PROCEDURES OF LIMITED CLINICAL VALUE (PLCV)

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Consultation

Consultee	**Date**
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2	Nov 2014	See version control document for changes
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Document Status

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TABLE OF CONTENTS

PURPOSE OF THE POLICY

The purpose of the Clinical Commissioning Referral Policies Procedures of Limited Clinical Value (PLCV) Policy is to clarify the commissioning intentions of Clinical Commissioning Groups (CCGs) across Derbyshire who consist of Erewash Clinical Commissioning Group, Hardwick Clinical Commissioning Group, North Derbyshire Clinical Commissioning Group and Southern Derbyshire Clinical Commissioning Group in respect of procedures of limited clinical value. All on-going reference to the four Derbyshire CCGs in this policy will be referred to as the CCGs.

Please note, this document does not reference those interventions where the CCGs have previously published policy statements setting out restrictions/criteria/prior approval requirements.

NHS Funds

Clinical Commissioning Groups (CCGs) buy healthcare on behalf of the local population. The money for this comes from a fixed budget. By law, we are required to keep within this budget.

Demand for healthcare is greater than can be funded from this fixed budget. Unfortunately, this means that some healthcare which patients might wish to receive and which professionals might wish to offer cannot be funded. This has always been the situation since the start of the NHS.

Assessing what the overall population most needs

Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed.

This assessment of need is made across the whole population and wherever possible, on the basis of best evidence about what works. We also aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services. This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations.

One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which do not work well enough to justify any use within the local NHS. The Derbyshire policy group aim is to continue to review the list of procedures to ensure that it reflects the best available evidence and are affordable and fair.

Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied. Where a patient satisfies the threshold statement or criteria the procedure or treatment is prior approved and can be undertaken. Where the threshold statement or criteria are not met then the procedure or treatment is excluded for that patient.

1. EQUALITY STATEMENT

Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs aim is to design and implement policy documents that meet the diverse needs of the populations to be served and the NHS workforce has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012.

The CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, disability (including learning disability), gender reassignment, and marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equality of opportunity for all. This document has been designed to ensure that no-one receives less favourable treatment owing to their personal circumstances.

2. DUE REGARD

In carrying out their functions, the Derbyshire Affiliated Commissioning Policy Committee made up of Derbyshire CCGs is committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the CCGs are responsible, including policy development and review.

3. INTRODUCTIONS

The purpose of this policy is to ensure that CCGs and their successor organisations fund treatment only for clinically effective interventions delivered to the right patients at the right place. It sets out the treatments deemed to be of insufficient priority to justify funding from the available fixed budget.

This policy has been developed to support the decision making process associated with the allocation of resources for commissioning. It will be used to support the development of effective, efficient and ethical agreements with provider organisations.

The policy establishes the framework within which CCGs can demonstrate that its decision making processes are fair, equitable, ethical and legally sound.

4. DEFINITIONS

Procedures of limited clinical value (PLCV) are those which deliver a relatively poor output/outcome to the population. In this policy, the term PLCV is extended to include procedures which may be effective but where there may be significant differences in value depending on the setting in which the procedure is delivered (usually due to large differences in pricing between providers).

Procedures of limited clinical value and low value procedures are those which:

4.1 Have clear evidence that they are ineffective.

4.2 Have no evidence of effectiveness and are **not** being delivered in a context that would allow the gathering of an evidence base to judge effectiveness, i.e. through ethically approved research.

4.3 Have evidence of effectiveness but are being offered to patients whose characteristics are different from the characteristics of the patients in the research studies which produced the evidence for effectiveness.

4.4 Use resources that would produce more value, namely a better balance of benefit, if invested in some other service for the same group of patients for example, the procedure is of better value when delivered in a specific setting.

4.5 Low level of evidence with associated high cost verses current standard practice.

4.6 Definition of a child: Unless otherwise defined within the policy a child is defined as an individual who has not yet reached their 18th birthday.

Within this document the terms “procedure of limited clinical value” and “low priority procedure” are used synonymously.

5. HEALTH OPTIMISATION

Any surgical intervention carries a risk, however small, to the patient. These risks are increased in those who are overweight/ obese or who smoke. When surgery is planned this is an ideal opportunity to encourage patients to stop smoking and reduce their weight in order to reduce their risks and improve their recovery and outcomes. This should usually be achieved by referral to an appropriate lifestyle service and is likely to reduce complications, reducing associated length of stay and other healthcare costs. Care should also be taken to maximise the management of any long-term conditions, e.g. Chronic Obstructive Airways Disease, Diabetes etc., prior to referral to secondary care.

6. BACKGROUND

CCGs receive the funding to commission health services for their resident populations and make decisions within the context of statutes, statutory instruments, regulations and guidance. CCGs have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them. They are required to commission comprehensive, effective, accessible services which are free to users at the point of entry (except where there are defined charges) within a finite resource. It is, therefore, necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.

This Policy is designed to help CCGs to meet this obligation in providing equitable access to health care. It aims to achieve this by supporting a robust decision making process that is reasonable and open to scrutiny.

7. OPERATING POLICY FOR THE DEVELOPMENT AND IMPLEMENTATION

A number of national and local organisations, such as National Institute for Health and Clinical Excellence (NICE), have developed evidence based advice to inform commissioning decisions on low priority treatments. These treatments or procedures are not usually funded by the NHS. In addition CCGs have responsibility to decide the priorities for commissioning in line with agreed criteria.

7.1 Making Commissioning Decisions

Commissioning involves specifying, securing and monitoring services that are evidence-based, cost effective, of high quality and meet individuals "needs" and provide "value for money in the use of public resources".

7.2 Determining the Evidence Base

Evidence for treatment effectiveness and efficacy is available from many sources, including NICE, Cochrane Institute, Royal Colleges, Professional guidelines, and sources such as peer reviewed journals or technical notes. Evidence varies in its robustness, ranging from meta-analyses of randomised control trials with large populations of participants, to traditional consensus about best practice. CCGs have considered the source, extent and quality of the evidence in reaching their decisions.

7.3 Managing Exceptions

In their dealings with patients and the public providers should, if necessary, make it clear that the decision by NHS Commissioners to consider treatments or procedures to be of low priority under this policy is a considered decision made against their responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them and that it is necessary for the NHS Commissioners to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the local population.

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Where individual patient circumstances require the escalation of their care providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests,

7.4 Ethical and Legal Policy for Decision Making

The CCG has a Decision-Making Framework which is kept under review by the CCGs individual Governing Bodies.

7.5 Implementation

The PLCV schedule is set out below and can be incorporated into contractual and service level agreements. Derbyshire CCGs will require primary and secondary care service providers to embrace and abide by the policy and advise patients accordingly.

7.5.1 The Schedule of PLCV

The schedule is informed by indicative codes. There may be cases where a code is not included but the procedure is called the same; it should be assumed that the threshold will apply in the same way.

This policy should be read in conjunction with other policies e.g. East Midlands Commissioning Policy for Cosmetic Procedures 2014.

7.5.2 Distribution

All providers, all referrers, secondary care services, primary care services, community care services, associate commissioners.

8. MONITORING THE POLICY

8.1 NHS Commissioners will monitor the adherence to this policy through the contractual process, using contractual levers where breaches of the Policy are identified.

8.2 Referrals to secondary care that are outside of this Policy will be routinely monitored by the Commissioning Management and the Contracts Management Teams of the NHS Commissioners.

8.3 NHS Commissioners will provide periodic reports to their reporting committees reporting the number and nature of breaches of the Policy, by provider and by procedure.

8.4 Where there are defined thresholds, the compliance with the criteria will be subject to regular clinical audits carried out or organised by NHS Commissioners. The audit process will require providers to produce patient specific evidence that confirms the threshold criteria for procedures were satisfied at the time the decision to offer the procedure to the patient was taken. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the threshold criteria were met at the time the decision to perform the procedure was taken, then the default will be to consider the procedure was excluded and therefore it will not attract payment from the NHS Commissioners.

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8.5 NHS Commissioners reserve the right to reduce the value of all payments for procedures with OPCS codes that match those for Excluded and Restricted procedures (as listed within this policy).

8.6 Any procedures marked as ‘Requires Prior Approval’ must be approved by CCGs before the surgery is undertaken using the agreed form. Commissioners will not pay for any procedures undertaken without the required approval from the responsible commissioner.

9. MAINTAINING AN UP TO DATE POLICY

CCGs will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the CCGs is to:

- monitor the implementation of the policy and the impact it has on clinical decision making;
- inform referrers including all Primary Care Practitioners, medical or non-medical;
- inform all service providers, with whom the CCG has formal contractual arrangements, of the policy;
- review the policy and the accompanying schedule on a 2 yearly basis or where an urgent consideration of new evidence is justified.

10. COMMISSIONING OF NICE INTERVENTIONAL PROCEDURES GUIDANCE (IPG)

Whilst information regarding the commissioning of NICE Interventional Procedure Guidance (IPGs), is not included within the scope of this policy, it should be noted that the CCGs will not commission any IPG without the submission and subsequent approval of a robust, evidence based business case.

Should new evidence emerge a provider must submit a robust evidenced based business case for consideration if it wishes the commissioner to fund a service, as would be the case for any new service. The CCGs reserve the right at all times to maintain their current commissioning decisions for all procedures/treatments contained within this Policy, including after consideration of such a business case should it not meet the criteria of clinical effectiveness, cost effectiveness and affordability.

NOT ROUTINELY COMMISSIONED PROCEDURE LIST

The procedures listed below are NOT routinely commissioned	
Cosmetic Procedures (for further information see East Midlands Commissioning Policy for Cosmetic Procedures 2014)	Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm or other areas.
	Facelifts -unless part of the treatment of facial nerve palsy/congenital facial abnormalities/ treatment of specific facial skin condition e.g. cutis laxa, pseudoxanthoma elasticum
	Fat grafts except in post-trauma cases and/or as part of planned reconstruction surgery (e.g. for cancer)
	Suction assisted lipectomy (liposuction) except as part of planned reconstruction surgery e.g. for cancer or a congenital syndrome
	Labiaplasty, vaginoplasty, and hymen reconstruction P055 P056 P057
	Phalloplasty
	Chin implant (genioplasty, mentoplasty) /cheek implants except in post trauma cases and/or as part of planned reconstruction following surgery (e.g. for cancer)
	Collagen implant except in post-trauma cases and/or as part of planned reconstruction following surgery e.g. for cancer
	Cranial banding for positional plagiocephaly
	Earlobe repair
	Botulinum Toxin for wrinkles, frown lines or aging neck
	Resurfacing by laser for skin conditions causing scarring – including post-acne and post-traumatic scarring
	Correction of nipple inversion
	Mastoplexy (breast uplift) except where criteria are fulfilled
	Procedures related to gender reassignment not included in the original package of care
	Hair depilation (removal) for excessive hair growth (hirsutism)
	Hair transplantation
	Laser treatment for facial hyperpigmentation unless criteria are met
	Electrolysis treatment for any condition
	Scar reduction unless it meets criteria
ENT	Surgery / Treatment for snoring
General Surgery	Anal / rectal skin tags,
	Cholecystectomy for asymptomatic gallstones
Gynaecology and Fertility	Reversal of female sterilisation
	Reversal of male sterilisation
Ophthalmology	Laser treatment of myopia
Orthopaedics	Autologous Chondrocyte Implantation
	Hip Arthroscopy
	Knee diagnostic arthroscopy
	Shoulder resurfacing arthroplasty
	Therapeutic use of ultrasound in hip and knee osteoarthritis
	Joint Fascit injections
Therapies	Acupuncture (all)

EAR NOSE AND THROAT (ENT)	
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Grommets (Restricted) **Children**	The Commissioner will fund treatment with grommets for children, who are over the age of two, who have otitis media with effusion (OME) where: OME persists after a period of at least three months watchful waiting from the date that the problem was first identified by the GP to the date of referral. During this time, auto inflation should be offered as part of self-care and purchased 'over the counter' in those children thought to tolerate the procedure (usually at least 3 years old). If these do not improve symptoms, children can be referred if they have one of the following: A. There have been at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment in the last 12 months. In cases of recurrent OME, adenoidectomy may be considered as an additional treatment with grommets. B. There is hearing loss of at least 25dB, particularly in the lower tones (low frequency loss). C. There is evidence of delay in speech development; educational or behavioural problems attributable to the hearing loss or a significant second disability that may itself lead to developmental problems, e.g. Down's syndrome, Turner's syndrome of a cleft palate.
Adults	The commissioner will fund grommets in adults with OME if at least one of the following criterias are met A. A period of 3 months of watchful waiting prior to referral. Significant negative middle ear pressure measured on two sequential appointments, with no resolution within 3 months of first presentation. During this time, auto inflation should be offered as part of self-care and purchased 'over the counter'. If these do not improve symptoms, hearing aids should be the next intervention offered prior to further treatment. B. Repetitive acute otitis media (AOM) (3 episodes in 6 months or 4 in 12 months) when it doesn't respond to ongoing antibiotic therapy and impairs speech, hearing or both. C. Barotrauma (persistent Eustachian tube dysfunction): Damage from changes in pressure, such as scuba diving or flying, causing pain. D. Unilateral middle ear effusion where a post nasal space examination and/or biospy is required to exclude an underlying malignancy.
Base / Evidence **ENT**	Criteria based on NICE Clinical Guidance 60: Surgical Management of Otitis Media with Effusion in Children, 2008 Medtech innovation briefing Published: 15 March 2016: NICE.org.uk/guidance/mib59-CSR can be found at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006285.pub2/full Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis, Author : Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ Journal: Health Technology Assessment Volume: 18 Issue: 5 Publication date: January 2014 DOI: http://dx.doi.org/10.3310/hta18050

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Tonsillectomy and/or Adenoidectomy (Restricted)	The Commissioner will fund tonsillectomy for indications A or B in adults or children. It will fund tonsillectomy for indication C in children only. **A.** Any of the following: Suspected malignancy More than one episode of peri-tonsillar abscess (quinsy) Acute upper airways obstruction **B.** Recurrent sore throat where criteria 1 and 2 both apply and the principlal cause is tonsillitis: 1. 7 or more eligible episodes in the last year OR 5 or more eligible episodes in each of the last 2 years OR 3 or more eligible episodes in each of the last 3 years NB. An "eligible episode" must have three of the following criteria: • Tonsillar exudates • Tender anterior cervical lymph nodes • History of fever (>38^{o} C) • Absence of cough [Centor clinical predicition score] 2. A significant and documented impact on quality of life e.g.absence from school/work. **C.** The Commissioner will fund tonsillectomy and/or adenoidectomy for any of the following indications with approval for each case required prior to the procedure: • Failure to thrive due to difficulty eating solid foods. • A strong clinical history suggestive of sleep apnoea. • A significant impact on quality of life e.g. loud and persistent noisy / mouth breathing leading to social difficulties, difficulty eating solid foods that creates unreasonably slow eating, difficulity exercising. NB: The case is much more likely to be approved where there is supporting evidence such as growth charts, letters from GPs employer or school.
Base / Evidence	[Taken from SIGN guidelines 117 – management of sore throat]

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Surgical Treatment Sleep Apnoea (Restricted) **Secondary** ⇨	The Commissioner will fund surgical treatment of sleep apnoea when one of criteria 1 is met along with 2, 3 and 4 1. Patient has already tried continuous positive airways pressure (CPAP) unsuccessfuly for 6 months prior to being considered for surgery OR patient had major side effects to CPAP such as significant nosebleeds. 2. Patient has a score of greater than or equal to 15 on the Epworth Sleepiness Scale OR patient is sleepy in dangerous situations such as driving or operating machinery (i.e. has significant symptoms regardless of Epworth sleepiness scale score) 3. Patient has significant sleep disordered breathing (as measured during a sleep study, usually by the Apnoea/Hypopnoea Index: 15- 30/hr = moderate, > 30/h = severe) 4. Referral has been made to a weight management service where the patient is overweight or obese. Additional notes: **Secondary** ⇨ Palatal surgery, such as Uvulopalatopharyngoplasty and Laser assisted uvulopalatoplasty is not recommended by SIGN (2003) and it may compromise the patient's subsequent abilitiy to use nasal CPAP. Soft palate implants should not be used in the treatment of this condition.
Base / Evidence **Sleep Apnoea**	Taken from SIGN guidelines 117 – management of sore throat, 2010 A multicentre randomised controlled trial and economic evaluation of continuous positive airways pressure for the treatment of obstructive sleep apnoea syndrome in older people: PREDICT Health Technology Assessment, No 19.40;2015 Alison McMillan, Daniel J Bratton, Rita Faria, Magda Laskawiec-Szkonter, Susan Griffin, Robert J Davies, Andrew J Nunn, John R Stradling, Renata L Rhia and Mary J Morrell. Health Technol Assess. 18 October 2014 (67): 1-296.doi: 10.3310/hta 18670. Clinical effectiveness and cost effectiveness results from the randomised controlled Trial or Oral Mandibular Advancement Devices for Obstructive sleep apnoea hypopnoea (TOMADO) and long-term economic analysis of oral devices and continuous pressure. Sharples L1, Glover M2, Clutterbuck-James A3, Bennett M4, Jordan J2, Chadwick R3, Pittman M3, east C3, Cameron M5, Davies M3.

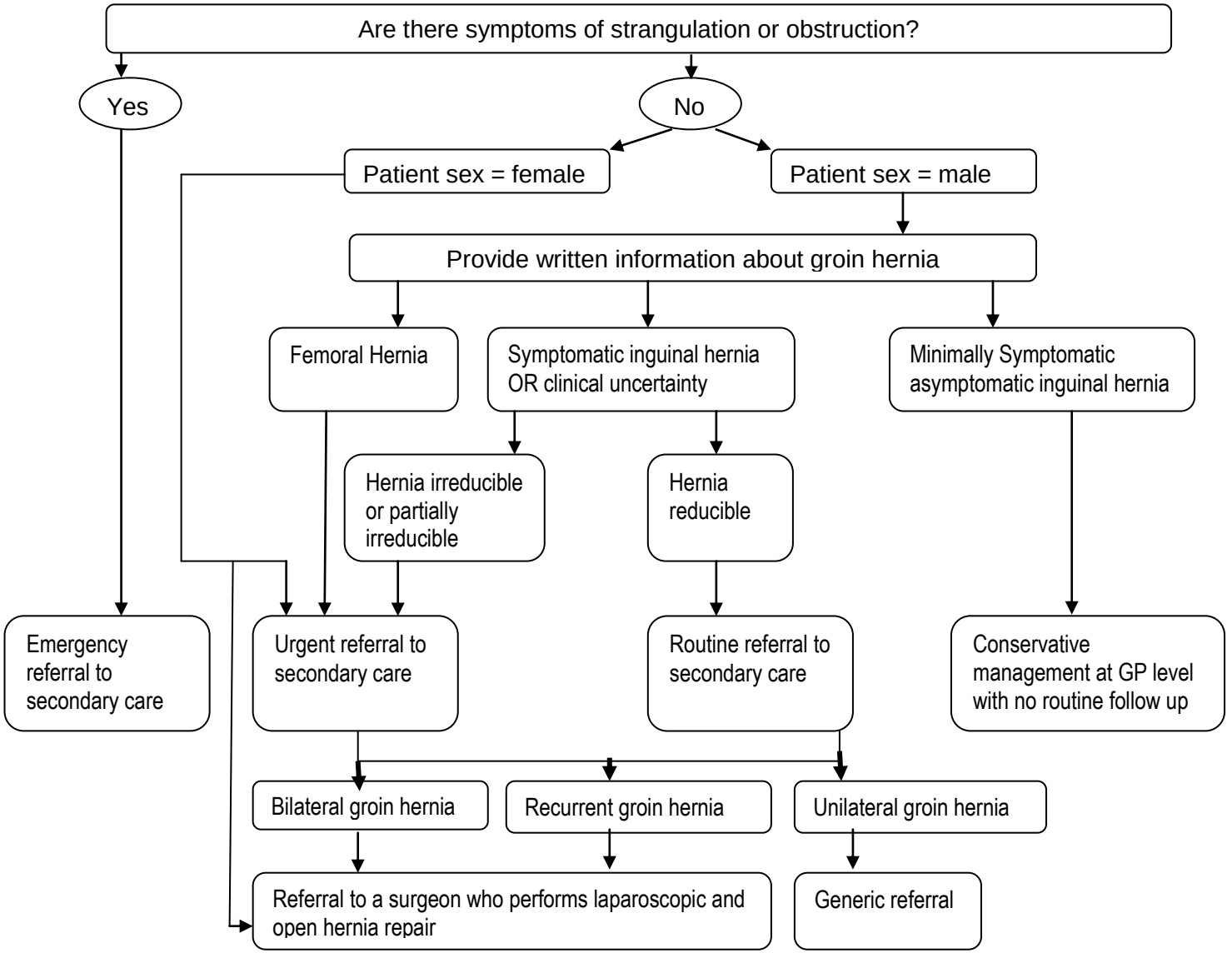
GENERAL SURGERY	
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Cholecystectomy	The CCG does not routinely fund removal of the gallbladder for asymptomatic gall stones. Asymptomatic gallstones are gallstones found incidentally when having an ultrasound for another reason unconnected to galllstone disease and in patients who have been symptom free for at least 12 months. The CCG will **only** fund the treatment if one of the following criteria are met: • Patient has diabetes mellitus, is a transplant recipient or has cirrhosis, and has been managed conservatelively but subsequently develops symptoms which cause significant functional impairment. • Where there is clear evidience from an ultrasound scan that the patient is at riskl of gallbladder carcinoma. • Confirmed episode of gall stome induced pancreatitis. • Confimred episode of cholecystitis • Confimred episode of obstructive jaundice caused by billary calculi
Base /Evidence	The NICE Clinical Guideline (2014) on gallstone disease recommended that onkly symptomatic gallstone should be treated with laparoscopic cholecytectomy. 20% of the adult population have asymptomatic gallstones and 70% of these will never have a clinical event. The incidence of developing symptoms is 2-4% per annum.

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Surgical Haemorrhoidectomy (Restricted)	The Commissioner will only fund treatment for Surgical Haemorrhoidectomy if indication A or B is met: A. Recurrent and persistent bleeding that fails to respond to conservative treatment. Patients should be recommended to try the following options in primary care- • Oral fluid intake, high fibre diet and fibre supplementation • Topical treatment • Rubber band ligation (dependent on training and equipment availability within primary care) B. Haemorrhoids that cannot be successfully reduced. Alternative treatment within secondary care should also be considered prior to referral / surgery which include- • Injection sclerotherapy • Infrared coagulation/photocoagulation • Direct current electrotherapy
Base Evidence	https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/rectal-bleeding-guide/ RCS Commissioning Guide 2013 Other non surgical treatment mentioned in NICE CKS https://cks.nice.org.uk/haemorrhoids

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Hernia (Restricted) Groin Hernia (including inguinal and femoral) Other hernia procedures	Primary Care Referral Guidelines: • Refer all patients with an overt or suspected symptomatic inguinal hernia. Male patients with asymptomatic or minimally symptomatic inguinal hernias should be managed by watchful waiting. • Refer all overt or suspected femoral hernias • irreducible and partially reducible inguinal hernias, and all groin hernias in women should be **"urgent referrals"** • Patients with suspected strangulated or obstructed inguinal hernia should be '**emergency referrals'** • All children < 18 years with inguinal hernia should be referred to a paediatric surgical provider • Modifiable risk factors such as smoking cessation, diabetic control and weight reduction should be optimised in the primary care setting prior to referral for elective surgery.
Base Evidence	Commissioning guide: Groin Hernia (Nov 2016), Royal College of Surgeons and British Hernia Society Laparoscopic surgery for inguinal hernia repair; Technology appraisal guidance [TA83] Published: 22 September 2004 The clinical effectivieness and cost effectiveness of open mesh repairs in adults presenting with a clinically diagnosed primary unilateral inguinal hernia who are operated in an elective setting: systematic review and economic evaluation Sharma P et al Health Technol Assess 2015; 19(92). https://www.journalslibrary.nihr.ac.uk/hta/hta9140/#/abstract Awaiting additional references here from RD

Procedure

Primary care flow diagram



Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure

Gastroscopy for Dyspepsia (Restricted)	Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without ALARM signs, is not necessary.
	
	The CCGs will only fund gastroscopy for dyspepsia in urgent cases and patients with alarm signs and symptoms.
	
	Offer urgent direct access upper gastrointestinal endoscopy (to be performed within 2 weeks) to assess for oesophago-gastric cancer in people with:
	• Chronic gastrointestinal bleeding
	• Progressive unintentional weight loss
	• Progressive dysphagia
	or
	• aged 55 and over with weight loss and any of the following:
	  • upper abdominal pain
	  • reflux
	  • dyspepsia
	
	Consider non-urgent upper gastrointestinal endoscopy to assess for oesophago-gastric cancer in people:
	
	• aged 55 years and older with unexplained and persistent recent onset dyspesia
	• upper abdominal pain with low haemoglobin levels
	or
	• raised platelet count with any of the following:
	  • nausea
	  • vomiting
	  • weight loss
	  • reflux
	  • dyspepsia
	  • upper abdominal pain
	or
	• nausea or vomiting with any of the following:
	  • weight loss
	  • reflux
	  • upper abdominal pain
	
	NICE states: do not routinely offer endoscopy to diagnose Barrett's oesophagus, but consider it if the person has GORD. Discuss the person's preferences and their individual risk factors (for example, long duration of symptoms, increased frequency of symptoms, previous esophagitis, previous hiatus hernia, oesophageal stricture or oesophageal ulcers, or male gender).

	Refer to Derbyshire Medicines Management Dyspepsia and GORD Clinical Guideline http://www.derbyshiremedicinesmanagement.nhs.uk/assets/ClinicalGuidelines/Formularyby BNFchapter prescribing guidelines/BNF chapter 1/Dysepsia&GOD.pdf No restrictions are applied to gastroscopy for indications other than dyspepsia.
Base Evidence	1, 2 and 3 are taken from or based on susepected cancer: recognition and referral NICE guidelines [NG12] Published date: June 2015 Taken directly from NICE cg 184 Dyspepsia and gastro-esophageal reflux disease; Investigation and management of dyspepsia, symptoms suggestive of gastro-esophageal reflux disease, or both. http://www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/chapter_1/

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Varicose Veins (Restricted) **Secondary** ⇨ See East Midlands Commissioning Policy for Cosmetic Procedures 2014 **Secondary** ⇨	The CCGs will only fund surgical treatment of varicose veins when **ALL** the following criteria are met: • Appropriate weight management advice has been given to those with a raised BMI, including referral for weight management where appropriate • Non-smoker or referral made to smoking cessation service and ○ confirmed abstinence for at least 6 weeks prior to procedure . **AND** one or more of the following clinical indications are present: • Patient has lipodermatosclerosis, venous eczema or a venous ulcer • Patient has had, superficial thrombophlebitis with suspected venous incompetence as the most likely cause • Patient has had a major episode of bleeding from the varicosity **Surgical treatment will only be funded if the following procedures have been offered prior to surgery if appropriate or available:** • Endothermal ablation, • Ultrasound-guided foam sclerotherapy • Endovernous laser treatment of the long saphenous vein
Base Evidence	NICE QS 67 Aug 2014 varicose veins in the Legs https://www.abdn.ac.uk/heru/documents/Policy_Briefs/HERU_PB_April_2015.pdf Varicose veins: diagnosis and management clinical guidelines [CG168] Published date: July2013 (reviewed in June 2015 but nothing further to add)

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Irritable Bowel Syndrome	The management of IBS is commissioned according to the Medicines Management Guideline. Refer people with possible IBS symptoms to secondary care for further investigation if they have any of the following **'red flag'** indicators: • Unintentional and unexplained weight loss • Rectal bleeding • A family history of bowel or ovarian cancer • If aged >60 years, a change in bowel habit lasting >6 weeks with looser and/or more frequent stools Assess and clinically examine all people with IBS symptoms for the following **'red flag'** indicators. Refer to secondary care for further investigation if any are present: • Anaemia • Abdominal or rectal mass • Inflammatory markers for inflammatory bowel disease Consider assessment for IBS if the following symptoms persist for at least 6 months: • Abdominal pain or discomfort • Bloating • Change in bowel habit Faecal calprotectin testing is recommended as an option to support clinicians with the differential diagnosis of inflammatory bowel disease (IBD) or irritable bowel syndrome (IBS) in adults with recent onset lower gastrointestinal symptoms for whom specialist assessment is being considered, if cancer is not suspected, having considered the risk factors (for example, age) Measure serum CA125 in any woman of 50 or over who has experienced symptoms within the last 12 months of IBS; IBS rarely presents for the first time in women of this age (NICE National Guidance 12 – Suspected Cancer) People with IBS should be given information about self-help including information on general lifestyle, physical activity, diet and symptom-targeted medication Advise people with IBS how to adjust their doses of laxatives or anti-motility agent according to clinical response Tricyclic antidepressants may be considered as a second line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped
Base Evidence	Derbyshire Medicines Management Clinical Guidelines Primary care management of Irritable Bowel Syndrome (IBS)

GYNAECOLOGY AND FERTILITY	
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Elective/Planned Caesarean Section (Restricted)	Derbyshire CCGs routinely commission elective caesarean sections in line with the requirements stipulated by NICE CG132. Elective caesarean section will only be commissioned for women who do not meet the requirements stipulated in NICE CG132 if the decision has been made on clinical grounds by more than one consultant, at least one of whom is a consultant obstetrician. A planned CS should not be routinely offered to women with: ● Twin pregnancy (if first twin is cephalic at term) ● Preterm birth ● A 'small for gestational age' baby ● HIV to prevent mother–to-child transmission to: a) Women on highly active anti-retroviral therapy (HAART) with a viral load of less than 400 copies per ml or b) Women on any anti-retroviral therapy with a viral load of less than 50 copies ● Hepatitis B virus ● Hepatitis C virus ● Recurrent genital herpes at term Maternal request is not on its own an indication for caesarean section. If a woman requests an elective caesarean, there should be discussion of risks and benefits, and offer of support to enable vaginal delivery where clinically appropriate. Elective caesarean section for non-clinical reasons is a LOW PRIORITY and will NOT routinely be commissioned. Where there is genuine tocophobia (fear of pregnancy and childbirth), the woman should be referred and assessed by the Specialist Perinatal Mental Health Team.
Base Evidence	[NB: All of the criteria are taken directly from NICE CG132 Caesarean section]

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
D & C (Dilation and Curettage) (Restricted) **Secondary** ⇨	The CCGs will only fund dilation and curettage in the context of heavy menstrual bleeding in line with NICE CG44 2007. • D & C alone should not be used as a diagnostic tool. • D & C should not be used as a therapeutic treatment. The Commissioner will fund D&C for endometrial sampling.
Base Evidence	(CG44 Heavy menstrual bleeding 2007, updated August 2016)

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Hysterectomy for Menorrhagia (Restricted) **Secondary** ⇨	The CCGs will only fund hysterectomy for menorrhagia when either all of criteria 1 or all of criteria 2 are met. 1. The CCGs will fund hysterectomy for heavy menstrual bleeding only when there has been an unsuccessful trial with a levonorgestrel intrautine system e.g Mirena® and it has failed to relieve symptoms unless it is medically inappropriate or contraindicated. **AND** At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence (NICE) guidelines CG44 Heavy menstrual bleeding) • Non-steroidal anti-inflammatory agents (such as naproxen) • Tranexamic acid • Other hormone methods (injected progesterones, combined oral contrceptives) **AND** Surgical treatments such as endometrial ablation or myomectomy have been offered and failed to relieve symptoms or are not appropriate, or are contra-indicated. 2. Hysterectomy can be offered to patients with **heavy menstrual bleeding due to fibroids** greater than 3 cms when all of the following apply (based on NICE CG44 Heavy menstrual bleeding): Other symptoms (e.g. pressure) are present **AND** There is evidence of severe impact on quality of life. **AND** Other pharmaceutical options including ulipristal acetate*, have failed or are clinically inappropriate. **AND** Patient has been offered myomectomy (unless medically contraindicated or inappropriate). *Please refer to Derbyshire pathway for Presribing of Ulipristal Acetate for Symptomatic Fibroids in Pre-Menopausal Women: http://www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/chapter_6/

Base Evidence	CG44 published 2007, last updated Aug 2016: updated recommendations for women with large fibroids (relating to ulipristal): hysterectomy recommendations not changed in 2016 update.

Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Intra-uterine Contraceptive Devices (Restrictions apply to secondary care) (IUCDs) and Mirena Coils	**Secondary** ⇩ The fitting/ removal of IUCDs or Mirena coils in secondary care will only be commissioned in one of the following circumstances: • A medical issue requires the procedure to be performed in secondary care • Fitting is offered following a termination of pregnancy • Fitting is offered within 0-48 hrs postpartum • Fitting is performed at the same time as another secondary care procedure • Removal is technically difficult requiring removal under general anesthesia
Base Evidence	NICE CG30 LARC (2005); FSRH Clinical Guidance: Intra-uterine Contraception (April 2015); Cochrane Review: Immediate postabortal insertion of intrauterine devices (2014); UKMEC (2016); Sonalkar et al. (2015) "Intrauterine device insertion in the postpartum period: a systematic review"; Gariepy et al. (2015) "Cost effectiveness of immediate compared with delayed postpartum etonogestrel implant insertion".

Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Vaginal Pessaries (Restrictions apply to secondary care)	**Secondary** ⇩ The CCGs will only fund vaginal pessaries described below: Replacement /reinsertion of vaginal ring pessaries should only be undertaken in a primary care setting, it is not commissioned as a secondary care service. This does not include any more technically difficult pessaries such as shelf pessaries. There is no restrictuion applied to the incidental first fitting of ring pessaries in secondary care if the patient has been referred for a separate reason, however patients should not be referred specifically for the first fitting of ring pessaries.
Base Evidence	RCOG Green Top Guideline 46 (2015). Cheung, R, Y, et al . (2016) "Vaginal Pessary in Women with Symptomatic Pelvic Organ Prolapse: A Randmized Controlled Trial." De Albuquerque et al. (2016) "Female pelvic organ prolapse using pessaries; systematic review."

OPHTHALMOLOGY		
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral.	■ Blue – criteria to be met prior to procedure
Cataract Surgery (Restricted)	The CCGs will only fund cataract surgery as described below: **FIRST EYE** Cataract surgery will be funded where the visual acuity after refractive correction is 6/12 or worse in the worst eye (the eye to be treated) AND the patient has one of the following (with correction): Reduced mobility, experiencing difficulties in driving, for example, due to glare, or experiencing difficulty with steps or uneven ground. Ability to work, give care or live independently is affected. **OR** The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment **OR** The patient has glaucoma and requires cataract surgery to control the intra ocular pressure **OR** The patient has posterior subcapsular or cortical cataracts and experiences problems with glare and a reduction in acuity in bright conditions **OR** The patient's visual field defects are borderline for driving, and cataract extraction would be expected to significantly improve the visual field This information, together with a report from a recent sight test, should form the minimum data on the referral form. **SECOND EYE** Cataract surgery will not be funded in the second eye if the first eye has achieved a visual acuity of 6/9 or better, with refractive correction, and the acuity of the second eye is 6/24 or better with refractive correction. These patients should be reviewed by their optometrist annually or earlier if there is any deterioration in vision. Cataract surgery in the second eye will be funded if: • The first does not achieve an acuity of 6/9 or better, with refractive correction, and the procedure is clinically indicated for the patient's individual circumstances. • The patient has diabetes, or retinal condition, and requires clear views of their retina to monitor their disease or treatment • The patient has glaucoma and requires cataract surgery to control the intra ocular pressure • There is, after first eye operation, resultant anisometropia (a large refractive difference between the two eyes) which	

	would result in diplopia (double vision) or an uncorrectable loss of acuity in the second eye (with first eye corrected) that effectively renders the second eye vision worse than 6/24. This information, together with a report from a recent sight test, should form the minimum data on the referral form.
Base Evidence	The Royal College of Ophtalmologists Cateract Surgery Guidelines (2010); The Royal College of Ophthalmologists Commssioning Guidance (2015); Cooper et al. (2015) " The cost-effectiveness of second –eye cataract surgery in the UK"; Kessel et al. (2016) "Indication for cataract surgery. Do we have evidence of who will benefit from surgery? A systematic review and meta-analysis".

ORTHOPAEDICS		
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure	
Low Back Pain Injections and Elective Surgery (Restricted) **Secondary** ⇨	Back pain injection and elective surgery. These policies relate to patients aged 16 years and over, with non-specific low back pain (with or without sciatica), and not to back pain arising from specific serious underlying pathologies, such as cancer, infection, trauma or inflammatory disease (e.g. spondyloarthritis). It does not cover the care of people with sciatica with progressive neurolgical deficit or cauda equina syndrome. Management of Low Back Pain should be in accordance with NG59. The CCGs will only fund back pain injections and elective surgery as described below: A. Spinal decompression: for people **with sciatica** will be funded when nonsurgical treatment has not improved pain or function, and when radiological findings are consistent with sciatica. B. Spinal fusion: the CCGs will not routinely fund spinal fusion for low back pain. C. Injections (spinal, epidural, medial branch block). Spinal injections are not routinely funded for patients who have non-specific low back pain. Medical branch block injections will only be funded as a diagnostic method in advance of carrying out radiofrequency denervation. D. Radiofrequency denervation: will only be funded for people with **moderate or severe levels of localisd back pain**, and only when: 1. A diagnostic medical branch block has produced a positive response 2. Nonsurgical treatment has not improved pain CCGs are the responsible commissioner for posterior lumbar uninstrumented fusions, lumbar instrumented fusion for 2 levels or less and revision, instrumented lumbar fusion for 2 levels or less)	
Base Evidence	NICE Clinical Guideline NG59, low back pain and sciatica in over 16s: assessment and management, 30th November 2016.	

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
X-Ray (Pain) and MRI of Back for Low back Pain (Restricted)	The CCGs will only fund imaging for low back pain as described below. NB the policy relates only to non-specific lower back pain (with or without sciatica) and does not relate to the investigation of potential “red flag” conditions. Imaging should be undertaken in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management. Imaging should not be undertaken simply to remove diagnostic uncertainty, e.g. to reassure a patient vis-à- vis their diagnosis. Imaging should only be undertaken where there is an expectation that management may change as a result, e.g.when considering surgery. **Secondary** ⇨ Imaging should not be offered as a prerequisite for carrying out radiofrequency denervation.
Base Evidence	NICE Clinical Guideline NG59, Low back pain and sciatica in over 16s: assessment and management, 30th november 2016.

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Carpal Tunnel Syndrome ***(Restrictions apply to secondary care)***	Non-surgical treatments for mild to moderate symptoms is only funded in Primary Care, they include physiotherapy; neutral wrist splints; single steroid plus local anaesthetic injection. **Mild symptoms**: intermittent paraesthesia in the correct distribution; nocturnal symptoms (or exacerbated at night) **Moderate symptoms**: intermittent paraesthesia in the correct distribution; regular night waking, NO persistent hypoesthesia. Patients with moderate symptoms are likely to have a score of 3 or 4 on the Levine self-assessment questionnaire or Boston Carpal Tunnel Questionnaire. Referral for surgical management of Carpal Tunnel Syndrome is only funded for patients with: • Sudden and severe symptoms • Symptoms that are moderate to severe or deteriorating • Daily symptoms, frequent night waking • Persistent symptoms causing functional impairment not responding to up to 12 weeks of evidence-based non-surgical treatments (including treatments received in primary care). Patients who score 3 or 4 –up to 12 week trial of neutral wrist splinting or other evidence-based treatment (physiotherapy, single injection of steroid) Patients who score 3 or 4 and receive no relief from neutral wrist splinting or other evidence based treatment after 12 weeks, to be referred by GP to hand surgeon / neurologist. Refer urgently if symptoms are deteriorating before this point. Patients should be immediately referred to secondary care if: • Symptoms occur in the presence of a tumour or fracture, or onset of symptoms was after injury Urgent referral (<4/52) to secondary care if any of the following apply or a patients has a severe symptoms score of 5 or more on the CTS questionnaire (Levine self-assessment questionnaire or Boston Carpal Tunnel questionnaire): • evidence of thenar wasting • permanent numbness • symptoms are severe/frequent/functionally impairing • the condition makes daily activities impossible. • Neurological diseases • Inflammatory joint disease (including gout and RA) • Peripheral limb ischaemia (thoracic outlet syndrome or Raynaud's disease) • Cervical nerve root entrapment

Base Evidence	British Orthopaedic Association Commissioning Guide for Consultation BMJ Clinical review – Carpal Tunnel Syndrome, MiddletonS et al., BMJ 2014; 349:g6437, November American Academy of Orthopaedic Surgeons (AAOS) clinical practice guideline on management of carpal tunnel syndrome. February 2016. South Staffs CCGs' Commissioning Policy: Excluded and Restricted Procedures, Incorporating Procedures of Low Clinical Value (PLCV), March 2016. Manchester C CGs 2016-17 Effective Use of Resources Treatment Policies Updated: 30 September 2016.

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Dupuytren's Contracture ***(Restrictions apply to secondary care)***	Management of Dupuytren's Contracture will depend on the stage of the disease. The CCGs will only fund treatment for Dupuytren's Contracture according to the three stages described: **Mild** • No functional problems • No contracture or mild MCP contracture (<30^{o}) No treatment beyond reassurance and observation **Moderate** Functional problems interfering with daily living • Moderate MCP contracture (>30^{o}<60^{o}) • Moderate PIP contracture (<30^{o}) • First web contracture Treatments: • Needle fasciotomy for MCPJ contracture. • Referral for limited fasciectomy if rapidly progressing **Severe** Severe functional impairment • Severe contracture of both metacarpo-phalangeal (>60 degrees) joint and proximal inter-phalangeal joint (>30 degrees). Treatments: • Limited fasciectomy • Dermofasciectomy
Secondary ⇨	
Secondary ⇨	
Base Evidence	Revised to use mild/moderate/severe functional categorisation.

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Ganglion Cysts (Restricted)	The CCGs will only fund treatment according to the three stages of severity described – only those ganglion cysts graded as severe should be referred for surgery. **Mild** • An asymptomatic lump. Treatment • Reassurance and observation. • **Moderate** Symptomatic lump with a long duration of symtoms • Occult ganglion. Treatment • Reassurance and observation • Aspiration in primary care for reassurance **Severe** • Severe pain • Restriction of activities of daily living • Concern over the diagnosis. Treatment • Referral for surgical removal The condition described below would be regarded as severe in this respect. • Ganglion on wrist with evidence of neurovascular compromise or significant pain • Seed ganglia at base of digits with significant pain • Mucoid cysts at DIP joint which has disrupted the nail growth or there are cysts that tend to discharge • Ganglia on foot and ankles with evidence of neurovascular compromise or significant pain or causing difficulties with foot wear or mobility.
Base Evidence	British Society for Surgery of the hand information leaflet, 2016. Revised to adopt mild/moderate/severe nomenclature.

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Hip and Knee Replacement and Revisions (Restricted) Knee replacement (Primary)(Restricted) **Secondary** ⇨	The core treatment for symptoms of osteoarthritis is as follows : • Access to appropriate information (including self –care programmes) • Activity and exercise • Referal to a lifestyle service for interventions to achieve weight loss if the person is overweight or obese • Pharmacological treatment for symptoms of pain and swelling **Hip and Knee Replacement** The CCGs will only fund hip and knee replacement under the following conditions: • The patient has engaged with the above core treatment options, when relevant. • Decision based on discussions with patient rep and clincian rather than scoring tools • The patient experiences joint symptoms (pain, stiffness and reduced function) that have a substantial impact on their quality of life and are refractory to non-surgical treatment. • When discussing the possibility of joint surgery, check that the person has accessed the core treatments and give information about them: ▪ The benefits and risks of surgery and the potential consequences of not having surgery ▪ Recovery and rehabilitation after surgery ▪ How having a prosthesis might affect them ▪ How care pathways are organised in their local area • These discussions should be informed and guided by use of shared decision making tools Referring clinicans should follow the MSK clinical pathway for this condition when considering a referral to secondary care. Compliance with the pathway is required to support referrals. **Note:** The Derbyshire MSK clinical pathways are currently under review and will be updated in 2017. In the meantime, please follow the current CCG MSK pathway for this condition where there is one in place. **Hip Revision** The CCGs will only fund hip revision, which is a repeat hip replacement, when a patient has one of the following conditions: • Joint has multiple dislocations, • Becomes loose or fails, • Infected • Worn out. Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.

Base Evidence	NICE technology appraisal Guidance 304 (Total hip replacement and resurfacing arthroplasty for end stage arthritis of the hip (review of technology appraisal guidance 2 and 44) February 2014 NICE guidance CG177 and TA 304

Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Hip Resurfacing (Restricted) **Secondary** ⇨	The CCGs will fund for those who otherwise qualify for primary total hip replacement (see hip replacement referral guidance), but are likely to outlive conventional primary hip replacements. Referring clinicians should follow the MSK clinical pathway for this condition when considering a referral to secondary care. Compliance with the pathway is required to support referrals. **Note:** The Derbyshire MSK clinical pathways are currently under review and will be updated in 2017. In the meantime, please follow the current CCGs MSK pathways for this condition where there is one in place. Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years.
Knee – Washouts Debridement (Not Funded) **Secondary** ⇨	The CCGs will not routinely fund knee washouts alone. The CCGs will only fund knee washouts with debridement when the patient has mechanical features of true locking.
Base Evidence	NICE IPG230 Arthroscopic surgery is ineffective in knee osteoarthritis and results in high costs – Swedish council on health technology assessment, October 15, 2014 Arthroscopic surgery for degenerative knee: systematic review and meta-analysis of benefits and harms. Thorlund J et al, BMJ 2015;350:h2747ldoi: 10.1136/bmj.h2747 Arthroscopic Debridement of the Knee: An Evidence Update, Ontario Health Technology Assessment Series; Vol. 14: No.13, pp.1-43, November 2014

Procedure/Condition	Criteria ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Trigger Finger (Restricted)	The CCGs will only fund surgical treatment for trigger finger (percutaneous or open release) as described below: Following a failure to respond to conservative measures (which should include at least one steroid and local anaesthetic injection) – i.e. symptoms fail to resolve or there is a recurrence. These measures to be tried prior to referral. Referral directly to surgical treatment will be allowed where injection is contraindicated or is clinically inappropriate.
Base Evidence	British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST) – guideline, based on systematic review of operative and non-operative treatments for adult tigger digits, published October 2016.

APPENDIX 1 VERSION CONTROL

Version No	Date	Policy	Changes
3	April 17	Cholecystectomy	Criteria added for funding
3	March 17	Grommets children /adults	A clearer flow for layout of symptoms.
3	Feb 2017	Lower back pain	Remove evidence of NICE say to “consider” where sciatica acute and severe
3	Feb 2017	Carpal Tunnel	A clear flow of layout for with mild and moderate symptoms first
3	Dec 2016	Dental – third molar extraction and dental implants	Removal of dental policies from PLCV as these are now commissioned by NHS England
3	Dec 2016	ENT - Grommets	Inclusion of auto inflation and reference to adenoidectomy in conjunction with grommet insertion
3	Dec 2016	ENT – Tonsillectomy	No update
3	Dec 2016	ENT- sleep Apnoea	Clearer reference to CPAP and distinction from snoring
3	Dec 2016	Hip, knee and other joint revisions	Updated following consultation and CPAG feedback in November 2016. Refers to policy on primary replacement and following relevant MSK pathway.
3	Dec 2016	Hip, knee and other joint revisions Hip replacement (primary)	Updated following consultation and CPAG feedback in November 2016. Includes outline of NICE guidance for conservative management of OA, use of shared decision making tools and following relevant MSK pathway.
3	Dec 2016	Hip Resurfacing	Updated following consultation and CPAG feedback in November 2016. Refers to primary hip replacement policy and to following relevant MSK pathway.
3	Dec 2016	Knee replacement (primary)	Updated following consultation and CPAG feedback in November 2016. Includes outline of NICE guidance for conservative management of OA, use of shared decision making tools and reference to following relevant MSK pathway.
3	Dec 2016	General Surgery Haemorrhoidectomy	Updated to include clearer approach to conservative treatment prior to surgical intervention
3	Dec 2016	General Surgery Hernia	Updated to reflect RCS commissioning guidance from 2016 – removal of asymptomatic hernias
3	Dec 2016	General Surgery Gastroscopy	No update
3	Dec 2016	General Surgery Varicose Veins	Standardisation of minimally invasive offer pre surgical treatment across North and South Derbyshire
3	Dec 2016	IBS	Will be removed from PLCV as this is a pathway issue for primary care clinicians
3	Dec 2016	Dilation and Curettage	No update
3	Dec 2016	Elective/Planned Caesarean Section	Update postponed until January 2017

3	Dec 2016	Hysterectomy for Menorrhagia	Heavy menstrual bleeding due to fibroids greater than 3cm may only be offered hysterectomy once ulipristal acetate (amongst other treatment options) has failed
3	Dec 2016	Intra-uterine Contraceptive Devices and Mirena Coils	Updated to reflect new evidence re-fitting during 0-48hrs postpartum period, such that fitting of Mirena coils or IUCDs may now be conducted in secondary care during the 0-48 hour postpartum period. Reference to' community setting' removed. Wording simplified
3	Dec 2016	Vaginal pessaries	No up date
3	Dec 2016	Cataract Surgery	Modelling of revised policy options underway – policy update anticipated January 2017
3	Dec 2016	Back Pain Injections and Elective Surgery	Revised in line with new NICE guidelines NG59. Now applies to 16+ (rather than 18+) and does not apply any duration limits to condition. Non-specific back pain now includes sciatica A. Changed to more general "spinal decompression" with criteria simplified B. Spinal fusion – further restricted C. Injections restricted. Only for sciatica where severe and acute. Medical branch block permitted only as diagnostic tool (see D) D. Facet joint injections removed, as no longer funded. Replaced with criteria for radiofrequency denervation E. Section removed, as now included within A
3	Dec 2016	Carpal Tunnel Syndrome	Reviewed in the light of BOA consultation commissioning guide (final publication pending), and informed by S Staffs and Manchester policy reviews. Referrals now based on mild/moderate/severe categorisation with equivalent Boston Questionnaire scores given. Red and yellow flag listed.
3	Dec 2016	Dupuytrens Contracture	Provisionally reviewed in response to local consultation, to take account of functional impairment level. Criteria replaced with definitions for mild/moderate/severe and acceptable treatments for each. Informed by S Staffs and Manchester policy reviews.
3	Dec 2016	Ganglion Cysts	Provisionally reviewed in response to local consultation, re-advantage of categorising severity. Mild/moderate/severe symptoms defined along with allowable treatments. INFORED BY Greater Manchester policy and Coventry GP Gateway and British Society for Surgery to the Hand 2016 information leaflet.
3	Dec 2016	Knee-washouts and Debridement	"Washouts" changed to "washouts with debridement" in light of IPG230, which suggests that washout alone not likely to be effective.
3	Dec 2016	Trigger finger	Reviewed in light of BEST guidance (published October 2016). One attempted injection required (unless contraindicated)' prior to surgery – following failure to respond or recurrence.
3	Dec 2016	Imaging	Revised in line with new NICE guideline, NG59. Imaging should be instigated in secondary care, and only in order to inform change in management.

Version No	Date	Changes
2	Nov 2014	Ear Nose and Throat – Removal of the need for pain as a requirements for adults
2	Nov 2014	Changes to frequency of occurrence of tonsillitis made and parental concern about breathing removed as a criteria; fever defined as defined as 38 ^{o}C.
2	Nov 2014	Hernia – changes to policy. Deletion of need for individuals with a raised BMI to be given weight management advice.
2	Nov 2014	Gastroscopy for Dyspepsia –Changes to policy. "Unexplained" and "persistent" defined; deletion of some restrictions for routine endoscopic investigation of dyspepsia (atypical symptoms e.g. satiety, nausea, bloating; investigation of upper abdominal pain/non-cardiac chest pain; being considered for anti-reflux surgery); addition of indications for gastroscopy for worsening dyspepsia.
2	Nov 2014	Varicose veins – updated to remove 6 months trial of compression hosiery as a criteria for referral; to allow referral after a single episode of thrombophlebitis; to allow surgical management only if endothermal ablation, endovascular laser treatment and ultrasound-guided foam sclerotherapy are unsuitable.
2	Nov 2014	Irritable Bowel Syndrome – Changes to policy. Use of faecal calprotectin in primary care.
2	Nov 2014	Dilation and Curettage – changes made to clarify that this relates to D & C in the context of heavy menstrual bleeding and additional indication of endometrial sampling added.
2	Nov 2014	Intrauterine Contraceptive Devices and Mirena Coils – changes to include clarification added that Mirena coils may be fitted in community services; clarification of when they may be offered to patients who have had a termination.
2	Nov 2014	Vaginal Pessaries –changes to include clarification of restrictions in fitting of ring pessaries in secondary care added.
2	Nov 2014	Back Pain injections and Elective Surgery – Changes to include definitions of radicular pain and positive straight leg raised deleted; duration of symptoms required for a discectomy changed from 6 weeks to 8 weeks.
2	Nov 2014	Carpal Tunnel – changes to include treatment length in the community before referral to secondary care; criteria for urgent/immediate secondary care referral.
2	Nov 2014	Hip and Knee and other joint revisions- changes include additional requirements for hip prostheses used in revision surgery.
2	Nov 2014	Hip replacement – changes include updating the name of NICE technology appraisal that sets requirements for prostheses and removing the Oxford score.
2	Nov 2014	Knee replacement (primary) – changes include removing the Oxford score.
2	Nov 2014	Trigger Finger – changes include the addition of a requirement for steroid injection to be attempted prior to surgery.

Glossary

Adenoidectomy	Surgical removal of the adenoids.
Asymptomatic	When doctors talk about someone being **asymptomatic**, they are usually referring to a patient who has been exposed to an illness or is sick but doesn't have any symptoms of disease.
Auto inflation	Is a technique where the tube connecting the middle ear and the back of the nose is reopened. This can be achieved by blowing up a balloon through each nostril or using an anaesthetic mask
British Orthopaedic Association	The Surgical Specialty Association for Trauma and Orthopaedics in the UK, for doctors who specialize in orthopaedic surgery.
British Society for Surgery of the Hand	Is the information and education body for Hand Surgery in the UK.
Carpal Tunnel Syndrome	is a medical condition due to compression of the median nerve as it travels through the wrist at the carpal tunnel at the front of the wrist
Cataract Surgery	is the removal of the natural lens of the eye (also called "crystalline lens") that has developed an opacification, which is referred to as a cataract
CCGs	Clinical Commissioning Groups
Cochrane Institute	Is a global independent network of researchers, professionals, patients, carers and people interested in health
Dermofasciectomy	removes all of the diseased fascia plus a generous amount of the overlying skin which is replaced by skin from other parts of the body
Dilation and Curettage (D&C)	refers to the dilation (widening/opening) of the cervix and surgical removal of part of the lining of the uterus and/or contents of the uterus by scraping and scooping (curettage).
Dupuytrens Contracture	is a condition in which there is fixed forward curvature of one or more fingers, caused by the development of a fibrous connection between the finger tendons and the skin of the palm.
Endometrial ablation	is a procedure that destroys (ablates) the uterine lining, or endometrium. This procedure is used to treat abnormal uterine bleeding.
Epworth sleep scale	The Epworth Sleepiness Scale can be used in the field of sleep medicine as a subjective measure of a patient's sleepiness
Ganglion cysts	are noncancerous lumps that most commonly develop along the tendons or joints of your wrists or hands
Gastroscopy	is an examination of the upper digestive tract (the oesophagus, stomach and duodenum) using an endoscope
Grommets	a tube surgically implanted in the eardrum to drain fluid from the middle ear.
Health Optimisation	vision is to achieve the best health and wellbeing for everyone
Haemorrhoidectomy	is the surgical removal of a haemorrhoid, which is an enlarged, swollen and inflamed cluster. Haemorrhoids can occur inside the rectum
Hernia	is a general term used to describe a bulge or protrusion of an organ through the structure or muscle that usually contains it.
Highly active antiretroviral therapy (HAART)	is treatment of people infected with human immunodeficiency virus (HIV) using anti-HIV drugs. The standard treatment consists of a combination of drugs (often called “highly active antiretroviral therapy” or HAART) that suppress HIV replication.
Hip replacement	Surgery in which the diseased ball and socket of the hip joint are completely removed and replaced with artificial materials.
Hip resurfacing	A type of hip arthroplasty in which the femoral head is shaped to receive a metal cap or resurfacing, which contrasts to a “total hip” in which the femoral head is excised and a mechanical prosthesis is put in its place.
Hysterectomy	a surgical operation to remove all or part of the uterus
Irritable Bowel Syndrome(IBS)	is a group of symptoms—including abdominal pain and changes in the pattern of bowel movements without any evidence of underlying damage
Individual Funding Requests (IFR)	Where a treatment or service is not routinely offered by the NHS, a healthcare professional may submit to NHS England an Individual Funding Request (IFR).
Intra-uterine Contraceptives Devices (IUCDs)	can be a coil, loop, triangle, or T in shape made of plastic or metal. An IUCDs is inserted into the uterus by a health-care professional
Knee Replacement	is a surgical procedure to replace the weight-bearing surfaces of the knee

	joint to relieve pain and disability
Knee washouts debridement	involves flushing the joint with fluid, which is introduced through small incisions in the knee. The procedure is often done with debridement, which is the removal of loose debris around the joint.
Limited fascietomy	the diseased tissue is completely removed and sometimes also parts of the aponeurosis.
Lower back pain injections	is a minimally invasive procedure that delivers steroids via a needle directly into the epidural space to help reduce inflammation.
Menorrhagia	is defined as excessive uterine bleeding occurring at regular intervals or prolonged uterine bleeding
MSK clinical pathway	Musculoskeletal disorders (MSDs) are problems affecting the muscles, tendons, ligaments, nerves or other soft tissues and joints. The MSK pathways allow clinicians to provide a framework to allow for the correct referral pathway for low back pain
Myomectomy	is the removal of fibroids (noncancerous tumours) from the wall of the uterus
NICE	National Institute for Health and Clinical Excellence
NICE Interventional Procedure Guidance	An interventional procedure is a procedure used for diagnosis or for treatment that involves making a cut through the skin, using instruments to enter the patients for example, when carrying out an operation or inserting a tube into a blood vessel
Osteoarthritis	is degeneration of joint cartilage and the underlying bone, most common from middle age onward. It causes pain and stiffness, especially in the hip, knee, and thumb joints.
Otitis media (OME)	is a collection of non-infected fluid in the middle ear space. It is also called serous or secretory otitis media (SOM). This fluid may accumulate in the middle ear as a result of a cold, sore throat or upper respiratory infection.
Paraesthesia	is an abnormal condition in which you feel a sensation of burning, numbness, tingling, itching or prickling. Paresthesia can also be described as a pins-and-needles or skin-crawling sensation. Paresthesia most often occurs in the extremities, such as the hands, feet, fingers, and toes,
PLCV	Procedures of Limited Clinical Value
Primary Care	Primary care is the day-to-day healthcare given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a healthcare system, and coordinates other specialist care that the patient may need.
Primary Care Practitioners	A primary care practitioner (PCP) is a health care practitioner who sees people that have common medical problems. This person is most often a doctor. However, a PCP may be a physician assistant or a nurse practitioner
Requires Prior Approval	Prior Approval means the prior approval by the CCG for an individual patient, for whom the CCG is the Responsible Commissioner, to access care or treatment, including diagnostics, under a Prior Approval Scheme
Royal Colleges of Surgeons	Committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care
Sciatica	pain affecting the back, hip, and outer side of the leg, caused by compression of a spinal nerve root in the lower back
Secondary Care	medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill, or equipment than the primary care physician can provide.
Sleep Apnoea	is a common disorder in which you have one or more pauses in breathing or shallow breaths while you sleep**.**
Spinal Decompression	commonly used to refer to a surgical procedure to alleviate pain caused by a pinched nerve (neural impingement, compressed nerve) in the spine.
Spinal fusion	Is a surgical procedure in which two or more of the vertebrae in the spine are united together so that motion no longer occurs between them
Symptomatic	Pertaining to or of the nature of a symptom.**2.** indicative (of a particular disease or disorder).**3.** exhibiting the symptoms of a particular disease but having a different cause.**4.** directed at the allaying of symptoms, as symptomatic treatment.
Tocophobia	an abnormal fear of giving birth or becoming pregnant.
Tonsillar exudates	A bacteria or virus infects the tonsils, causing swelling and a sore throat.

	The tonsil may develop a grey or white coating (exudate).
Tonsillectomy	is the surgical removal of the tonsils, two oval-shaped pads of tissue at the back of the throat — one tonsil on each side.
Trigger finger	is a painful condition in which a finger or thumb clicks or locks as it is bent towards the palm.
Uvulopalatoplasty	is a surgical procedure performed with the aim of reducing or eliminating snoring.
Vaginal Pessaries	is a plastic device that fits into your vagina to help support your uterus (womb), vagina, bladder or rectum.