responsibilities of the receiving and referring clinician

Please refer to table below for referral process.

Table 3: Responsibilities of accepting and referring clinicians in operation of the clinical thresholds policy

Intervention	Referring clinician responsibility	Receiving clinician responsibility
Grommets for Adults	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Benign Perianal skin tags	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Cholecystectomy	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Hernia Repair	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Blepharoplasty	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Cataract Surgery	Optometrist completes and signs checklist. Checklist from GP not usually required	Complete relevant secondary care section of checklist and check and electronically sign/accept the checklist. (The checklist must be completed for second eye surgery if required). If a Cataract LES or locally commissioned service is in place: Where a patient has been referred outside of the Cataract LES, the receiving clinician must ensure that the patient meets the threshold.
Hallux Valgus	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Hip and Knee replacement[1]	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Ingrown Toe Nail	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Male Circumcision	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist

[1] *Sheffield CCG - Referrals will be made to the MSK service who will apply the criteria (checklist not required)*

10 Making a Referral

Where an evidence based threshold applies, clinicians are required to complete the referral checklist and attach the document to the referral. Referrals without a completed checklist will be returned to the referral source indicating the reason for rejection. The provider will confirm that the electronic checklist is present and that the patient meets the threshold, criteria. The secondary care element of the referral checklist will be completed (where this applies to an intervention) and electronically signed/accepted by the receiving clinician to evidence that the patient meets the criteria. The referral checklist will be included within the patient notes / filed for future compliance audit.

A referral should only proceed to treatment if the patient meets the threshold or specific criteria in the category 2 intervention and a completed and compliant referral checklist is in place.

In some circumstances, GPs, Consultants or NHS clinicians may consider an individual has exceptional clinical circumstances and may benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by the clinician. This request will then be considered, approved or rejected by an independent panel. The referral process is illustrated at **Diagram 1.**

Consultant to Consultant referrals for hysterectomy for heavy menstrual bleeding must comply with the Consultant to Consultant Policy. In these circumstances the receiving Consultant must complete a checklist to indicate whether or not the patient meets the Threshold criteria. Any qualifying evidence must also be documented within the patient's medical records.

Tables 2 and 3 (pages 9 to 11) show the responsibilities of the clinician for each condition.
The criteria for treatment and referral checklists for each procedure are set out in **Part 3** of this document. Where patients do not meet the criteria for referral they should be advised to return to their GP or other appropriate health care professional should their condition change. Likewise where patients are on a pathway for elective care, clinical review should be available where necessary should a patient's condition require earlier intervention.

Get Fit First in Barnsley (For Barnsley CCG patients only)
The Get Fit First Programme is a health and wellbeing initiative introduced by NHS Barnsley Clinical Commissioning Group that encourages patients who are smokers and/or have a Body Mass Index (BMI) of 30 or over to ensure they are in the best possible health before they go for a routine, non-urgent operation. Patients will receive support to stop smoking and/or lose weight.

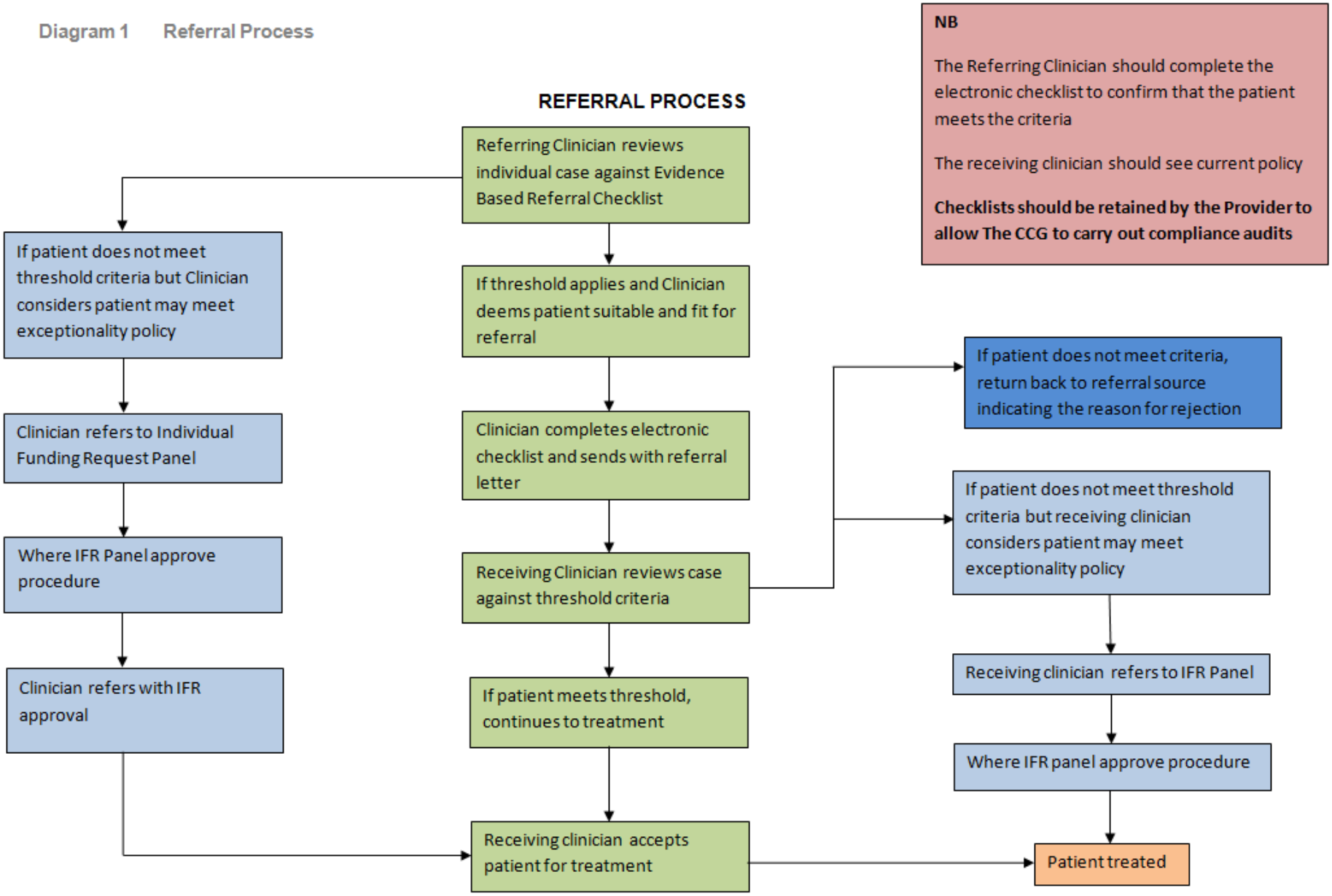
Barnsley CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients (over 18 years old) who are active smokers or whose BMI is 30 or more.

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 6 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 6 months from initial consultation (subject to clinical opinion).

Note: Some interventions in this policy include a specific BMI as part of the criteria for referral; Varicose Vein surgery (BMI 30), Specialist Plastics Policies (BMI 18.5 – 27). The completion of 6 months health improvement does not overrule these specific BMI criteria. For Hip / Knee Replacement the previous BMI requirement (35) is replaced with 'Patient meets GFF criteria'.

For further information about the initiative visit http://www.barnsleyccg.nhs.uk/patient-help/getfitfirst

Diagram 1 Referral Process



11. Individual Funding Requests (IFR)

11.1 Process for IFR Referral

If a clinician feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel.

The criteria for treatment and referral checklists for each intervention are set out in Part 3 of this document.

12. Prior approval for treatment outside of this policy

Tables 2 and 3 (pages 9 to 11) make clear the requirements of the referring and receiving clinician for evidence based interventions. Clinicians will seek prior approval for treatment where patients are to be treated outside of these policies. Where a clinician believes that a patient might benefit from an intervention but where they do not meet the clinical threshold, the clinician may apply to the IFR Panel to make the case for exceptionality. In these circumstances clinicians will be required to evidence the reasons for exceptionality. Where a procedure has a BMI restriction, patients whose high BMI is due to bulk muscle should be referred to the IFR panel as an exception.

13. Exceptionality

The CCG commissions according to the policy criteria. Requests for individual funding can be made only where exceptional circumstances exist and can be made through the NHS Individual Funding Request (IFR) procedure.

Responsibility for demonstrating exceptionality rests with the referring clinician.

A patient may be considered exceptional to the general standard policy if both the following apply:

- He/she is different to the general population of patients who would normally be refused the healthcare intervention, and
- There are good grounds to believe that the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

In assessing exceptionality, the IFR panel will not consider social, demographic or employment circumstances.

Where a patient has already been established on a health care intervention, for example as part of a clinical trial or following payment for additional private care, this will be considered to neither advantage nor disadvantage the patient. However, response to an intervention will not be considered to be an exceptional factor.

The IFR policy for each CCG is shown in **Appendix 7**.

Where prior approval is required it should be sought from the CCG in advance of the treatment being provided.

All requests should be sent to:

Individual Funding Requests
722 Prince of Wales Road,
Sheffield,
S9 4EU

or sent electronically to:

sheccg.sybifr@nhs.net (safehaven) or by safehaven fax to 0114 305 1370 adhering to confidentiality procedures. Only request by letter will be accepted. A clinical letter with a completed checklist (where relevant) should be sent to the IFR panel outlining why the patient does not meet the criteria and evidence supporting their exceptionality.

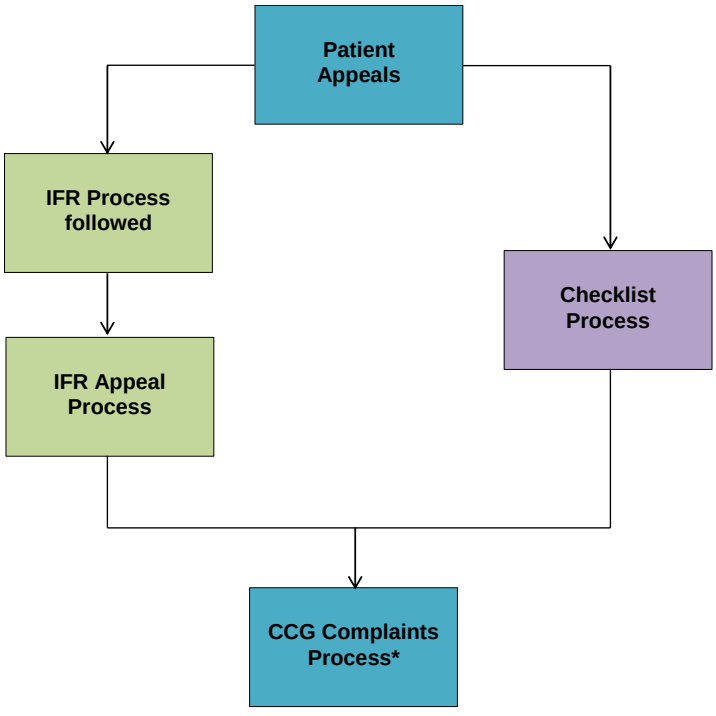
Service Condition 29.26 of the NHS Standard Contract makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat. The IFR team aims to process requests through the panel within 14 days and request further information from the GP where required.

14. Appeals

SY&B CCGs recognise that there may be times when members of the public are dissatisfied with the decisions. We are committed to undertaking engagement and consultation work that, at a minimum meets national expectations of best practice, and believe that doing so will help ensure our decisions are in the interests of the public of SY&B.

Any patient/carer who feels that a decision is not justified may register a complaint or appeal, as per the below process. Ultimately, the CCGs' decisions may be the subject to legal challenge from individuals or groups.

Figure 2- Patient Appeals Process



***Individual CCG complaints processes are detailed at the following Link**

Part 3
Summary of Commissioning Position and Evidence Base

15. List of Treatments and Services where evidence based interventions apply

15. 1 National Evidence Based Interventions - Category 1 Interventions which are not be routinely commissioned or offered

Speciality	Ref	Procedure	Commissioning Position	Evidence Base	Process
ENT	A	Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))	**Not routinely commissioned**	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Exceptionality can be applied for via a clinical letter to the IFR panel.
Gynaecology	B	Dilation and curettage (D&C) for heavy menstrual bleeding (HMB) in women			
Orthopaedics	C	Knee arthroscopy for patients with osteoarthritis			
Orthopaedics	D	Injection for non-specific low back pain			

15.2 **National Evidence Based Interventions - Category 2 Interventions which are only routinely commissioned or performed when specific criteria are met**

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Plastics	E	Breast reduction / asymmetry and Gynaecomastia	See 'Breast Reduction' and 'Gynaecomastia' section of Specialist Plastics Policy Summarised in Appendix 3	SY&B Commissioners have elected to follow the existing local Specialist Plastics Policy for these interventions. Breast Reduction Referrals for breast reduction under the national criteria would require the clinician to accurately assess the weight of breast tissue to be removed [500gms or 4 cup sizes]. Additional clinical input is required hence the recommendation to use IFR. The local policy requires a minimum G cup which has been professionally measured to ensure equity. For cases that are borderline medical photographs are requested. Asymmetrical Breasts For asymmetrical breasts the Evidence Based Interventions guidance states a difference of 150-200g is required whereas the local policy stipulates a difference of two cup sizes with a professional measurement. Gynaecomastia The national Evidence Based Interventions guidance states that surgery to correct gynaecomastia will only be commissioned for men with a history of prostate cancer. SY&B Commissioners have elected to follow the existing local Specialist Plastics policy for gynaecomastia which provides more comprehensive guidance on where this corrective intervention may be funded.	**Prior Approval via IFR (Clinical Letter and Checklist)** The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality.

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Dermatology	F	Removal of Benign Skin Lesions	National Evidence Based Interventions Policy	For Benign Skin Lesions SY&B commissioners have elected to maintain the existing referral checklist (which is in line with the EBI policy) as the national criteria are very broad and unmanageable via checklist in long-form. To ensure the referral process is manageable the checklist groups the criteria where a lesion might be removed. Any patients that do not meet the threshold criteria can be referred to the IFR panel who will assess patients against the EBI guidance. **National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
ENT	G	Grommets in children	**National Evidence Based Interventions policy only applies to glue ear (otitis media with effusion).** **The CCG will routinely fund additional conditions which are detailed in Appendix 2 provided a checklist is completed to evidence a patient meets the criteria.**	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention - refer using checklist. IFR for exceptionality

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
ENT	H	Tonsillectomy	**National Evidence Based Interventions policy only applies to recurrent tonsillitis.** **Additional local guidance provided for conditions broader than recurrent tonsillitis in Appendix 2**	SY&B Commissioners noted that referrals for tonsillectomy for recurrent tonsillitis require additional clinical input to assess against national criteria (number of occurrences of sore throats) hence the recommendation to use IFR. Conditions broader than recurrent tonsillitis include: • Recurrent Quinsy (peri-tonsillar abscess) • Severe halitosis secondary to tonsillar crypt debris • Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils • Obstructive sleep apnoea causing severe daytime and night time symptoms • Biopsy/removal of lesion on tonsil	**Prior Approval via IFR (Clinical Letter and Checklist)** The IFR panel will provide clinical oversight on the management of these policies. Refer through IFR for exceptionality.
General Surgery	I	Haemorrhoid surgery	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Gynaecology	J	Hysterectomy for heavy menstrual bleeding	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Ophthalmology	K	Chalazia removal	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Orthopaedics	L	Arthroscopic shoulder decompression for sub-acromial shoulder pain	**See Appendix 2 for additional local guidance**	Commissioners have elected to follow the existing local policy for Arthroscopic shoulder decompression for sub-acromial shoulder pain. Although the national policy mentions that non-operative management is effective, the existing SY&B policy is clearer on the clinical criteria for conservative treatments.	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	M	Carpal tunnel release	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	N	Dupuytren's surgery	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	O	Ganglion surgery	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality
Orthopaedics	P	Trigger finger release	National Evidence Based Interventions Policy	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	Evidence Based Intervention – refer using checklist. IFR for exceptionality

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base / Local Guidance	Process
Vascular	Q	Varicose vein surgery	National Evidence Based Interventions Policy In addition the SYB Policy requires patients to have a BMI of 30 or less. (The BMI criteria will not apply for Sheffield patients). Note: If a patients BMI remains above 30, completion of Get Fit First 6 month health improvement does not negate this criterion for Barnsley patients.	**National Evidence Based Interventions Policy** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf **National Institute for Health and Care Excellence** (July 2013) Varicose veins: diagnosis and management [CG 168] London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg168/evidence/full-guideline-pdf-191485261 NICE clinical guidance 168 notes that a raised BMI is identified as factor associated with increased risk of progression of varicose veins and notes that the surgical outcome with increased BMI is worse (there is a higher risk of reoccurrence).	Evidence Based Intervention – refer using checklist. IFR for exceptionality Sheffield CCG excluded from the BMI requirement for this procedure.

15. 3 Local Evidence Based Interventions - Not Routinely Commissioned

Intervention	Commissioning Position	Evidence Base	Process
Acupuncture	**Not Routinely Commissioned except for chronic tension type headaches and migraine**	NICE Guideline NG59 https://www.nice.org.uk/guidance/ng59 NICE CKS – Migraine https://cks.nice.org.uk/migraine CG 150 Headaches in over 12s – Diagnosis and Management https://www.nice.org.uk/guidance/cg150/chapter/recommendations	Refer through IFR for exceptionality
Vasectomy under General Anaesthetic	**Not Routinely Commissioned** Needle phobia is no longer an exception for this procedure	**NHS Choices** https://www.nhs.uk/conditions/contraception/vasectomy-male-sterilisation/	Refer to local service in community. Refer through IFR for exceptionality

15. 4 Local Evidenced Based Interventions – Criteria Led

Speciality	Procedure	Criteria / Evidence	Process
ENT	Grommets for Adults	**For Local Evidence Base and Criteria See Appendix 2**	Refer using checklist. IFR for exceptionality.
General Surgery	Benign Perianal Skin Tags		Refer using checklist. IFR for exceptionality.
General Surgery	Cholecystectomy		Refer using checklist. IFR for exceptionality.
General Surgery	Hernia Repair • Inguinal • Femoral • Umbilical • Para-umbilical • Incisional		Refer using checklist. IFR for exceptionality.
Ophthalmology	Blepharoplasty		Refer using checklist. IFR for exceptionality.
Ophthalmology	Cataract Surgery		Refer using checklist. IFR for exceptionality.
Orthopaedics	Hallux Valgus		Refer using checklist. IFR for exceptionality.
Orthopaedics	Hip/Knee Replacement for osteoarthritis		Refer using checklist. IFR for exceptionality. For Sheffield CCG – refer to MSK (without checklist). Sheffield CCG excluded from the BMI requirement for this procedure.
Orthopaedics	Ingrown Toe Nail in secondary care		Refer using checklist. IFR for exceptionality. For Sheffield CCG refer to community podiatry service who will determine if referral to secondary care is required.
Urology	Male Circumcision		Refer using checklist. IFR for exceptionality.

16. Plastics and fertility procedures

16.1 Fertility

Speciality	Procedure	Commissioning Position	Evidence Base	Process
Obstetrics & Gynaecology	Reversal of Female Sterilisation	**Not Routinely Commissioned**	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality
Obstetrics & Gynaecology	In-vitro fertilisation (IVF)/ Assisted conception	IVF is approved in accordance with Policy. Prior Approval if referred via primary care	Y&H fertility policy Link for Rotherham Link for Sheffield Link for Barnsley Link for Doncaster Link for Bassetlaw	Referral through IFR
Urology	Reversal of Male Sterilisation	**Not Routinely Commissioned** Reversal of sterilisation is not routinely commissioned. Informed consent for sterilisation requires that patients have understood the irreversible nature of the procedure. The clinician may still submit an application to sheccg.sybifr@nhs.net (safehaven) if exceptionality can be demonstrated.	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf **Faculty of Sexual and Reproductive Healthcare (FSRH)** Clinical Guidance- Male and Female Sterilisation - Summary of Recommendations Clinical Effectiveness Unit September 2014 **http://www.fsrh.org/pdfs/MaleFemaleSterilisationSummary.pdf**	Refer through IFR for exceptionality

16.2 Specialist Plastic Surgery Procedures

Speciality	Procedure	Commissioning Position	Process
Plastic and Cosmetic surgery	1. Abdominoplasty	**Not Routinely Commissioned** **See Appendix 3 for information on when cases may be considered on an exceptional basis and evidence base.**	Refer through IFR for exceptionality
	2. Breast Surgery 2.1 Breast Augmentation 2.2 Breast Reduction 2.3 Breast Asymmetry 2.4 Breast Reduction for gynaecomastia 2.5 Breast lift mastopexy 2.6 Correction of nipple inversion		
	3.Hair 3.1 Hair removal 3.2 Correction of male pattern baldness 3.3 Hair transplantation		
	4. Acne scarring		
	5. Buttock, thigh and arm lift surgery		
	6. Congenital vascular abnormalities		
	7. Correction of Prominent Ears		
	8. Facelift, browlift & Botulinum toxin		
	9. Labioplasty, Vaginoplasty and Hymen Reconstruction		
	10. Liposuction		
	11. Rhinoplasty		
	12. Rhinophyma		
	13. Surgical scars		
	14. Thread vein/ Telangiectasia		
	15. Tattoo removal		
	16. Surgical Repair of Torn Ear Lobes		

17. Monitoring and payment

Zero payment or Category 1 Interventions without IFRs

These procedures are not routinely commissioned. Only activity that is approved by IFR will be paid for. Any activity that does not meet this threshold will be reimbursed at £0 (zero tariff) to reflect changes to the NHS Standard Contract and National Tariff Payment System from 1 April 2019.

Category 2 Interventions and Local Evidence Based Interventions

These interventions are only commissioned when specific criteria are met. CCGs will audit adherence to Evidence Based Interventions. Where there is no evidence that the patient meets the criteria for treatment, CCGs will not pay for the patient's treatment. Service Condition 29.22 of the NHS Standard Contract makes clear that the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed prior approval schemes.

CCGs will monitor activity and finance levels on a monthly basis through Contract Performance Meetings. A baseline will be established and activity monitored against the procedure and diagnostic codes listed in Appendix 5

Part 4
Appendices

Appendix 1 - Evidence Based Threshold Checklists

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Removal of Benign Skin Lesions

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund management of benign skin lesions when **one or more** of the following criteria are met*:

Where it is safe to do so, every attempt should be made to manage benign skin lesions in primary care/community setting *provided removal would not be purely cosmetic.*	Delete as appropriate	
Diagnostic uncertainty exists and there is suspicion of malignancy ***(please refer as appropriate).***	Yes	No
The lesion is painful or impairs function and warrants removal, but it would be unsafe to do so in primary care/community setting, for example because of large size (>10mm), location (e.g. face or breast) or bleeding risk. ***Removal would not be purely cosmetic.***	Yes	No
Viral warts in immunosuppressed patients.	Yes	No
Patient scores >20 in Dermatology Life Quality Index** ***administered during a consultation with the GP or other healthcare professional.***	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information*

***See* http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html *for information on the use of the Dermatology Life Quality Index.*

This policy does not apply to treatment of benign skin lesions in the perianal area.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets for Otitis Media with Effusion in Children

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Otitis Media with Effusion in children (when the following criteria are met:

In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria when presenting in a Primary Care setting:	**Delete as appropriate**	
Recurrent acute otitis media - 5 or more recorded episodes in the preceding 12 month period.	Yes	No
Suspected hearing loss at home or at school / nursery,	Yes	No
Speech delay, poor educational progress due to the hearing loss, following 3 months of watchful waiting	Yes	No
Abnormal appearance of tympanic membrane	Yes	No
In ordinary circumstances*, procedure should not be considered unless the patient meets one or more of the following criteria when presenting in a Secondary Care	**Delete as appropriate**	
Persistent hearing loss for at least three months (in any setting) with hearing levels of: • 25dBA or worse in both ears on pure tone audiometry or • 25dBA or worse or 35dHL or worse on free field audiometry testing and • Type B or C2 tympanometry	Yes	No
Suspected underlying sensorineural hearing loss	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk.	Yes	No
OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down's Syndrome, cleft palate.	Yes	No
Persistent OME (more than three months) with fluctuating hearing but significant delay in speech, educational attainment or social skills.	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information.*

As the presence of a second disability such as Down's syndrome or cleft palate can predispose children to OME in such children it is left to the clinician's discretion how far this policy will apply.

Tonsillectomy

INFORMATION TO ACCOMPANY AN INDIVIDUAL FUNDING REQUEST (IFR)
FOR TONSILLECTOMY (CHILDREN & ADULTS)

Instructions for Use
Please send this form to the IFR panel.
PLEASE ATTACH A BRIEF REFERRAL LETTER IN SUPPORT OF YOUR REQUEST

Patient Details	
PATIENT NAME	
DATE OF BIRTH	
NHS NUMBER	
ADDRESS	
REFERRING GP	

ADDITIONAL INFORMATION: A six month period of watchful waiting is recommended prior to referral for tonsillectomy in order to establish a pattern of symptoms.

	Delete as appropriate	
Sore throats are due to acute tonsillitis	Yes	No
Episodes of sore throat are disabling and prevent normal functioning as evidence by three of the Centor criteria (tonsillar exudates, tender anterior cervical lymph nodes, history of fever [over 38], and absence of cough).	Yes	No

Please supply ALL dates of disabling episodes of tonsillitis when your patients has been seen AND treated over the past 3 years:

	Delete as appropriate	
Two or more documented episodes of quinsy (peri-tonsillar abscess)	Yes	No
Severe halitosis secondary to tonsillar crypt debris	Yes	No
A child with failure to thrive due to difficulty swallowing secondary to tonsillar hypertrophy	Yes	No

THE COMMISSIONING CRITERIA ARE DETAILED OVERLEAF

GP Signature	
Date	

Criteria for Commissioning Tonsillectomy (Children and Adults)

The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met:

- Recurrent attacks of tonsillitis as defined by:
  - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning

  AND
  - 7 or more well documented, clinically significant*, adequately treated episodes in the preceding year **OR** 5 or more such episodes in each of the preceding 2 years **OR** 3 or more such episodes in each of the preceding 3 years
- Two or more episodes of Quinsy (peri-tonsillar abscess)
- Severe halitosis secondary to tonsillar crypt debris
- Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils
- Obstructive sleep apnoea causing severe daytime and night time symptoms#
- Biopsy/removal of lesion on tonsil#

**A Clinically significant episode is characterised by at least three of the following (Centor criteria):*

- *Tonsillar exudate*
- *Tender anterior cervical lymphadenopathy or lymphadenitis*
- *History of fever (over 38'C)*
- *Absence of cough*

Refer to ENT for opinion and treatment for possible sleep apnoea or biopsy / removal of lesion.

National Supporting Evidence

Scottish Intercollegiate Guidelines Network
Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010
https://www.sign.ac.uk/assets/sign117.pdf

Evidence Based Interventions: Guidance for CCGs
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf

Individual Funding Requests (IFR) should be sent to:

Alison Ball
Head of Individual Funding Requests
722 Prince of Wales Road
Sheffield S9 4EU
Safehaven Fax: 0114 3051370
Safehaven Email: sheccg.sybifr@nhs.net

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund haemorrhoidectomy when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Recurrent third or fourth degree combined external/internal haemorrhoids with persistent pain or bleeding **OR**	Yes	No
Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR**	Yes	No
Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct-current electrotherapy.)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hysterectomy for Management of Heavy Menstrual Bleeding

Instructions for use:
To Secondary Care Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund Hysterectomy when the following criteria are met:
Dilation and Curettage (D&C) is not routinely funded as per Evidence Based Interventions Policy. Patients **WILL NOT** receive a D&C:

- As a diagnostic tool **ALONE** for heavy menstrual bleeding, **or**
- As a therapeutic treatment for heavy menstrual bleeding.

Patients **WILL** receive hysterectomy in the investigation and management of heavy menstrual bleeding only when the following criteria are met respectively for each procedure:

Hysterectomy for HMB will only be funded if ALL the following criteria are met:	**Delete as appropriate**	
A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialled for *at least 6 months* (unless declined or contraindicated) and has not successfully relieved symptoms **AND**	Yes	No
A trial of *at least 3 months each* of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include: • NSAIDs e.g. mefenamic acid • Tranexamic acid • Combined oral contraceptive pill • Oral and injected progestogens **AND**	Yes	No
Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE) have either been ineffective or are not appropriate, or are contraindicated	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Meibomian cyst (Chalazion)

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund management of benign skin lesions when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **two or more** of the following criteria*	**Delete as appropriate**	
Conservative treatment has been tried for at least 3 months **AND**	Yes	No
Interferes with vision **OR**	Yes	No
Interferes with the protection of the eye due to altered lid closure or anatomy **OR**		
Is a source of infection requiring medical attention at least twice within the last six months **OR**	Yes	No
Is a source of infection causing an abscess requiring drainage	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information.*

A meibomian cyst/chalazion that keeps coming back should be biopsied to rule out malignancy. Use the appropriate referral route for suspected malignancy in this case.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Arthroscopic Subacromial Decompression of the Shoulder (ASAD)

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund ASAD as a standalone procedure when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **ALL** of the following criteria.*	**Delete as appropriate**	
Patient has had symptoms for at least 3 months from the start of treatment **AND**	Yes	No
Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND**	Yes	No
Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at least 6 weeks **AND**	Yes	No
Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND**	Yes	No
Referral is at least 8 weeks following steroid injection **AND**	Yes	No
Patient confirms they wish to have surgery	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG Individual Funding Request policy for further information.*

Primary sub-acromial decompression in isolation is not normally funded unless the patient has a massive sub-acromial spur scoring the muscle and may otherwise require a cuff repair.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Carpal Tunnel Syndrome Surgery.

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund Carpal Tunnel Surgery when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	Delete as appropriate	
Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms that significantly interfere with daily activities)**	Yes	No
If there is no improvement in mild-moderate symptoms after 6 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required)	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information.*

**This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Dupuytren's Disease

Instructions for use:

Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund correction of Dupuytren's disease when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one of the following criteria.*	Delete as appropriate	
30 degrees or more fixed flexion at the metacarpophalangeal (MCPJ) joint **OR	Yes	No
30 degrees or more fixed flexion at the proximal interphalangeal (PIPJ) joint **OR	Yes	No
Severe thumb contractures which interfere with function	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.*

*** Inability to flatten fingers or palm on table*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Ganglions

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund correction of Ganglion(s) when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Painful seed ganglia** that persist or recur after puncture/aspiration **OR**	Yes	No
Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) **OR**	Yes	No
Wrist ganglia associated with neurological deficit, restricted hand function or severe pain	Yes	No
If the diagnosis is in doubt	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The Individual funding request policy for further information*

*** A seed ganglia is a fluid filled swelling that appears at the base of the finger on the palm side.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Common Hand Conditions – Trigger Finger

Instructions for use:

Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund Trigger finger correction when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria:*	Delete as appropriate	
Failure to respond to up to two steroid injections** or splinting of the finger for 3-12 weeks (does not apply if the patient has had 2 previous trigger digits unsuccessfully treated with non-operative methods) **AND**	Yes	No
Loss of complete active flexion **OR** Diabetics	Yes	No

*** Where injection of trigger finger is not available in primary care, please refer to MSK for this treatment*

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Varicose Vein Surgery

Instructions for use:

Please refer to policy for full details, complete the checklist and file for future compliance audit.

Treatment of varicose veins in secondary care is considered a low priority treatment and will only be funded by the CCG if the criteria below have been met. Treatment will NOT be funded for cosmetic reasons or in pregnancy.

Patients can be considered for surgery if they meet the following criteria:	Delete as appropriate	
Patient's BMI is 30[#] or less **AND**	Yes	No
Intractable ulceration secondary to venous stasis **OR**	Yes	No
Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity) **OR**	Yes	No
Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral) **OR**	Yes	No
Thrombophlebitis associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living* **OR**	Yes	No
If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply: • Symptoms must be caused by varicosity and cannot be attributed to any other comorbidities or other disease affecting the lower limb. • There must be a documented unsuccessful six month trial of conservative management.** • Evidence that symptoms are affecting activities of daily living and/or Instrumental activities of daily living.	Yes	No

[#] This criteria does not apply to Sheffield CCG patients. For Barnsley Patients – If a patients BMI remains above 30 completion of Get Fit First 6 month health improvement does not negate this criterion.

*Activities of daily living include: functional mobility, eating, bathing and personal care. They can be measured using the Barthel activities of daily living index. Instrumental activities of daily living include more complex tasks such as care of others, community mobility, health management and meal preparation.

** Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss and compression stockings if appropriate.

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to CCG's Individual funding request policy for further information.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Grommets in Adults

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund Grommets for Adults when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets one or more of the following criteria.*	**Delete as appropriate**	
Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **OR**	Yes	No
Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or**	Yes	No
Eustachian tube dysfunction causing pain **OR**	Yes	No
Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **OR**	Yes	No
As a conduit for drug delivery direct to the middle ear **OR**	Yes	No
In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician **or**	Yes	No
Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy	Yes	No

** If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.*

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Treatment of benign perianal skin lesions in secondary care

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund surgical treatment of benign skin lesions when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
There is clinical uncertainty about the benign nature of the skin lesion	Yes	No
Viral warts in immunocompromised patients where underlying malignancy may be masked	Yes	No
Recommended by GU Med when conservative treatment has failed	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Management of Gall bladder disease including **mild and asymptomatic/incidental gallstones

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will **only** provide funding for cholecystectomy in **mild (see policy) or asymptomatic gallstones if **one or more** of the following criteria are met:	**Delete as appropriate**	
*High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer).	Yes	No
Transplant recipient (pre or post-transplant).	Yes	No
Diagnosis of chronic haemolytic syndrome by a secondary care specialist.	Yes	No
Increased risk of complications from gallstones, e.g. presence of stones in the common bile ductstones smaller than 3mm with a patent cystic duct, presence of multiple stones.	Yes	No
Acalculus cholecystitis diagnosed by a secondary care specialist.	Yes	No

** (Annual USS for smaller asymptomatic polyps)*

The CCG will continue to fund cholecystectomy for patients with moderate to severely symptomatic gallstones:

Patient has moderate or severely symptomatic gallstones and agrees to surgery	Yes	No

***** Barnsley and Rotherham CCG patients will only be referred after one episode of mild abdominal pain. The threshold in respect of mild (one episode of mild abdominal pain) does not apply to Doncaster, Bassetlaw and Sheffield CCG***

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgical Repair of Hernias

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit. (This policy only applies to patients aged over 16 years)

PATIENTS WITH DIVARICATION OF THE RECTI SHOULD NOT BE REFERRED FOR SURGICAL OPINION

The CCG will only fund ***inguinal*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Symptomatic hernias i.e. those which limit work or activities of daily living **OR**	Yes	No
Hernias that are difficult or impossible to reduce **OR**	Yes	No
Inguino-scrotal hernias **OR**	Yes	No
An increase in the size of the hernia month on month (please use your clinical discretion when referring/surgical repair of these patients)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.*

Please note that for asymptomatic or minimally symptomatic inguinal hernias, the CCG advocates a watchful waiting approach (informed consent regarding the potential risks of developing hernia complications e.g. incarceration, strangulation, or bowel obstruction). Patients should also be advised regarding weight loss as appropriate.

The CCG will only fund ***umbilical, para umbilical and midline ventral*** hernia surgery when the following criteria are met:

In ordinary circumstances, referral/treatment should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Pain or discomfort interfering with activities of daily living **OR**	Yes	No
An increase in the size of the hernia month on month **OR**	Yes	No
To avoid strangulation and incarceration of bowel where hernia is ≥ 2cm	Yes	No

The CCG will only fund ***Incisional*** hernia surgery when the following criteria are met:

Pain or discomfort interfering with activities of daily living	Yes	No

The CCG will only fund **femoral** hernia surgery when the following criteria is met:

All suspected femoral hernias must be referred to secondary care due to the increased risk of incarceration/ strangulation	Yes	No

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Upper Eyelid Blepharoplasty

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund management of blepharoplasty when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria*	**Delete as appropriate**	
Does the patient complain of symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue?	Yes	No
Did the patient develop symptoms following skin grafting for eyelid reconstruction?	Yes	No
Did the patient develop symptoms following surgery for ptosis?	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information.*

If the above criteria are not met, does the patient meet ALL of the following exceptions:–

Is there documentation that the patient complains of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND**	Yes	No
Is there redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND**	Yes	No
Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	Yes	No

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Cataract Surgery

Instructions for use:

First Eye Surgery: **Please complete Part 1 and 2.**
Second Eye Surgery: Please complete Part 1 and 3.
Where a patient has been referred outside of the Cataract LES or locally commissioned service, the receiving clinician must ensure that the patient meets the Clinical Threshold.

The CCG will only fund Cataract Surgery, when the following criteria are met:

Part 1 - Assessment

VA Scores* VA 6/6 = 0 VA 6/9 = 1 VA 6/12 = 2 VA 6/18 = 7		**SPH**	**CYL**	**AXS**	**VA**	**Dominant Eye**	**Score**	
	R							**VA Score**
	L							

Lifestyle Questions to ask patient*	**Not at all**	**Slightly**	**Moderately**	**Very Much**
Is the patient's quality of life affected by vision difficulties (*e.g. car driving, watching TV, doing hobbies, etc?)*				
Is the patient's social functioning affected by vision difficulties (*e.g. crossing roads, recognising people, recognising coins etc?)*				

*These questions are designed to elicit the information from pts as to the effect on their lifestyle. The clinician will use the responses to weight the scoring below

	Circle Score	**Yes**	**No**
Any difficulties for patient with mobility *(including aspect of travel, e.g. driving, using public transport)*?		2	0
Is the patient affected by glare in sunlight or night (*car headlights)*?		2	0
Is the patient's vision affecting their ability to carry out daily tasks?		2	0

Part 2 - First Eye Cataract Surgery

FIRST EYE TOTAL ASSESSMENT SCORE (*VA AND LIFESTYLE SCORE)*

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for first eye cataract surgery	**Yes**	**No**

Part 3 - Second Eye Cataract Surgery

Complete Part 1 for Second Eye

SECOND EYE TOTAL ASSESSMENT SCORE (VA AND LIFESTYLE SCORE) | |

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR SECOND EYE SURGERY OR THE PATIENT MEETS ONE THE EXCEPTIONS (PLEASE DOCUMENT IN PART 4)***

The patient meets the Clinical Threshold for second eye cataract surgery.	**Yes**	**No**

Part 4 - Exceptions

Exceptions are applicable to first or second eye.

The only exceptions to the referral criteria are as follows:	Delete as appropriate	
Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls.	Yes	No
Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma	Yes	No
Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.	Yes	No
Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	Yes	No
Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)	Yes	No
Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)	Yes	No
Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography	Yes	No
Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)	Yes	No
Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual funding request policy for further information

*Snellen / Logmar Conversion Chart:

Snellen	Logmar
6/6	0.0
6/9	0.10 – 0.20
6/12	0.20 – 0.30
6/18	0.40 – 0.50
6/24	0.50 – 0.70
6/36	0.70 – 0.90
6/60	1.00

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hallux Valgus Surgery

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund hallux valgus surgery when the following criteria are met:

This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus.

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Ulcer development over the site of the bunion or the sole of the foot **OR**	Yes	No
Evidence of severe deformity (over or under riding toes) **OR**	Yes	No
Significant and persistent pain when walking **AND** conservative measures (e.g. bunion pads / insoles / altered footwear) have failed to provider symptomatic relief in sensible shoes **OR**	Yes	No
Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Hip Replacement

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will **only** fund hip replacement for osteoarthritis if the following criteria have been met:	**Delete as appropriate**	
Referral to the Hip Pathway **AND**	Yes	No
Patient has a BMI of less than 35. (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6 months.. If the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process**.) **AND EITHER**	Yes	No
Intense to severe persistent pain (defined in table one and documentation to support is required) which leads to severe functional limitations (defined in table two and documentation to support is required), **OR**	Yes	No
Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures*	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to The CCG's Individual funding request policy for further information.

*Conservative measures = oral NSAIDs, physiotherapy or referral to the Hip Referral Pathway, and paracetamol based analgesics and patient education (e.g. activity / lifestyle modification). Documentation of dates and types of conservative measures required to be included with this form.
** Not applicable to Barnsley patients due to Get Fit First Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects
Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.(Refer through IFR)	Yes	No
Rapid onset of severe hip pain	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Knee replacement

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund knee replacement for osteoarthritis when the following criteria have been met	**Delete as appropriate**	
Referral has been made to the Knee Pathway **AND**	Yes	No
Patient has a BMI of less than 35** (Patients with BMI>35 should be referred to for weight management interventions for a minimum of 6 months. If the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process) **AND**	Yes	No
Osteoarthritis of the knee causes persistent, severe pain as defined in table 1 **AND**	Yes	No
Pain from osteoarthritis of the knee leads to severe loss of functional ability and reduction in quality of life as defined in table 2 **AND**	Yes	No
Symptoms have not adequately responded to 6 months of conservative measures* OR conservative measures are contraindicated. Documentation of dates and types of measures is required.	Yes	No

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further details.

* Conservative measures =, oral NSAIDs, physiotherapy or referral to the Knee Referral Pathway and paracetamol based analgesics, intra-articular corticosteroid injections and patient education (e.g. activity / lifestyle modification). See policy for further details.

** Not applicable to Barnsley patients due to Get Fit First Programme

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects
Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense / Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

Minor	Functional capacity adequate to conduct normal activities and self-care Walking capacity of more than one hour No aids needed
Moderate	Functional capacity adequate to perform only a few of the normal activities and self-care Walking capacity of between half and one hour Aids such as a cane are needed occasionally
Severe	Largely or wholly incapacitated Walking capacity of less than half hour Cannot move around without aids such as a cane, a walker or a wheelchair. Help of a carer is required.

If the above criteria are not met, does the patient meet the following exceptions:–

Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. (Refer through IFR)	Yes	No
Patients whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. (Refer through IFR)	Yes	No

Patients with co-morbidities should be optimised prior to referral for possible surgery

Diabetes	Hypertension	Anaemia	Sleep Apnoea
HbA1c ≤ 70 nmol/ml	**BP ≤ 160/100 Aim for 140/85 non Diabetic Aim for 140/80 Diabetic**	**Hb > 13 in men Hb > 12 in women**	**Referred for Sleep Studies with STOP BANG Score ≥ 5**

Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgery for Ingrown Toenails

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund surgery for ingrown when the following criteria are met:

*In ordinary circumstances**, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Patient is in clinical need of surgical removal of ingoing toe nail has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed.	Yes	No
Patient has infection and/or recurrent inflammation due to ingrown toenail **AND** has high medical risk*.	Yes	No

**Medical risk is determined by the referring clinician - including, but not limited to, vascular disease, neurological disease or diabetes which are categorised as having high medical need due to the risk of neuropathic complications.*

***If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*

Patient Name: Address: Date of Birth: NHS Number Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Male Circumcision

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund male circumcision when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Phimosis (inability to retract the foreskin due to a narrow prepucial ring) or recurrent paraphimosis (inability to pull forward a retracted foreskin)	Yes	No
Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)	Yes	No
Balanoposthitis (recurrent bacterial infection of the prepuce).	Yes	No
Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*

This policy does not apply to:

- Penile malignancy. Use the 2ww cancer referral pathway
- Traumatic foreskin injury where it cannot be salvaged

Appendix 2 - Local Evidence Based Interventions – Criteria and Evidence base

Get Fit First in Barnsley

Note: For Barnsley CCG patients over 18, the Get Fit First policy applies prior to referral. Barnsley CCG does not routinely commission referral to secondary care for routine, non-urgent elective surgery for patients who are active smokers or whose BMI is 30 or more.

- Evidence of smoking abstinence will be required prior to referral for surgery. Patients who stop smoking can be referred after 12 weeks. Patients who do not stop smoking will be referred for surgery after 6 months from initial consultation and advised to abstain from smoking for a minimum of 2 days prior to surgical intervention. This will allow a period of health improvement.
- Patients who do not reduce BMI to ≤30 or make a 10% reduction from their starting weight will be referred for surgery after 6 months from initial consultation (subject to clinical opinion).

For further information about the initiative visit http://www.barnsleyccg.nhs.uk/patient-help/getfitfirst

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base

ENT	G	Grommets in children	The CCG will **only** fund grommet insertion in children (age under 18 for Barnsley/Doncaster/ Bassetlaw/Rotherham or 16 and under for Sheffield) when one or more of the following criteria are met:
			
			• Recurrent otitis media – 5 or more recorded episodes in preceding 12 month period
			• Suspected hearing loss at home or at school / nursery
			• Speech delay, poor educational progress due to hearing loss, following 3 months of watchful waiting
			• Abnormal appearance of tympanic membrane
			• Persistent hearing loss for at least 3 months with hearing levels of:
			  • 25dBA or worse in both ears on pure tone audiometry **OR**
			  • 25dBA or worse or 35dHL or worse on free field audiometry testing **AND**
			  • Type B or C2 tympanometry
			• Suspected underlying sensorineural hearing loss
				Evidence Based Interventions
				https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf
				
				NICE
				Surgical management of otitis media with effusion [CG 60] (February 2008)
				https://www.nice.org.uk/guidance/cg60/documents/cg60-surgical-management-of-ome-full-guideline2

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			• Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk • OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down Syndrome, cleft palate • Persistent OME (more than 3 months) with fluctuating hearing but significant delay in speech, educational attainment or social skills. This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes.	
ENT	H	Tonsillectomy	The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met: • Recurrent attacks of tonsillitis as defined by: - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning **AND** - 7 or more well documented, clinically significant *, adequately treated episodes in the preceding year **OR** - 5 or more such episodes in each of the preceding 2 years **OR** - 3 or more such episodes in each of the preceding 3 years • Two or more episodes of Quinsy (peritonsillar abscess) • Severe halitosis secondary to tonsillar crypt debris • Failure to thrive (child) secondary to difficulty swallowing caused by enlarged tonsils	**Burton MJ, Glasziou PP.** Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD001802. First published online: July 26 1999. Available from: http://www.cochrane.org/reviews/en/ab001802.html (accessed 2019) **Osbourne MS, Clark MPA.** The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. Annals RCS. 2018.May (100) 5: 406-408 **Paradise JL, Bluestone CD, Bachman RZ.** Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			• Obstructive sleep apnoea causing severe daytime and night time symptoms • Biopsy/removal of lesion on tonsil **A Clinically significant episode is characterised by at least three of the following (Centor criteria):* • *Tonsillar exudate* • *Tender anterior cervical lymphadenopathy or lymphadenitis* • *History of fever (over 38'C)* • *Absence of cough*	parallel randomized and non-randomized clinical trials. N England J Med 1984:310(11):674-83 **Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J**. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. Trials. 2015 Jun 6;16:263. https://www.ncbi.nlm.nih.gov/pubmed/26047934 (accessed 2019) **Scottish Intercollegiate Guidelines Network** Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010 https://www.sign.ac.uk/assets/sign117.pdf (accessed 2019)
Orthopaedics	L	Arthroscopic shoulder decompression for sub-acromial shoulder pain	The CCG will **only** fund Arthroscopic shoulder decompression for sub-acromial shoulder pain as a standalone procedure when the following criteria are all met: • Patient has had symptoms for at least 3 months from the start of treatment **AND** • Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat) **AND** • Patient has been compliant with conservative intervention (education, rest, NSAIDs, simple analgesia, appropriate physiotherapy) for at	**British Medical Journal** Subacromial decompression surgery for adults with shoulder pain: a clinical practice guideline BMJ 2019;364:l294 https://doi.org/10.1136/bmj.l294 (accessed 2019) **British Elbow & Shoulder Society (BESS), British Orthopaedic Association (BOA), Royal College of Surgeons for England (RCSEng)** Commissioning Guide: Subacromial Shoulder Pain https://www.boa.ac.uk/wp-

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			least 6 weeks **AND** • Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management **AND** • Referral is at least 8 weeks following steroid injection **AND** • Patient confirms they wish to have surgery	content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf **Evidence Based Interventions** https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf
ENT	Grommets for Adults		**Adults** should meet at least one of the following criteria. • Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **or** • Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or** • Eustachian tube dysfunction causing pain **or** • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **or** • As a conduit for drug delivery direct to the middle ear **or** • In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician. Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media	ENT UK 2009 OME/Adenoid and Grommet **Perera R.** Autoinflation for hearing loss associated with otitis media with effusion.(Cochrane review). In: Cochrane database of systemic reviews, 2006. Issue Chichester: Wiley Interscience. http://www.cochrane.org/CD006285/ENT_autoinflation-for-hearing-loss-associated-with-otitis-media-with-effusion-glue-ear **Fickelstein Y. et al.** Adult-onset otitis media with effusion. Archives of Otolaryngology -- Head & Neck Surgery, May 1994, vol./is. 120/5(517-27). **Dempster J.H. et al.** The management of otitis media with effusion in adults. Clinical Otolaryngology & Allied Sciences, June 1988, vol./is. 13/3(197-9) **Yung M.W. et al.** Adult-onset otitis media with effusion: results

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			with facial palsy This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear. This includes grommets - myringotomy tubes - and tympanostomy or T tubes	following ventilation tube insertion. Journal of Laryngology & Otology, November 2001, vol./is. 115/11(874-8). **Wei W.I. et al**. The efficacy of myringotomy and ventilation tube insertion in middle-ear effusions in patients with nasopharyngeal carcinoma. Laryngoscope, November 1987, vol./is. 97/11(1295-8) **Ho W.K. et al**. Otorrhea after grommet insertion for middle ear effusion in patients with nasopharyngeal carcinoma. American Journal of Otolaryngology, January 1999, vol./is. 20/1(12-5) **Chen C.Y. et al.** Failure of grommet insertion in post-irradiation otitis media with effusion. Annals of Otology, Rhinology & Laryngology, August 2001, vol./is. 110/8(746-8) **Ho W.K. et al.** Randomized evaluation of the audiologic outcome of ventilation tube insertion for middle ear effusion in patients with nasopharyngeal carcinoma. Journal of Otolaryngology, October 2002, vol./is. 31/5(287-93) **Park J.J. et al.** Meniere's disease and middle ear pressure - vestibular function after transtympanic tube placement. ACTA OTOLARYNGOL, 2009 Dec; 129(12): 1408-13 **Sugaware K. et al.**

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
				Insertion of tympanic ventilation tubes as a treating modality for patients with Meniere's disease: a short- and long-term follow-up study in seven cases. Auris, Nasus, Larynx, February 2003, vol./is. 30/1(25-8) **Montandon P. et al.** Prevention of vertigo in Meniere's syndrome by means of transtympanic ventilation tubes. Journal of Oto-Rhino-Laryngology & its Related Specialties, 1988, vol./is. 50/6(377-81)
General Surgery		Benign Perianal Skin Tags	Referral should only be undertaken when one or more of the following criteria have been met: • There is doubt about the benign nature of the skin lesion • Viral warts in immunocompromised patients where underlying malignancy may be masked. • Recommended by GU Med when conservative treatment has failed	**NHS England.** Interim Clinical Commissioning Policy: Anal Skin Tag Removal https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC002.pdf **McKinnell and Gray**, 2010, QIPP Programme Right Care: Value Improvement Identifying Procedures of Low Value, Public Health Commissioning Network. **NHS Choices** Lumps and swellings http://www.nhs.uk/conditions/lumps-swellings/Pages/Introduction.aspx (accessed January 2017)
General Surgery		Cholecystectomy	The CCG will **only** support the funding of cholecystectomy in mild or asymptomatic gallstones if **one or more** of the following criteria are met: • High risk of gall bladder cancer, e.g. *gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer). (**Annual USS for smaller asymptomatic polyps)*	**Sanders G, Kingsnorth AN**. Gallstones. *BMJ*. 2007;335:295-9. **Sakorafas GH, Milingos D, Peros G.** Asymptomatic cholelithiasis: is cholecystectomy really needed? A critical reappraisal 15 years after the introduction of laparoscopic cholecystectomy. *Dig Dis Sci*. 2007;52:1313-25.

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			• Transplant recipient (pre or post-transplant). • Diagnosis of chronic haemolytic syndrome by a secondary care specialist. • Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones smaller than 3mm with a patent cystic duct, presence of multiple stones. • Acalculus cholecystitis diagnosed by a secondary care specialist. **Exclusion Criteria:** The CCG **will not** support the funding of cholecystectomy for patients in the following scenarios: • Patients with gallstones who experience one episode of mild abdominal pain only which can safely be managed with oral analgesia in primary care/community setting. Such patients should be advised to follow a low fat diet and only require referral if: - they have further episodes, **OR** - their pain is not controlled by oral analgesia **OR** - is associated with other symptoms, i.e. vomiting • Asymptomatic gallstones in patients with diabetes mellitus. • Asymptomatic gallstones in patients undergoing bariatric surgery, unless intra-operatively the gall bladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy. • All patients with asymptomatic gallstones who do not meet any of the above criteria	**Royal College of Surgeons** https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/gallstones--commissioning-guide.pdf **Behari A and Kapoor VK.** Asymptomatic Gallstones (AsGS) – To Treat or Not to? *Indian J Surg*. 2012;74: 4–12. **Tsirline VB, Keilani ZM, El Djouzi S *et al*.** How frequently and when do patients undergo cholecystectomy after bariatric surgery? *Surg Obes Relat Dis* 2013;1550-7289(13)00335-3. **Taylor J, Leitman IM, Horowitz M**. Is routine cholecystectomy necessary at the time of Roux-en-Y gastric bypass? *Obes Surg*. 2006;16:759-61. **Caruana JA, McCabe MN, Smith AD *et al*.** Incidence of symptomatic gallstones after gastric bypass: is prophylactic treatment really necessary? *Surg Obes Relat Dis*. 2005;1(6):564-7; discussion 567-8.

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			Barnsley and Rotherham CCG patients will only be referred after one episode of mild abdominal pain. The threshold in respect of mild (one episode of mild abdominal pain) does not apply to Doncaster, Bassetlaw and Sheffield CCG	
General Surgery		Hernia Repair • Inguinal, • Femoral, • Umbilical, para-umbilical, • Incisional	***Inguinal:*** Surgical treatment should only be offered when one of the following criteria is met: • Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living **OR** • The hernia is difficult or impossible to reduce, **OR** • Inguino-scrotal hernia, **OR** • The hernia increases in size month on month ***Femoral:*** All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation ***Umbilical/Para-umbilical and midline ventral hernias:*** Surgical treatment should only be offered when one of the following criteria is met: • pain/discomfort interfering with activities of daily living **OR** • Increase in size month on month **OR** • to avoid incarceration or strangulation of bowel where hernia is ≥ 2cm ***Incisional:*** Surgical treatment should only be offered the following criteria are met: • Pain/discomfort interfering with activities of daily	**National Institute for Health and Care Excellence** (2004) laprascopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ta83 (Accessed 2016) **Medscape: *Hernias*.** Available from: http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 2016) **McIntosh A. Hutchinson A. Roberts A & Withers, H**. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice, 2000;17(5), 442-447. GP notebook: *Paraumbilical hernias*. Available from: http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1811546097&linkID=17862&cook=n (accessed 2016) **Friedrich M. Müller Riemenschneider F. Roll S. Kulp W. Vauth C. Greiner W & von der Schulenburg JM**. Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety,

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			living	efficacy and cost-effectiveness. *GMS health technology assessment*. 2008;*4*. **Dabbas.** Frequency of abdominal wall hernias: is classical teaching out of date. JRSM *Short Reports*: 2011;2/5. **Fitzgibbons**. Watchful waiting versus repair of inguial hernia in minimally symptomatic men, a randomised controlled trial. *JAMA*: 2006;295, 285-292 **Purkayastha S. Chow A, Anthanasiou T, Tekkis P P & Darzi A**. Ingunal hernias. *Clinical evidence, 2008;*0412, 1462-3846 **Rosenberg J. Bisgaard T. Kehlet H. Wara P. Asmussen T. Juul P & Bay-Nielsen M.** Danish Hernia Database recommendations for the management of inguinal and femoral hernia in adults. *Dan Med Bull*, 2011;*58*(2), C4243. **Simons M P. Aufenacker T. Bay-Nielsen M. Bouillot J L. Campanelli G. Conze J & Miserez, M**. European Hernia Society guidelines on the treatment of inguinal hernia in adult patients. *Hernia*, 2009;*13*(4),343-403. **Primatesta P & Goldacre MJ.** Inguinal hernia repair: incidence of elective and emergency surgery, readmission and mortality.

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
				International journal of epidemiology, 1996;*25*(4), 835-839. **Patient Care Committee & Society for Surgery of the Alimentary Tract.** Surgical repair of incisional hernias. SSAT patient care guidelines. Journal of gastrointestinal surgery: official journal of the Society for Surgery of the Alimentary Tract. 2004;8(3), 369. **The Society for Surgery of the Alimentary Tract**. *Surgical Repair of Groin Hernias. Available from: http://www.ssat.com/cgi-bin/hernia6.cgi* (accessed 2016)
Ophthalmology	Blepharoplasty		Referral should only be made for the following indication: • To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue. **OR** • Following skin grafting for eyelid reconstruction **OR** • Following surgery for ptosis For all other individuals, the following criteria apply: • Documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND** • There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND** • Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120°	**Minhas A, Ronoh J., Badrinath P., 2008.** "Upper Eyelid Blepharoplasty for the Treatment of Functional Problems: A Brief to the Suffolk PCT Clinical Priorities Group". Suffolk PCT. **Hacker H.D. and Hollsten D.A, 1992.** "Investigation of automated perimetry in the evaluation of patients for upper lid blepharoplasty". Ophthalmic, Plastic & Reconstructive Surgery 8 (4) pp. 250-255. **Purewal B.K. and Bosniak S., 2005.** "Theories of upper eyelid blepharoplasty". Ophthalmology Clinics of North America 18 (2) pp 271-278. **American Academy of Ophthalmology, 1995.** "Functional Indications for Upper and Lower Eyelid Blepharoplasty". Ophthalmic Procedures Assessment American Journal of Ophthalmology

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			laterally and/or 20° or less superiorly.	102 (4) pp. 693-695. **Kosmin A.S., Wishart P.K., Birch M.K.,** 1997. "Apparent glaucomatous visual field defects caused by dermatochalasis". Eye 11 pp. 682-686
Ophthalmology		Cataract Surgery	All requests for the surgical removal of cataract(s) will **only** be supported by the CCG when the following applies: The total assessment score is 7 or above as per the cataract assessment and referral form Second eye surgery will be considered on the same basis as first eye surgery. ***Exceptions*** Exceptions are applicable to first or second eye. The only exceptions to the above referral criteria are as follows: • Anisometropia (a large refractive difference between the two eyes, on average about dioptres) which would result in poor binocular vision or disabling diplopia which may increase falls. • Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma • Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. • Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction	**NICE Guidance** Cataracts in adults: management (NG77) https://www.nice.org.uk/guidance/ng77 NICE February 2014. Eye conditions pathway http://pathways.nice.org.uk/pathways/eye-conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209.February 2007. http://guidance.nice.org.uk/IPG209 **Department of Health**. National Eye Care Plan (2004) **The Royal College of Ophthalmologists**: Cataract Surgery guidelines (2004) **NHS Executive** Action on Cataracts; Good Practice Guidance (2000). **Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S.** Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			or where further surgery on the ipsilateral eye will increase the risks of cataract surgery • Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) • Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis) • Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography • Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) • Post Vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia. Cataracts progress fairly rapidly following vitrectomy and are age dependent. Patients over the age of 50, especially those over 60 can have a rapid increase in the density of a cataract.	people in the community. *Br J Ophthalmol* 2002; 86: 795-800
Orthopaedics	Hallux Valgus		This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus. Surgery for hallux valgus will be funded if the following criteria are met and evidenced in clinic letters: • ulcer development over the site of the bunion or the sole of the foot **OR**	**NICE** Clinical Knowledge Summaries – Bunions https://cks.nice.org.uk/bunions **Patient Info** – Hallux valgus http://patient.info/doctor/hallux-valgus

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			• evidence of severe deformity (over or under riding toes) **OR** • Significant and persistent pain when walking **AND** conservative measures tried for at least six months (e.g. bunion pads / insoles / altered footwear) have failed to provide do not provide symptomatic relief in sensible shoes **OR** • Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees.	
Orthopaedics	Hip/Knee Replacement for osteoarthritis		Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures: (If more than one joint replacement is being considered **EACH** surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required. Patients **DO NOT** require referral back to the GP for re referral) The CCG will **only** fund hip/knee replacement for osteoarthritis when conservative measures have failed (listed below) or its successor **AND** the following criteria have been met: • Referral to the Hip or Knee Pathway **AND** • Patient has a BMI of less than 35** (Patients with BMI>35 should be referred for weight management interventions for a minimum of 6	**NICE** http://pathways.nice.org.uk/pathways/musculoskeletal-conditions (accessed 2016) **National Institute of Health.** Consensus development program. Dec 2003 https://consensus.nih.gov/2003/2003totalkneereplacement117html.htm (accessed 2016) The musculoskeletal services framework – A joint responsibility: doing it differently. **Department of Health**. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf **Namba, R., Paxton, L., Fithian, D., and Stone, M.** Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50.

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			months. If the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process **AND** • Intense to severe persistent pain (defined in table one provided in the checklist and documentation to support is required) which leads to severe functional limitations (defined in table two provided in the checklist and documentation to support is required), ***OR*** • Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures* including referral to the local hip pathway or its successor. ***Exceptions include:*** • Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. • Rapid onset of severe hip pain ***Conservative measures:*** • Patient education such as elimination of damaging influence on hips/knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND** • Physiotherapy **AND** • Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics. Documentation of	**Hawkeswood MD, J.,Reebye MD, R.** Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles. **College of General Practitioners.** 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip Procedures criteria. 2013. **NICE.** TA44 Metal on Metal Hip Resurfacing. 04 January 2013. https://www.nice.org.uk/guidance/TA2/documents/appendix-b-proposal-paper-presented-to-the-institutes-guidance-executive2 **NHS England.** Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC019.pdf **Kandala NB, Connock M, Pulikottil-Jacob R, Sutcliffe P, Crowther MJ, Grove A,Mistry H Clarke A.** Setting benchmark revision rates for total hip replacement: analysis of registry evidence. BMJ 2015;350:h756 doi: 10.1136/bmj.h756 (Published 9 March 2015)

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
			dates and medication types is required. ** Not applicable to Barnsley patients due to Get Fit First Programme. The requirement for "Patient has a BMI of less than 35" is replaced with "Patient meets Get Fit First criteria" i.e. • Patient has a BMI of less than 30 *OR* • Patient has engaged with Get Fit First health improvement and reached target weight (lost 10% from starting weight) *OR* • If the patients completes Get Fit First health improvement but fails to achieve necessary weight loss then referral is at the discretion of the clinicians involved, however further weight will likely be advised and the surgeon may not operate due to increased risk. ** BMI not applicable to Sheffield patients	
Orthopaedics		Ingrown Toe Nail in secondary care	Referral to secondary care should only be undertaken when: • the patient is in clinical need of surgical removal of ingrown toe nail, has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. **OR** • People of all ages with infection and/or recurrent inflammation due to ingrown toenail **AND** who have high medical risk*. **Medical risk is determined by the referring clinician*	**Eekhof JAH, Van Wijk B, Knuistingh Neven A, van der Wouden JC**. Interventions for ingrowing toenails. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD001541. DOI: 10.1002/14651858.CD001541.pub3 **NICE (2016).** Clinical Assessment Service: foot and ankle pathway | QP Case Study | Local practice | NICE. [online] Available at: https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f959489%2fattachment%3fniceorg%3dtrue

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
Urology		Male circumcision	Circumcision will **only** be commissioned for the following indications as confirmed by an appropriate clinician: • Phimosis (inability to retract the foreskin due to a narrow prepucial ring) • Recurrent paraphimosis (inability to pull forward a retracted foreskin) • Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin) • Balanoposthitis (recurrent bacterial infection of the prepuce) • Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	**NHS Choices.** Circumcision in adults: http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx (Accessed 16 January 2017) **Royal College of Surgeons**. Commissioning guide: Foreskin conditions. 2013. Available from: http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions **Moreno G, Corbalán J, Peñaloza B, Pantoja T**. Topical corticosteroids for treating phimosis in boys. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD008973. DOI: 10.1002/14651858.CD008973.pub2 **Liu, Yang, Chen et al**. Is steroids therapy effective in treating phimosis? A meta-analysis. Int Urol Nephrol. 2016 Mar; 48(3):335-42. doi: 10.1007/s11255-015-1184-9 **Zhu, Jia, Dai et al.** Relationship between circumcision and human papillomavirus infection: a systemic review and meta-analysis. Asian J Androl. 2016 March. http://www.ajandrology.com/article.asp?issn=1008-682X;year=2017;volume=19;issue=1;spage=125;epage=131;aulast=Zhu **Singh-Grewal D,Macdessi J, Craig J.**

Speciality	Ref	Intervention	Criteria for treatment	Evidence Base
				Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child. 2005 Aug;90(8):853-8 **Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al.** Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The Lancet. 2007;369 (9562): 643–56

Appendix 3 – Commissioning Guidelines for Specialist Plastic Surgery Procedures

BACKGROUND AND INTRODUCTION

This policy sets out the criteria for access to NHS funded cosmetic specialist plastic surgery procedures.

Cosmetic surgery is any surgery carried out to enhance outward appearance. It is carried out on people with abnormal appearance from a range of clinical or congenital conditions or syndromes or as a result of surgery or injury. It can also be carried out to enhance appearance or to correct changes due to ageing or obesity.

In any health care system there are limits set on what is available and on what people can expect.

Clinical Commissioning Groups are required to achieve financial balance. They have a complex task in balancing this with individuals' rights to health care. It is the purpose of the criteria set out in this document to make the limits on cosmetic specialist plastic surgery procedures fair, clear and explicit.

Referrals within the NHS for the revision of treatments originally performed outside the NHS will not normally be permitted.

Referrals should where possible be made to the practitioner who carried out the original procedure.

This policy will be reviewed by the review date or in the light of any new guidance or clinical evidence, whichever is the earliest.

These guidelines cover a group of surgical procedures with cosmetic indications.

It is important to note that a substantial proportion of specialist plastic surgery is carried out by a number of specialities other than Plastic Surgery e.g. ENT Surgery, Ophthalmology, Maxillofacial Surgery, General Surgery and Dermatology. This policy only concerns procedures carried out in hospitals.

Severity of the condition, effectiveness of intervention requested, cost and cost effectiveness should all be taken into consideration in the decision making process.

Commissioning approval is required for NHS funding through the Individual Funding Request process prior to referral to the specialist clinician.

If funding is approval, the decision whether or not to go through with a particular procedure rests with the clinician and the patient in relation to the appropriateness of the procedure, its likelihood of success and risks of failure.

GENERAL GUIDELINES

1. Patients requiring reconstruction surgery to restore normal or near normal appearance or function following cancer treatment or post trauma do not fall within this policy.

2. For cosmetic procedures an NHS referral is inappropriate if the patient falls within the normal morphological range.

3. Patients should not be referred unless they are fit for surgery.

4. Patients should not be referred to the specialist service until approval has been obtained from the CCG through the IFR process and a copy of the approval should be appended to the referral.

5. Inevitably some patients may not fit the guidelines. If the referring clinician feels that a case merits funding on an exceptional basis they should discuss the case with the IFR team or submit an IFR with evidence of exceptionality to be considered by the panel.

6. Patients who have been operated on privately will not normally be eligible for NHS treatment for complications or secondary procedures. However there may be unusual or severe complications or circumstances that require transfer of a patient to the NHS for appropriate management.

7. Body Mass Index(BMI) is referred to as per SIGN[1] guidance

where: Less than 18.5	Underweight
18.5 -24.9	Normal BMI
25.0 - 29.9	Overweight
30.0 - 39.9	Obese
40 or above	extremely obese

The BMI should be measured and recorded by the NHS.

8. Plastic surgery procedures will only normally be considered in patients with a BMI in the range of 18.5 to 27 unless weight is not relevant to the proposed surgery. Completion of Get First 6 month health improvement does not overrule this criteria for Barnsley patients.

9. Plastic surgery procedures will not be funded to alleviate psychological problems alone.

10. All decisions will be taken in the context of the overall financial position of the CCG.

11. Photographic evidence may be requested to facilitate thorough consideration of a case.

[1] SIGN (1996) Integrated Prevention and Management of Overweight and Obesity, Edinburgh

PROCEDURE SPECIFIC GUIDANCE

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**1. Abdominoplasty/ apronectomy (tummy tuck)**	**Abdominoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Abdominoplasty may rarely be considered on an exceptional basis, for example where the patient: • has lost a significant amount of weight (moved down two levels of the BMI SIGN guidance) and has a stable BMI, which would normally be below 27 for a minimum of 2 years, and • is experiencing severe difficulties with daily living, for example ambulatory or urological restrictions. Other factors may be considered: • recurrent severe infection or ulceration beneath the skin fold despite appropriate conservative treatment • significant abdominal wall deformity due to surgical scarring or trauma • problems associated with poorly fitting stoma bags
Plastic and Cosmetic surgery	**2. Breast Surgery**	
	2.1 Breast Augmentation	**Breast augmentation will not be routinely commissioned by the NHS for cosmetic reasons, for example for enhancement of small breasts, for tuberous breasts or for breast tissue involution (including post-partum changes).** Breast augmentation may rarely be considered on an exceptional basis, for example where the patient: • has a complete absence of breast tissue either unilaterally or bilaterally or • has suffered trauma to the breast during or after development and • has a BMI within the range 18.5 - 27 and • has completed puberty as surgery is not routinely commissioned for individuals who are below 19 years of age Patients who have received feminising hormones for an adequate length of time as part of a recognised treatment programme for gender dysphoria will only be considered when they meet the above criteria. Revision surgery will only be commissioned for implant rupture, or for other physical symptoms, for example capsule contracture associated with pain, and not for aesthetic indications. Implant replacement will only be considered if the original procedure was performed by the NHS.

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.2 Breast Reduction**	**Breast reduction will not routinely be commissioned by the NHS for cosmetic reasons.** Breast reduction may rarely be considered on an exceptional basis, for example where the patient: • has a breast measurement of cup size G or larger and • has a BMI in the range 18.5 - 27 or and • is 19 years of age or over and • has significant musculo-skeletal pain causing functional impairment which in the opinion of the referrer is likely to be corrected or significantly improved by surgery and • has tried and failed with all other advice and support, including a professional bra fitting and assessment by a physiotherapist where relevant **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance.pdf • NHS Website https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/ • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.3 Breast Asymmetry**	**Surgery to correct breast asymmetry will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may rarely be considered on an exceptional basis, for example where the patient: • has a difference of at least 2 cup sizes and • has a BMI in the range 18.5-27 and • has tried and failed with all other advice and treatment, including a professional bra fitting and • has completed puberty - surgery is not normally commissioned below the age of 19 years **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**2.4 Breast Reduction for gynaecomastia (male)**	**Surgery to correct gynaecomastia will not routinely be commissioned by the NHS for cosmetic reasons.** Surgery may be considered on an exceptional basis, for example where the patient: • has more than 100g of sub areolar gland and ductal tissue (not fat) and • has a BMI in the range 18.5 - 27 or and • has been screened prior to referral to exclude endocrine and drug related causes (if drugs have been a factor then a period of one year since last use should have elapsed) and • has completed puberty - surgery is not routinely commissioned below the age of 19 years and • has been monitored for at least 1 year to allow for natural resolution if aged 25 or younger **National Evidence Base** • Evidence Based Interventions https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance.pdf • The British Association of Plastic, Aesthetic and Reconstructive Surgeons http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Plastic and Cosmetic surgery	**2.5 Breast lift mastopexy**	**Mastopexy will not be routinely commissioned by the NHS for cosmetic reasons.** For example post lactation or age related ptosis but may be included as part of the treatment to correct breast asymmetry.
Plastic and Cosmetic surgery	**2.6 Correction of Nipple inversion**	**Surgical correction of benign nipple inversion will not be routinely commissioned by the NHS for cosmetic reasons.**
Plastic and Cosmetic surgery	**3. Hair**	
	3.1 Hair removal	**Hair removal will not be routinely commissioned by the NHS for cosmetic reasons.** Hair removal may be considered on an exceptional basis, for example where the patient: • has had reconstructive surgery resulting in abnormally located hair bearing skin or • has a pilonidal sinus resistant to conventional treatment in order to reduce recurrence risk
Plastic and Cosmetic Surgery	**3.2 Correction of Male Pattern Baldness**	**Treatments to correct male pattern baldness will not be routinely commissioned by the NHS for cosmetic reasons.**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**3.3 Hair transplantation**	**Hair transplantation will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender.** Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma.
Plastic and Cosmetic surgery	**4. Acne scarring**	**Procedures to treat facial acne scarring will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.
Plastic and Cosmetic surgery	**5. Buttock, thigh and Arm lift surgery**	**Not Routinely Commissioned** **Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has an underlying skin condition, for example cutis laxa or • has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living and • has a normal BMI in the range18.5 - 27 for a minimum of 2 years
Plastic and Cosmetic surgery	**6. Congenital vascular abnormalities**	**Procedures for congenital vascular abnormalities will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only
Plastic and Cosmetic surgery	**7. Correction of Prominent Ears (Pinnaplasty)**	**Surgical correction of prominent ears will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern and • has very significant ear deformity or asymmetry **National Evidence Base** • NHS England Interim Commissioning Policy for Pinnaplasty/Otoplasty November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC027.pdf

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**8. Facelift**	**Facelift procedures, Botulinum toxin and dermal fillers will not be routinely commissioned by the NHS for cosmetic reasons** Cases may be considered on an exceptional basis, for example in the presence of an anatomical abnormality or a pathological feature which significantly affects appearance.
Plastic and Cosmetic surgery	**9. Lapiaplasty, Vaginoplasty and Hymen Reconsturction**	**Not Routinely Commissioned - Refer through IFR for exceptionality**
Plastic and Cosmetic surgery	**10. Liposuction**	**Liposuction will not be routinely commissioned by the NHS simply to correct the distribution of fat or for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient has significant lipodystrophy**.**
Plastic and Cosmetic surgery	**11. Rhinoplasty**	**Rhinoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example in the presence of severe functional problems. Post traumatic airway obstruction or septal deviation does not need funding approval**.**
Plastic and Cosmetic surgery	**12. Rhinophyma**	**Surgical/laser treatment of rhinophyma will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an individual basis, for example where the patient has functional problems and where conventional medical treatments have been ineffective.
Plastic and Cosmetic surgery	**13. Surgical Scars**	**Revision surgery for scars will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis, for example where the patient: • has significant deformity, severe functional problems, or needs surgery to restore normal function or • has a scar resulting in significant facial disfigurement.
Plastic and Cosmetic surgery	**14. Thread veins/telangectasia**	**Not Routinely Commissioned - Refer through IFR for exceptionality**

Speciality	Procedure	Commissioning Position & Exceptionality Information
Plastic and Cosmetic surgery	**15. Tattoo removal**	**Tattoo removal will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example where the patient: • has suffered a significant allergic reaction to the dye and medical treatments have failed • has been given a tattoo against their will (rape tattoo) **National Evidence Base** • NHS England Interim Commissioning Policy for Tattoo Removal November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC032.pdf
Plastic and Cosmetic surgery	**16. Surgical Repair of Torn Earlobes**	**Surgical repair of torn ear lobes or holes resulting from gauge piercing will not be commissioned by the NHS for cosmetic reasons.**

DEFINITIONS

AESTHETIC	Concerned with beauty or the appreciation of beauty.
COSMETIC	Intended to improve outward appearance
GYNAECOMASTIA	A condition in the male in which the mammary glands are excessively developed.
CUTIS LAXA	A rare, inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds.
LABIAPLASTY	A surgical procedure to alter the size or appearance of the labia minora.
LIPODYSTROPHY	A disorder of fat metabolism.
LIPOSUCTION	A method of permanent fat removal through suction.
LIPOMA	A benign tumour composed of fatty tissue.
MORPHOLOGIC	Relating to form and structure.
PTOSIS	Drooping.
RHINOPLASTY	A surgical procedure to change the shape or structure of the nose.
RHINOPHYMA	Enlargement of the nose with redness and prominent blood vessels.

Appendix 4 - Patient Information Sheet

Evidence Based Interventions

Patient Information Leaflet to accompany the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy (Updated January 2019)

Background

During 2018, doctors, nurses and managers across the NHS, both locally in South Yorkshire and across the country, have been working hard to make sure that the interventions (treatments and operations) offered to all patients are the best ones available and that money is not spent on treatments that might not be effective.

The result is the Commissioning for Outcomes Policy (CFO), which will be effective from April 1st 2019. The policy has been agreed by all of the South Yorkshire and Bassetlaw Clinical Commissioning Groups (CCGs), which means that access to healthcare will be fair and equal for all patients in our region.

The policy is based upon the latest national guidance provided by the National Institute for Health and Care Excellence (NICE) and this has shown that some treatments or operations that have until now been routinely recommended might in fact not be the best option for some patients.

The aim of the policy is to make sure that the doctors and nurses involved in your care can offer you the most up to date treatments, based on the latest research and to ensure that NHS funds are spent on the things that will bring the greatest health benefits.

Your GP, hospital consultant or nurse specialist will discuss the different treatment options with you. Some operations or treatments will only be recommended for some patients and your doctor will assess whether or not you meet the clinical conditions or criteria.

If you meet the criteria then this will be the best treatment option for you and the procedure will be arranged.
If you don't meet the criteria then you will be offered the most effective treatment for your particular condition.

If you don't qualify for the treatment, but your doctor or nurse thinks that there are exceptional clinical circumstances in your case then they may submit an Individual Funding Request (IFR) to an independent panel for consideration.

Details about the IFR process and the guidance that is followed can be found by contacting your local CCG, please see the links below.

The table below shows all the treatments and operations that are included within this policy:

Table 1: Interventions in the Commissioning for Outcomes Policy

Intervention	
Acupuncture	Hallux Valgus (Bunion surgery)
Arthroscopic shoulder decompression	Hernia Repair
Benign Perianal Skin tags	Hip replacement
Blepharoplasty (eyelid deformities)	Hysterectomy for Heavy Menstrual Bleeding
Breast reduction / asymmetry and gynaecomastia	Ingrown Toe Nail
Carpal Tunnel release	Injection for non-specific low back pain
Cataract Surgery	Knee arthroscopy
Chalazia removal (eyelid bump removal)	Knee replacement
Cholecystectomy (removal of Gall Bladder)	Male circumcision
Dilation and curettage for heavy menstrual bleeding	Removal of Benign Skin Lesions
Dupuytren's Surgery	Snoring Surgery
Fertility procedures e.g. IVF	Specialist plastic surgery procedures
Ganglion Surgery	Tonsillectomy Adults / Children's
Grommets for adults	Trigger Finger release
Grommets for children	Varicose vein surgery
Haemorrhoid Surgery	Vasectomy under General Anaesthetic

The CFO policy and the list of clinical criteria for each treatment are available on the internet at: https://www.healthandcaretogethersyb.co.uk/about-us/useful-documents

Further information about the policy, including how to raise concerns or make a complaint can be found at the links below, please choose the CCG that is responsible for the area where you live.

Please be assured that your details will remain confidential and will only be shared with relevant staff in order to address your concerns.

BARNSLEY
http://www.barnsleyccg.nhs.uk/about-us/feedback-and-enquiries.htm

Write to: Quality Team, NHS Barnsley CCG, Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY
Telephone: 01226 433772
Email: qualityteam.safehaven@nhs.net

For further advice you can also contact Healthwatch at; Priory Campus, Pontefract Road, Barnsley, South Yorkshire. S71 5PN or Tel: 01226 320106
BASSETLAW

Write to: Complaints Department, Retford Hospital, North Road, Retford, Notts, DN22 7XF
Telephone: 01777 863321
Email: BASCCG.CommunicationOffice@nhs.net

For further advice you can also contact Healthwatch at; Unit 2, Byron Business Centre, Duke St, Hucknall, Notts, NG15 7HP or Tel: 01159635179

DONCASTER
Write to: Patient Experience Manager, Doncaster CCG, Sovereign House, Heaven's Walk, Doncaster, DN4 5HZ
Telephone: 01302 566228
Email: Donccg.enquiries@nhs.net

For further advice you can also contact Healthwatch at: 3 Cavendish Court, South Parade, Doncaster, DN1 2JD or Tel: 0808 8010391

ROTHERHAM
http://www.rotherhamccg.nhs.uk/concerns-and-complaints.htm
Write to: Rotherham CCG, Oak House, Moorhead Way, Rotherham, South Yorkshire S66 1YY
Telephone: 01709 302108
Email: complaints@rotherhamccg.nhs.uk

For further advice you can also contact Healthwatch at: Thornbank House, 38 Moorgate Rd, Rotherham S60 2AG or Tel: 01709717130

SHEFFIELD
http://www.sheffieldccg.nhs.uk/about-us/contact-us.htm
Write to: Complaints Team, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU
Telephone: (0114) 305 1000
Email: SHECCG.complaints@nhs.net

For further advice you can also contact Healthwatch at: The Circle, 33 Rockingham Lane, Sheffield, S1 4FW or Tel: 01142536688

Appendix 5 – Diagnostic and Procedure Codes

National Evidence Based Interventions

For each of the 17 interventions, the clinical definitions have been converted into combinations of one or more OPCS procedure codes and ICD-10 diagnosis codes.The following descriptors use Microsoft SQL Server structure but are easily adaptable to other systems.

For reference:

- A "%" symbol represents a wildcard for zero or more characters.
- Values in square brackets mean "one of these characters". E.g. [03] mean 0 or 3 and [0-3] means 0 or 1 or 2 or 3.
- The field "der_diagnosis_all" is a concatenation of all diagnosis fields in all episodes within the spell.

Intervention		Diagnostic and procedure codes
A	Intervention for snoring (not OSA)	when left(der.Spell_Dominant_Procedure,4) in ('F324','F325','F326') and der.Spell_Primary_Diagnosis not like '%G473%' and APCS.Age_At_Start_of_Spell_SUS between 18 and 120 then 'A_snoring'
B	Dilatation & curettage for heavy menstrual bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q103') and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'B_menstr_D&C'
C	Knee arthroscopy with osteoarthritis	when der.Spell_Dominant_Procedure in ('W821','W822','W823','W828','W829','W851','W852','W853','W858','W859','W861+KNEE','W831+KNEE','W832+KNEE','W833+KNEE','W834+KNEE','W835+KNEE','W836+KNEE','W837+KNEE','W838+KNEE','W839+KNEE','W841+KNEE','W842+KNEE','W843+KNEE','W844+KNEE') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and der.Spell_Primary_Diagnosis like 'M1[57]%' then 'C_knee_arth'
D	Injection for nonspecific low back pain without sciatica	when left(der.Spell_Dominant_Procedure,4) in ('A521','A522','A528','A529','A577','A735','V363','V368','V369','V382','V383','V384','V385','V386','V388','V389','V544','W903') and left(der.spell_primary_diagnosis,4) in ('G834','G551','M518','M519','M545','M549') and apcs.der_procedure_all like '%Z67[67]%' then 'D_low_back_pain_inj'
E	Breast reduction	when left(der.Spell_Dominant_Procedure,4) in ('B311') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'E_breast_red'
F	Removal of benign skin lesions	when left(der.Spell_Dominant_Procedure,4) in ('S063','S064','S065','S066','S067','S068','S069','S081','S082','S083','S088','S089','S091','S092','S093','S094','S095','S098','S099','S101','S102','S111','S112','D021','D022','D028','D029') and APCS.Der_Diagnosis_All not like '%C4[3469]%' then 'F_skin_lesions'

Intervention		Diagnostic and procedure codes
		In addition when the dominant procedure code is 'any' and the primary diagnosis is D17 or L82. In addition when the dominant procedure code is S103, S104, S105, S108, S109, S113, S114, S115, S118, S119 AND any primary diagnosis.
G	Grommets	when left(der.Spell_Dominant_Procedure,4) in ('D151','D289') and (der.Spell_Primary_Diagnosis like 'H65[23]%' or der.Spell_Primary_Diagnosis like 'H66[1-9]%') and (apcs.age_at_start_of_Spell_SUS between 1 and 17 or apcs.age_at_start_of_Spell_SUS between 7001 and 7007) then 'G_gromm'
H	Tonsillectomy	when left(der.Spell_Dominant_Procedure,4) in ('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%G47%' and apcs.der_diagnosis_all not like '%J36%' then 'H_tonsil' Note: If diagnosis is cancer (<> C0-9) then IFR not required. If diagnosis is sleep disorder (G47) or peritonsillar abscess (J36) then IFR required.
I	Haemorrhoid surgery	when left(der.Spell_Dominant_Procedure,4) in ('H511','H512','H513','H518','H519') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' then 'I_haemmor'
J	Hysterectomy for heavy bleeding	when left(der.Spell_Dominant_Procedure,4) in ('Q072','Q074','Q078','Q079','Q082','Q088','Q089') and apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and apcs.der_diagnosis_all not like '%O0[0-8]%' and apcs.der_diagnosis_all not like '%O6[0-9]%' and apcs.der_diagnosis_all not like '%O7[0-5]%' then 'J_hysterec'
K	Chalazia removal	when left(der.Spell_Dominant_Procedure,4) in ('C121','C122','C124','C191','C198') and left(der.Spell_Primary_Diagnosis,4) in ('H001') then 'K_chalazia'
L	Shoulder decompression	when (der.Spell_Dominant_Procedure ='W844+SHOULDER' or (der.Spell_Dominant_Procedure ='O291' and apcs.der_procedure_all like '%Y767%')) and (der.Spell_Primary_Diagnosis like 'M754%' or der.Spell_Primary_Diagnosis like 'M2551%') then 'L_should_decom' In addition when the dominant procedure code is 'any' and the primary diagnosis is M75.0, M75.1 or M75.4
M	Carpal tunnel syndrome release	when left(der.Spell_Dominant_Procedure,4) in ('A651','A659') and der.Spell_Primary_Diagnosis like '%G560%' then 'M_carpal'

Intervention		Diagnostic and procedure codes
N	Dupuytren's contracture release	when left(der.Spell_Dominant_Procedure,4) in ('T521','T522','T525','T526','T541') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and left(der.Spell_Primary_Diagnosis,4)='M720' then 'N_dupuytr'
O	Ganglion excision	when left(der.Spell_Dominant_Procedure,4) in ('T591','T592','T598','T599','T601','T602','T608','T609') and der.Spell_Primary_Diagnosis like '%M674%' then 'O_ganglion'
P	Trigger finger release	when der.Spell_Dominant_Procedure in ('T692+HAND','T691+HAND','T698+HAND','T699+HAND','T701+HAND','T702+HAND','T718+HAND','T719+HAND','T723+HAND','T728+HAND','T729+HAND','Z894+HAND','Z895+HAND','Z896+HAND','Z897+HAND') and (APCS.Age_At_Start_of_Spell_SUS between 18 and 120) and der.Spell_Primary_Diagnosis like '%M653%' then 'P_trigger_fing'
Q	Varicose vein surgery	when left(der.Spell_Dominant_Procedure,4) in ('L832','L838','L839','L841','L842','L843','L844','L845','L846','L848','L849','L851','L852','L853','L858','L859','L861','L862','L863','L868','L869','L871','L872','L873','L874','L875','L876','L877','L878','L879','L881','L882','L883','L888','L889') and der.Spell_Primary_Diagnosis like ('%I8[03]%') then 'Q_var_veins'

Local Evidence Based Interventions

Speciality	Intervention	Dominant Procedure Code	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
ENT	Grommets for Adults (Myringotomy)	D151, D153				Age >= 18
General Surgery	Benign Perianal Skin Tags	H482				
General Surgery	Cholecystectomy (Asymptomatic gallstones)	J181, J182, J183, J184, J185, J188, J189, J211, J212, J213, J218, J219			K802, K805	
General Surgery	Hernia Repair • Inguinal • Femoral • Umbilical	1) T191, T192, T198, T199,	1) <> N132		1) K402, K409, K439, K469	Age >= 18
		2) T201, T202, T203, T204, T208, T209, T211, T212, T213, T214, T218, T219,	2) NOT IN (G693, H111,		2) K402, K409, K439,	Age >= 18

Speciality	Intervention	Dominant Procedure Code	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
	• Para-umbilical • Incisional (Asymptomatic inguinal hernias in adults)	T251, T252, T253, T258, T259, T261, T262, T263, T264, T268, T269, T271, T272, T273, T274, T278, T279	G762, H175)		K469	
		3) T241, T242, T243, T244, T248, T249,			3) K429	Age >= 18
Ophthalmology	Blepharoplasty	C121, C122, C123, C124, C125, C126, C128, C129, C131, C132, C133, C134, C138, C139, C161, C162, C163, C164, C165, C168, C169 Note: Any these procedures that are accompanied by a primary diagnosis of H001 are categorised as Chalazion				
Ophthalmology	Cataract Surgery	C711, C712, C713, C718, C719, C721, C722, C723, C728, C729, C741, C742, C743, C748, C749, C751, C752, C753, C754, C758, C759				
Orthopaedics	Hallux Valgus	W791, W792, W799, W151, W152, W153, W154, W155, W156, W158, W159, W591, W592, W593, W594, W595, W596, W597, W598, W599			M201	
Orthopaedics	Hip Replacement for osteoarthritis	W371, W378, W379, W381, W388, W389, W391, W398, W399, W931, W938, W939, W941, W948, W949, W951, W958, W959			M15, M16, M17	
Orthopaedics	Knee Replacement for osteoarthritis	W401, W408, W409, W411, W418, W419, W421, W428, W429, O181, O188, O189			M15, M16, M17	

Speciality	Intervention	Dominant Procedure Code	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
Orthopaedics	Ingrown Toe Nail in secondary care	1) S641, S642, S681, S682, S683, S701	1) Z906, Z907, Z506			
		2) S641, S642, S681, S682, S683, S701	2) S641, S642, S681, S682, S683, S701	2) Z906, Z907, Z506		
Urology	Male Circumcision	Male Circumcision	N303			

Appendix 6 - Definitions

Definition of Clinical Thresholds
Clinical thresholds are a predetermined set of criteria that must be met before some procedures are considered. The threshold may be such that medication would deal with the problem. Surgery should be a last resort for a number of conditions and should not take place before considering and trying other non-surgical, reasonable options.

Definition of Commissioning
Assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

Definition of Individual Funding Request
An individual funding request is where prior approval for a patient's treatment is required due to that treatment or symptom criteria being outside of our approved commissioning policies and in such cases exceptionality will need to be proven.

Definition of Exceptionality
In order to demonstrate exceptionality the patient

1. Must be significantly different to the population of interest (i.e. patients with pulmonary hypertension and/or the subpopulation), and,
2. Be more likely to benefit from this intervention than might be expected than other patients with the condition

Appendix 7 – Links to South Yorkshire and Bassetlaw Individual Funding Request Policies

Barnsley CCG - Individual Funding Requests Policy

Bassetlaw CCG - Individual Funding Requests Policy

Doncaster CCG - Individual Funding Request Policy

Rotherham CCG - Individual Funding Request Policy

Sheffield CCG - Individual Funding Request Policy