

South East London

Treatment Access Policy

July 2024 v1

This policy has been developed by the South East London Treatment Access Group in consultation with Health Care Advisory Group, a collaboration across South East London, including Public Health.

This policy deals with treatments and procedures for which restricted access criteria have been agreed.

Background

This policy has been built upon over a number of years and it is applied equally to all boroughs within south east London.

Limited Resources

There will always be competing calls for limited resources and therefore a need for a clearly defined and co-ordinated approach to ensure that the resources are used in an equitable and effective way and that clear, consistent and fair procedures are in place. These are based on the principles of cost effectiveness found in the IFR policy.

Incorporating NHSE Evidence Based Interventions Access Criteria

Variations in treatment funding decisions are clearly undesirable, and from April 2019 this policy document incorporated the first tranche of 17 NHS England Evidence Based Interventions (EBI) access criteria. Where local guidance previously existed these have been superseded by EBI access criteria.

Review

This policy is reviewed and updated at least annually.

Procedures and treatments not mentioned in the SEL TAP

The South East London Integrated Care Board (SEL ICB) does not have policies in place for every procedure that a patient might request. If a particular procedure/approach is not listed within local policies then it is not commissioned and not available.

Policy document changes since December 2019

Change(s)	Reason
Caesarean for non-clinical reasons	Restriction no longer valid
Open MRI	Criteria added
Adenoidectomy	Replaced with EBI 2 access criteria
Reversal of vasectomy or sterilisation	No longer needing to be referenced in TAP
Hyperhidrosis	
Asymptomatic gallstones	
Micro-suction for ear wax removal	
Bariatric Surgery	
Breast Reduction Surgery	More appropriately classified as category 2
Gynaecomastia	
Pinnaplasty	
Blepharoplasty	
Scar revision	
Face or brow lift	
Hair removal	
General document updates to reflect establishment of SEL ICB.	

Policy document change July 2024

Change(s)	Reason
Removal of Fertility treatments	New separate fertility policy published July 2024
Removal of Fertility preservation Techniques	New separate fertility policy published July 2024

Equality Statement:

This document demonstrates the organisation’s commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities”.

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1. Category 1 – Interventions requiring an Individual Funding Request

Procedures in Category 1 require agreement through the 'Individual Funding Request Process',

Interventions that should not be routinely commissioned, with patients only able to access such treatments where they successfully make an individual funding request (referred to as Category 1 interventions).

All patients requiring a consultant opinion for diagnostic or symptomatic advice should continue to be referred by General Practitioners.

Please note that wherever the policy states that non surgical, alternative or conservative measures should have been tried, these must be documented and included in the referral. The same applies when a certain number of clinical episodes are required in order to meet the criteria for referral.

1.1 Breast augmentation

This procedure is not available on cosmetic grounds.

An exception may be made for congenital absence of breast tissue or there is gross asymmetry (difference in size minimum 2 cup sizes).

1.2 Breast implants

Breast implants and instant replacements are not available on the NHS.

However ruptured breast implants will be removed on the NHS if they are considered to be of danger to the patient. Replacement implants must not be inserted as part of the same procedure even if the patient wishes to self-fund this part of the treatment.

1.3 Correction of congenital nipple inversion

This procedure is not available on cosmetic grounds.

Nipple inversion is a common condition which responds well to conservative treatment, e.g. use of Niplette device.

1.4 Mastopexy (relocating the nipple and improving the shape of the breast)

This procedure is not available on cosmetic grounds.

Breast ptosis is inevitable in most women due to a combination of maturity, gravity and pregnancy/lactation. An exception may be made in gross cases.

1.5 Revision mammoplasty

This procedure is not available on cosmetic grounds, unless the original procedure was performed on the NHS in a hospital within south east London and due to health reasons, and the patient now has a gross deformity.

1.6 Body contouring

(Abdominoplasty or tummy tuck, thigh lift and buttock lift, excision of redundant skin or fat liposuction)

These procedures are not available on cosmetic grounds.

An exception may be made for post-traumatic surgery for contouring at diabetes injection sites or for lymphoedema.

1.7 Repair of lobe of external ear

This procedure is not available on cosmetic grounds.

1.8 Tattoo removal

This procedure is not available on cosmetic grounds.

1.9 Dermabrasion (chemical peel)

This procedure is not available for skin rejuvenation.

1.10 Male pattern baldness (hair grafting and flaps with or without tissue expansion)

This procedure is not available on cosmetic grounds.

Baldness is a natural condition.

1.11 Female baldness and alopecia – hair replacement

This procedure is not available on cosmetic grounds.

1.12 Dilatation and curettage (D&C) for heavy menstrual bleeding in women

NICE guidelines recommend that D&C is **not offered** as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.

1.13 Genital surgery

This procedure is not available on cosmetic grounds.

1.14 Knee arthroscopy for patients with osteoarthritis

Arthroscopic knee washout (lavage and debridement) **should not** be used as a treatment for osteoarthritis because it is clinically ineffective.

1.15 Injections for nonspecific low back pain without sciatica

NICE guidelines recommend that spinal injections **should not** be offered for nonspecific low back pain.

1.16 Adult snoring surgery (in the absence of obstructive sleep apnoea)

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.

1.17 Alternative therapies

Osteopathy

Osteopathy remains a low priority treatment due to the limited evidence of clinical effectiveness. Referral for osteopathy is not available on the NHS.

Acupuncture

Acupuncture remains a low priority treatment due to the limited evidence of clinical effectiveness. Referrals for acupuncture should be made in exceptional circumstances only. Funding for cases of nausea and vomiting and back pain shall be considered by the local Individual Funding Request (IFR) Panels.

Homeopathy

Homeopathy is not funded due to the lack of evidence that homeopathy has any identifiable biological effectiveness. Patients who are currently being treated should, in most cases, be encouraged to seek alternative treatments

All other complementary therapies are also not funded on the NHS.

Category 2 – Interventions only routinely commissioned or performed when specific criteria is met

The following procedures do not require prior agreement through an Individual Funding Request (IFR) process providing the specific access criteria are met.

Clinicians will need to demonstrate that the patient meets the criteria set out in this policy. If the patient does not meet the relevant access criteria, but the clinician feels the patient has exceptional clinical circumstances, the request for funding should be taken through the IFR process.

Please note that wherever the policy states that non-surgical, alternative or conservative measures should have been tried, these must be documented and included in the referral. The same applies when a certain number of clinical episodes are required in order to meet the criteria for referral.

Monitoring compliance will be through regular audit and engagements with clinicians.

2.1 Breast reduction

Section 1: bilateral breast reduction

The NHS will only provide bilateral breast reduction for women when all the following criteria are met:

1. The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain

AND

2. In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided

AND

3. Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps)

AND

4. Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes

AND

5. Body mass index (BMI) is <27 and stable for at least twelve months

AND

6. Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery

AND

7. Woman should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking

AND

8. Woman should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

Section 2: Unilateral breast reduction

This treatment is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons.

Surgery can be offered when all of the following criteria are met:

1. A difference of 150 -200gms size as measured by a specialist
AND
2. BMI is <27 and stable for at least twelve months

Additional information

Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

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

Breast reconstruction revision surgery following cancer

For patients who have undergone a breast reconstruction for a mastectomy, either as an immediate reconstruction, as a delayed reconstruction and for those who have undergone a salvage reconstruction following a failed previous reconstruction. This policy applies for both implant based and autologous reconstructions. In addition this will apply to patients referred to the plastic surgery department at Guy's and St Thomas' Hospital who have undergone a reconstruction procedure by the plastic surgery team due to a poor outcome following a wide local excision procedure for breast cancer at another hospital.

After the initial reconstruction procedure has been performed two revision procedures will be offered to patients. These will include surgery for both the reconstructed breast and any symmetrisation procedure for the contralateral breast. If a nipple reconstruction procedure has not been performed in one of the two revision procedures then a nipple reconstruction under a local anaesthetic may also be performed at a third stage.

2.2 Gynaecomastia¹

This procedure is not available on cosmetic grounds.

It can only be offered when the following criteria is met:

- True gynaecomastia (i.e. breast tissue is present as opposed to adipose tissue) has been diagnosed. Gynaecomastia is classified as Grade III (marked breast enlargement with major skin redundancy).
- The BMI is less than or equal to 25 kg/m
- Screening for endocrinological or drug related causes has taken place
- Underlying malignancy should be excluded, clinically or otherwise

¹ Gynaecomastia evidence review. SEL Exceptional Treatments Group, 2009.

2.3 Removal of benign skin lesions

This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:

- benign moles (excluding large congenital naevi)
- solar comedones
- corn/callous
- dermatofibroma
- lipomas
- milia
- molluscum contagiosum (non-genital)
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- spider naevi (telangiectasia)
- non-genital viral warts in immunocompetent patients
- xanthelasmata
- neurofibromata

The benign skin lesions, which are listed above, must meet at **least ONE** of the following criteria to be removed:

1. The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year

OR

2. The lesion causes severe pain requiring analgesia

OR

3. The lesion is obstructing an orifice or impairing field vision

OR

4. The lesion significantly impacts on function e.g. restricts joint movement

OR

5. The lesion causes pressure symptoms e.g. on nerve or tissue

OR

6. If left untreated, more invasive intervention would be required for removal

OR

7. Facial viral warts

OR

8. Facial spider naevi in children causing significant psychological impact

Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

The following are **outside** the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines.
- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care.
- Removal of lesions other than those listed above.

Referral to dermatology or plastic surgery:

- The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria
- This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwre), independent providers, and community or intermediate services.

2.4 Face or brow lift

This procedure is not available on cosmetic grounds. This excludes the treatment of facial palsy.

2.5 Scar revision

This procedure is not available on cosmetic grounds.

An exception may be made for scars which significantly interfere with function (e.g. following burns) or where scarring is exceptionally severe

Treatments of symptomatic keloids is accessed via the SEL Community Dermatology Service on eRS and does not require an IFR application for access or any subsequent onward referral to plastic surgery.

2.6 Hair removal²

This procedure using laser is not available on the NHS as there is no evidence of permanent effect with any type of hair removal treatment. The exception is for those having undergone reconstructive surgery leading to abnormally located hair-bearing skin to areas not covered by normal clothing. Referrals should be made on a tertiary basis only.

2.7 Removal of birthmarks

This procedure using laser is available only for facial vascular birthmarks (port wine stains). Referrals should be made on a tertiary basis only.

2.8 Grommets for glue ear in children

The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met.

This procedure is available when criteria 1, 2 and 3 are met. Or exclusively when either 4a or 4b are met:

1. All children must have had specialist audiology and ENT assessment

AND

2. Persistent bilateral otitis media with effusion over a period of 3 months

AND

3. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz

OR exclusively in one of the following circumstances

² Hair removal evidence review. SEL Public Health Commissioning Support Group, 2015.

4a. Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

OR

4b. Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

Additional information

The guidance is different for children with Down's Syndrome and Cleft Palate; these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.

It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see: <https://www.nice.org.uk/Guidance/CG60>.

The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age).

2.9 Adjuvant adenoidectomy

Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion.

This guidance applies to children aged 18 years and under.

Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:

1. The child has persistent and / or frequent nasal obstruction which is contributing to by adenoidal hypertrophy (enlargement)

OR

2. The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion

OR

3. The child is undergoing grommet surgery for treatment of recurrent acute otitis media

The guidance only refers to children undergoing adenoidectomy for the treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be offered:

1. As part of treatment for obstructive sleep apnoea or sleep disorder breathing in children (e.g. as part of adenotonsillectomy)

OR

2. As part of the treatment of chronic rhinosinusitis in children

OR

3. For persistent nasal obstruction in children and adults with adenoidal hypertrophy

OR

4. In preparation for speech surgery in conjunction with the cleft surgery team

2.10 Tonsillectomy for recurrent tonsillitis

The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance.

Section 1

This procedure is available when criteria 1 and 2 and one of criteria 3a or 3b or 3c are met:

1. Sore throats are due to acute tonsillitis

AND

2. The episodes are disabling and prevent normal functioning

AND

3a. Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year

OR

3b. Five or more such episodes in each of the preceding two years

OR

3c. Three or more such episodes in each of the preceding three years

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment. In these instances one of the following should be met:

Section 2

1. Acute and chronic renal disease resulting from acute bacterial tonsillitis

OR

2. As part of the treatment of severe guttate psoriasis

OR

3. Metabolic disorders where periods of reduced oral intake could be dangerous to health.

OR

4. PFAPA (Periodic fever, Aphthous stomatitis, Pharyngitis, Cervical adenitis)

OR

5. Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Additional information

Further information on the Scottish Intercollegiate Guidelines Network guidance can be found here:
<http://www.sign.ac.uk/assets/sign117.pdf>

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:

- Obstructive Sleep Apnoea / Sleep disordered breathing in Children
- Suspected Cancer (e.g. asymmetry of tonsils)
- Recurrent Quinsy (abscess next to tonsil)
- Emergency Presentations (e.g. treatment of parapharyngeal abscess)

It is important to note that a national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults which may warrant review of this guidance in the near future.

2.11 Pinnaplasty in children (correction of prominent or bat ears)

This procedure is available when the following criteria is met:

1. The patient is under the age of 18 at the time of referral for significant prominent or bat ears

AND

2. where the prominence measures >30mm (using the measuring guide below):

Measuring guide

One of the most consistent methods for measuring the degree of prominence is the helical-mastoid (H-M) distance. Typically, the HM distance is 18-20 mm. As the H-M distance increases, the ear is perceived to be increasingly prominent. To be confirmed by a clinician.

Measure from the posterior aspect of the Helix.

Prominence = H-M distance > 20mm.

Pinnaplasty should only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids.

2.12 Septo-rhinoplasty (reshaping of the nose)³

This procedure is not available on cosmetic grounds.

Septo-rhinoplasty can be considered in cases involving severe nasal deformity with chronic and complete obstruction of at least one nostril due to congenital or traumatic causes and severe functional limitation must be demonstrated.

2.13 Blepharoplasty (eyelid reduction)

This procedure is not available on cosmetic grounds. It is available in instances where the upper eyelid skin interferes with the visual field reducing it to 120° laterally and 40° vertically.

Corrective surgery for patients who are dissatisfied with the cosmetic appearance post-surgery is not funded.

2.14 Chalazia removal

This procedure involves incision and curettage (scraping away) of the contents of the chalazion.

Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.

The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery

This procedure is available when one of the following criteria have been met:

Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks

OR

1. Interferes significantly with vision

OR

³ Septo-rhinoplasty evidence review. SEL Individual Funding Request Strategy Group, 2011.

2. Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy

OR

3. Is a source of infection that has required medical attention twice or more within a six month time frame

OR

4. Is a source of infection causing an abscess which requires drainage

OR

5. If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

2.15 Hysterectomy for heavy menstrual bleeding

Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88]

Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Hysterectomy should be considered only when:

1. Other treatment options have failed

OR

2. Where other treatment options are contradicted

OR

3a. There is a wish for amenorrhoea (no periods)

AND

3b. The woman (who has been fully informed) requests it

AND

3c. The woman no longer wishes to retain her uterus and fertility.

NICE guideline NG88 1.5 Management of HMB: When agreeing treatment options for HMB with women, take into account: the woman's preferences, any comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis when one of the following criteria are met:

1. Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

OR

2. If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.

Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

OR

3. If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices,

including: pharmacological options not already tried, surgical options: second-generation endometrial ablation, hysterectomy.

OR

4. For women with submucosal fibroids, consider hysteroscopic removal.

Treatments for women with fibroids of 3 cm or more in diameter

Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.

Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described for treating women with fibroids.

Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

2.16 Surgery for female genital prolapse⁴

Description of intervention

Pelvic organ prolapse (POP) can be defined as the downward descent of the female pelvic organs (vagina, uterus, bladder and/or rectum) into or beyond the vagina. It is difficult to determine exact prevalence, however it is estimated that between 30-76% of women will have some degree of POP.

Current management options for women with symptomatic POP include conservative (lifestyle modification and pelvic floor exercises), mechanical (vaginal pessary insertion) and surgical intervention.

Surgical management is generally reserved for patients where conservative interventions have failed or in patients who are highly symptomatic. Modes of surgery can be categorised into restorative (using

⁴ Female genital prolapse evidence review. SEL Health Care Advisory Group, 2019.

patient endogenous tissue to enhance support), compensatory (use of mesh) and obliterative (colpocleisis). The goals of surgery are to restore functional anatomy and improve symptoms. The type of surgical intervention varies depending on the prolapse category, patient preference and pre-morbidity.

Clinical criteria

- Conservative and mechanical interventions should remain first-line treatment for the majority of cases. This includes pelvic floor muscle exercises and vaginal pessaries.
- Surgery should be offered to women in whom conservative management fails or if declined.
- Referral for further investigation or specialist opinion is appropriate in certain cases including pain and patients presenting with obstructive symptoms/incontinence.
- Adequate pre-operative counselling is crucial prior to any surgical intervention.
- Use of mesh should be avoided unless clearly clinically indicated and only if agreed by regional MDT. Risk of complication must be discussed with the patient

Rationale for recommendations

Current NICE guidelines [2017] state that mesh can be used provided that arrangements are in place for clinical audit, clinical governance and research (14; 15; 16; 17; 18), although use of mesh in transvaginal repair of anterior or posterior prolapse, in addition to laparoscopic mesh pectopexy for apical prolapse of the uterus or vagina should be used in the context of research only (19; 20). New guidelines are in development with a draft proposal suggesting mesh can be considered on a case-by-case basis, if an abdominal approach is contraindicated or if apical support is adequate and the risks are explained and accepted by the patient and agreed by a regional MDT (21).

The evidence for efficacy of surgical intervention in POP is varied, as are rates of recurrence, pending on procedure and patient pre-morbid status. There is currently limited evidence as to the best surgical technique, and thus it is clinician dependent and is individualised to patient needs.

There was limited data directly comparing success rates of conservative and surgical intervention. Further analysis is needed to determine the differences in efficacy between these two treatment groups.

2.17 Medical circumcision

Some circumcisions are requested for social, cultural or religious reasons; these procedures will not be funded on the NHS.

Medical penile circumcision is rarely indicated as a primary treatment. Most children presenting with penile problems require no intervention other than reassurance. Penile circumcision should only be performed for:

1. *Prevention of urinary tract infection in patients with an abnormal urinary tract

OR

2. Balanitis xerotica obliterans

OR

3. Persistent phimosis in children approaching puberty

OR

4. Recurrent balanoposthitis

ALL patients must have: Attempted a trial of non-operative interventions (*note this does not apply for the first indication above)

AND

A formally documented discussion of the risks and benefits of foreskin preserving surgery versus penile circumcision using a shared decision making framework. This guidance applies to children and young people under 18 years. This guidance excludes children with congenital penile conditions such as hypospadias.

2.18 Carpal tunnel syndrome release

Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

1. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)

OR

2. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:

1. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks

OR

2. A permanent (ever-present) reduction in sensation in the median nerve distribution;

OR

3. Muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

2.19 Dupuytren's contracture release in adults

Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.

An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for:

1. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint.

OR

2. severe thumb contractures which interfere with function

NICE concluded that collagenase should only be used for:

1. Participants in the ongoing clinical trial (HTA-15/102/04)

OR

2. Adult patients with a palpable cord if:

(a) there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints;

AND

(b) needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon.

2.20 Ganglion excision

Section 1: Wrist ganglia

Ganglion excision can proceed when 1 and 3 or 2 and 3 of the following criteria are met:

1. No treatment unless causing pain or tingling/numbness or concern (worried it is a cancer)

OR

2. Aspiration if causing pain, tingling/numbness or concern

AND

3. Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.

Section 2: Seed ganglia that are painful

Proceed when one of the following criteria are met:

1. Puncture/aspirate the ganglion using a hypodermic needle

OR

2. Surgical excision only considered if ganglion persists or recurs after puncture/aspiration

Section 2: Mucous cysts

Proceed when one of the following criteria are met:

1. No surgery considered unless recurrent spontaneous discharge of fluid

OR

2. Significant nail deformity

2.21 Trigger finger release in adults

Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with:

1. One or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics

OR

2. Splinting of the affected finger for 3-12 weeks (weak evidence).

Surgery should be considered if:

1. The triggering persists or recurs after one of the above measures (particularly steroid injections);

OR

2. The finger is permanently locked in the palm

OR

3. The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods

OR

4. Diabetics

Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

2.22 Hip arthroplasty⁵

Hip replacement surgery is available for patients who meet ALL of the following criteria:

1. The patient has osteoarthritis with joint symptoms (pain, stiffness and reduced function) that have a substantial impact on quality of life as agreed with the patient and / or the patient's representative, referring clinicians and surgeons

AND

2. The symptoms are refractory to non-surgical treatment (including analgesia, exercise, physiotherapy and weight loss, where appropriate)

AND

3. The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this

AND

4. The patient has been engaged in shared decision making regarding treatment options.

Exclusions:

- Children
- Patients with confirmed or suspected malignancy, acute trauma, suspected infection and inflammatory arthropathy
- Patients with underlying disease (such as haemophilia or sickle cell) related hip disease
- Young adults with abnormal hip anatomy

2.23 Knee arthroplasty⁶

Total or partial knee replacement surgery is available for patients who meet ALL of the following criteria:

1. Osteoarthritis with joint symptoms (pain, stiffness, reduced function, joint instability) that have a substantial impact on quality of life as agreed with the patient and/or the patient's representative, referring clinicians and surgeons

AND

2. The symptoms are refractory to non-surgical treatment (including pain relief, exercise, physiotherapy and weight loss where appropriate)

AND

3. The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this

AND

4. The patient has been engaged in shared decision making regarding treatment options

Exclusions:

- Patients with joint failure from causes other than degenerative disease / osteoarthritis

⁵ London Choosing Wisely, NHS England, 2018.

- Patients with confirmed or suspected malignancy
- Patients with acute trauma or suspected infection
- Patients with inflammatory arthropathies
- Paediatric patients

2.24 Bunion surgery⁶

There are a number of surgical options for Hallux valgus, including soft tissue procedures, osteotomy, arthrodesis, arthroplasty, and joint replacement surgery. The Royal College of Surgeons (RCS) guidance states that there is no conclusive evidence of the superiority of one operation over another, and that the procedure selected will depend on patient signs and symptoms and patient choice, having considered with the surgeon the risks and benefits of each.

Patients may be referred for surgery for bunions when the following criteria are met:

- Failure of appropriate conservative measures (e.g. oral analgesia, orthotics, bunion pads, ice packs or footwear advice from podiatry) after three months.
- Persistent pain and disability, or significant disruption to lifestyle or activities, not responding to up to 12 weeks of non-surgical treatments; this time to include any treatment received in primary care.
- Patient must be prepared to undergo surgery understanding that they will be out of sedentary work for 2- 6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks (2 weeks if left foot and driving automatic car).
- Patient must also understand that recurrence of deformity after hallux valgus surgery occurs in 8-15% of patients, and the risk of complications or side-effects of surgery.
- Patients should be informed that the decision to have surgery can be a dynamic process and that a decision to not undergo surgery does not exclude them from having surgery at a later date.
- Patients with significant co-morbidities [systemic or local] should have treatment which optimises these before referral.
- For clarification, co-morbidities must be managed through a shared decision making process with the patient, enabling patients to make joint decisions on referral and treatment.
- Surgery must not be undertaken for prophylactic or cosmetic reasons

If the patient has diabetes, they should be referred to the diabetic foot surgery service.

Rationale for recommendation

Hallux valgus is a common foot deformity, which can lead to functional disability, pain in the foot, impaired gait pattern, poor balance and falls in older people. For patients with diabetes, untreated bunions can lead to ulceration and deep infection. Hallux valgus is common with a prevalence of 28.4% in adults older than 40 years.

Conservative treatments are recommended initially, as most bunion pain can be alleviated by modifying activities and/or shoes.

The Royal College of Surgeons (RCS) advises that the majority of patients with great toe deformity (such as those with bunions, but including other conditions) and mild pain are expected to be managed in primary care, with referral to a specialist provider such as musculoskeletal (MSK) physiotherapy, podiatry (non-surgical and surgical) and orthotics * for patients meeting certain criteria.

⁶ Surgery for bunions evidence review. SEL Health Care Advisory Group, 2019.

*Devices such as shoe inserts or foot pads placed to correct foot problems without surgery

Referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes.

Surgery entails a long recovery time, and small risks of complications. If pain is bearable, the RCS recommends that there is no harm in delaying surgery and that surgery is successful even for more severe bunions and at older age.

Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery.

2.25 Arthroscopic shoulder decompression for subacromial shoulder pain

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases.

“Pure subacromial shoulder impingement” means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

2.26 Shoulder arthroscopy for other conditions⁷

Shoulder arthroscopy should be offered for treatment purposes if one of the below criteria is met.

1. Full thickness rotator cuff tear diagnosed through analysis of clinical picture and imaging.

OR

2. Partial thickness rotator cuff tear diagnosed through analysis of clinical picture and imaging which has failed to respond to 3 months conservative management.

OR

3. Adhesive capsulitis diagnosed according to the clinical picture which has failed to respond to 6 months of conservative management.

OR

4. Shoulder joint instability diagnosed according to clinical picture which has failed to respond to 6 months of conservative management.

OR

5. Major superior labrum anterior posterior tear diagnosed through analysis of clinical picture and imaging.

OR

6. Minor superior labrum anterior posterior tear diagnosed through analysis of clinical picture and imaging which has failed to respond to 3 months of conservative management.

OR

7. Impingement syndrome diagnosed according to clinical picture which has failed to respond to 6 months of conservative management.

⁷ Shoulder arthroscopy evidence review. SEL Health Care Advisory Group, 2019.

The arthroscopy will not be commissioned for solely diagnostic purposes. For traumatic injury or dislocation, there should be referral to secondary care for T&O opinion.

2.27 Open MRI

Open MRI is limited to:

1. Patients who suffer from claustrophobia where an oral prescription sedative has not been effective
OR
 2. Patients who are obese and cannot fit comfortably in conventional MRI scanners as determined by a Consultant Radiologist/Radiology department policy
OR
 3. Patients who cannot lie properly in conventional MRI scanners because of severe pain
AND
- There is a clear diagnostic need consistent with supported clinical pathways

2.28 Varicose veins

Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

Refer people to a vascular service if one of the following criteria is met:

1. Symptomatic * primary or recurrent varicose veins
OR
2. Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency
OR
3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence
OR
4. A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks)
OR
5. A healed venous leg ulcer

*Symptomatic: "veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching" [NICE CG 168]

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment.

Refer people with bleeding varicose veins to a vascular service immediately.

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

2.29 Haemorrhoid surgery

Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will

respond to outpatient treatment in the form of banding or perhaps injection. Surgical treatment should only be considered for those that:

1. Do not respond to these non-operative measures outlined above

OR if the haemorrhoids are more severe

2. Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding

OR

3. Irreducible and large external haemorrhoids

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.