NHS
Surrey Heartlands

CLIN03

TNRF2 - List of procedures with Restrictions and Thresholds

Policy number	CLIN03
Version	1.1
Approved by	Integrated Care Board (ICB) following recommendation from CCG Audit Committee
Name of originator/ author	Dr. Liz Saunders, on behalf of the Surrey Priorities Committee (SPC)
Owner (director)	Clare Stone, ICS Director of Multi-Professional Leadership, and Chief Nursing Officer
ate of last approval	September 2022
Next approval due	September 2027

Version control sheet

Version	Date	Author	Status	Comments / changes since last version
1	March 2013	Amended from NHS Surrey policy CLIN 13 (b) version 1 October 2012	Final	For approval by Executive Committee and Governing Body March 2013
2	July 2013	Amended from NHS Surrey policy CLIN 13 (b) version 1 October 2012	Final	Final version approved by Governing Body 19 July 2013
3	February 2015	Amended from NHS Surrey policy CLIN 13 (b) version 2 by Dr. Liz Saunders. Approved by Surrey Priorities Committee	Final	Changes agreed by Priorities Committee: TNRF2 003: Adenoidectomy, criteria added TNRF2 005: Grommets, thresholds clarified TNRF2 006: Pinnaplasty age limits increased TNRF2 009: D&C, NICE criteria added TNRF2 013: Labiaplasty criteria added Arthroscopy of hand and wrist removed from policy Arthroscopy of elbow removed from policy TNRF2 016: Balloon Kyphoplasty criteria clarified
3	February 2015	Amended from NHS Surrey policy CLIN 13 (b) version 2 by Dr. Liz Saunders. Approved by Surrey	Final	TNRF2 020: Hallux valgus, new criteria added TNRF2 023: Vertebroplasty, criteria clarified

		Priorities Committee		TNRF2 038: Radiofrequency denervation for facet joints, criteria clarified Metal on metal hip resurfacing removed and transferred to TNRF policy TNRF2 026: Blepharoplasty moved from TNRF1 policy and new criteria introduced TNRF 030: Breast reduction moved from TNRF1 policy. TNRF2 031: Criteria for removal and replacement of breast implants added. Varicose veins new criteria introduced. TNRF2 025: Chalazion criteria clarified TNRF2 019: Ganglion criteria clarified TNRF2 027/028/029; Hernia repair criteria clarified TNRF2 037: Circumcision criteria clarified
3.1	May 2015	Updates and Reformatting	Final	TNRF2 040: Hyperhidrosis, treatment of – criteria added TNRF2 039: Male Breast Reduction for Gynaecomastia criteria added TNRF2 033: Open MRI addition to criteria
3.2	January 2016	Updates as agreed by Surrey Priorities Committee	Final	Radiofrequency denervation for facet joints moved to TNRF1 policy TNRF2 002: Viral Wart procedures – criteria amended

				TNRF2 010: Female genital prolapse – criteria clarified TNRF2 023A: Total Hip Replacement – criteria added TNRF2 023B: Total Knee Replacement – criteria added TNRF2 023C: Hip Impingement Syndrome – criteria added TNRF 2 034: Epidural Injections for Sciatica – criteria amended Radiofrequency Spinal Denervation moved to TNRF1 policy TNRF2 026: Blepharoplasty /Ptosis Criteria amended
3.3	July 2016	Updates as agreed by Surrey Priorities Committee	Final	Inserted: Patients should be encouraged to stop smoking prior to surgery into each criteria TNRF2 030: Female Breast Reduction – Non-smoker removed from criteria TNRF2 033B: Inserted Ketogenic diet for the treatment of neurological conditions TNRF2 035: Facet Joint Injections – criteria reworded TNRF2 025: Excision of Chalazion –criteria reworded
3.4	October 2016	Updates as agreed by Surrey Priorities Committee	Final	TNRF2 034: Epidural injections for Sciatica – criteria reworded TNRF2 035: Facet Joint Injections – criteria reworded

				TNRF2 042: Gallstones, surgical treatment of – criteria inserted
3.5	April 2017	Updated as agreed by Surrey Priorities Committee	Final	TNRF2-004: – Bone Anchored Hearing Aid removed from policy, managed by NHS England. Continuous positive pressure for the obstructive sleep apnoea / hypoapnoea syndrome – Removed from policy. TNRF2 022: Trigger Finger, surgical techniques for the treatment of – Criteria revised. TNRF2 038: Varicose Veins – criteria amended.
3.6	May 2017	Updated as agreed by Surrey Priorities Committee	Final	Policy renamed TNRF2 041: Bariatric Surgery – criteria inserted TNRF2 024: Cataract – criteria revised
3.7	September 2017	Updated as agreed by Surrey Priorities Committee	Final	TNRF2 024: Cataract – criteria amended
3.8	December 2017	Updated as agreed by Surrey Priorities Committee	Final	TNFR2 001: Amendments to criteria, separate criteria for Lipomas TNRF2 007: Rhinoplasty and Septorhinoplasty - criteria separated; Septoplasty criteria introduced TNRF2 008: Tonsillectomy - criteria amended TNRF2 015: Carpal Tunnel - criteria amended

				TNRF2 018: Dupuytrens Contracture - criteria amended TNRF2 027: Inguinal Hernia - 'Or' added in between each threshold
3.9	February 2018	Updated as agreed by Surrey Priorities Committee	Final	TNRF2 024: Cataract Surgery - removed from this policy TNRF2 014: Arthroscopy of the knee - criteria amended
4	October 2018	Updated as agreed by Surrey Priorities Committee	Draft	TNRF2 005: Grommets - criteria updated to include detail relating to children with recurrent acute otitis media (rAOM) 'These criteria apply to adults only' added to each procedure below: TNRF2 027: Inguinal Hernia TNRF2 028: Umbilical Hernia TNRF2 029: Incisional Hernia
4.1	December 2018	Updated as agreed by Surrey Priorities Committee	Draft	TNRF2 020: Hallux Valgus, surgical treatment of – criteria reworded TNRF2 043: Haemorrhoids, surgical treatment of – criteria inserted
4.1	December 2018	Governing Body	Final	Approved by Governing Body
4.2	June 2019	Updated as agreed by Surrey Priorities Committee	Draft	TNRF2 014: Uterine Artery Embolisation for fibroids in women – Criteria inserted
4.2	July 2019	G&W Local Clinical Commissioning Committees. NWS Clinical	Final	Approved

		Executive and SD Governing Body (following review by Clinical Cabinet)		
4.3	September 2019	Updated as agreed by Surrey Priorities Committee	Draft	TNRF2 034: Epidural Injections for Sciatica - removed TNRF2 037: Facet joint injections - Therapeutic removed TNRF2 035: Lumbar Facet Joint injections - inserted to replace TNRF2 037 TNRF2 036: Spinal Epidural injections - inserted to replace TNRF2 034 TNRF2 045: Radiofrequency denervation - inserted TNRF2 044: Surgical removal of Varicocele – Criteria inserted Metal-on-metal hip resurfacing removed Equality Analysis reviewed
4.4	December 2019	Governing Body	Final	Approved by Governing Body
4.5	December 2019	Surrey Priorities Committee	Draft	TNRF2 026: Blepharoplasty – criteria amended TNRF2 010: Changes to criteria and intervention renamed to Pelvic Organ Prolapse from Female Genital Prolapse

				TNRF2 039: Male Breast Reduction for Gynaecomastia - removed and inserted into TNRF1 Equality Analysis reviewed
4.6	January 2020	Approved by: Governing Body Chair's Action	Final	Approved by Chair's Action
4.7	February 2020	Surrey Priorities Committee	Final	TNRF2 008: Tonsillectomy - criteria amended, reference to Tonsil Stones included
4.8	November 2020	Virtual Surrey Priorities Committee	Draft	Agreed by Surrey Heartlands CCG ICP Directors and Surrey Heath CCG Medical Director TNRF2 002A: Liposuction and compression therapy to resolve chronic Lymphoedema - criteria amended TNRF2 015: Carpal Tunnel - criteria amended
4.8	December 2020	Virtual Surrey Priorities Committee	Final	Approved and ratified by Quality & Performance Assurance Board via Chair's Action
4.9	January 2021	Virtual Surrey Priorities Committee	Draft	Agreed by Surrey Heartlands CCG ICP Directors and Surrey Heath CCG Medical Director TNRF2 021: Spinal fusion for the treatment of lower back pain – criteria amended TNRF2 023A: Total Hip Replacement – criteria amended TNRF2 023B: Total Knee Replacement – criteria amended

4.9	February 2021	Virtual Surrey Priorities Committee	Final	Approved and ratified by Quality & Performance Assurance Board
4.10	May 2021	Virtual Surrey Priorities Committee	Draft	Agreed by Surrey Heartlands CCG ICP Directors and Frimley CCG (Surrey Heath only) Medical Director TNRF2 037: Circumcision – criteria amended Review cycle moved from 3 to 5 years.
4.10	June 2021	Virtual Surrey Priorities Committee	Final	Agreed by the Quality & Performance Board, subsequently ratified by the Health & Care Professionals Executive
4.11	September 2021	Virtual Surrey Priorities Committee	Draft	TNRF2 033B: Referral for Ketogenic Diet - criteria amended TNRF2 012: Hysterectomy for Heavy Menstrual Bleeding – criteria amended TNRF2 040: Hyperhidrosis, treatment of – criteria amended TNRF2 013: Labiaplasty – criteria amended
4.11	October 2021	Virtual Surrey Priorities Committee	Final	Approved by the Health & Care Professionals Executive (HCPE)
5	May 2022	Virtual Surrey Priorities Committee	Draft	TNRF2 046: Continuous Positive Airway Pressure (CPAP) for the obstructive sleep apnoea / hypo apnoea syndrome – criteria inserted

				TNRF2 033A: Open MRI – criteria amended
5	May 2022	Virtual Surrey Priorities Committee	Final	Ratified for publication by the Health & Care Professionals Executive (HCPE)
CCG Abolished – ICB Established July 2022				
1.0	July 2022	Virtual Surrey Priorities Committee	Final	Version number of policy amended due to establishment of Surrey Heartlands ICB. Content remains unchanged from v5.
1.1	September 2022	Virtual Surrey Priorities Committee	Draft	TNRF2 006: Pinnaplasty - criteria amended TNRF2 023C: Hip Impingement Syndrome criteria amended TNRF2 026a: Brow Lift and Ptosis Correction – criteria inserted TNRF2 038: Varicose Vein - criteria amended TNRF2 040: Hyperhidrosis, treatment of – criteria amended TNRF2 047: Metal on Metal Hip Resurfacing – inserted
1.1	September 2022	Virtual Surrey Priorities Committee	Final	Ratified for publication by the Health & Care Professionals Committee (HCPC)

Equality statement

Surrey Heartlands Integrated Care Board (ICB) is committed to promoting equality and diversity in all its activities and to promoting inclusive processes, practices, and culture.

- We will strive to work to eliminate any unlawful or unfair discrimination including direct or indirect discrimination, discrimination by association, discrimination linked to a perceived characteristic, harassment, and victimisation.
- We will remain proactive in taking steps to ensure inclusion and engagement for all the people who work for and with us.
- We will continue to strive towards a culture that is diverse and inclusive that recognises and develops the potential of all staff and service users.
- We recognise the business benefits and opportunities of having a diverse community of staff who value one another and realising the contribution they can make to achieving the ICB's vision.

This includes promoting equality and diversity for all irrespective of:

- age*
- disability*
- ethnic group*
- sex*
- gender reassignment*
- religion or belief*
- sexual orientation*
- marriage and civil partnership*
- pregnancy and maternity*

*Under the Equality Act (2010) these are known as "protected characteristics".

In addition, it includes promoting equality and diversity for carers, people with diverse communication needs and veterans.

The ICB aims to meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. We take into account the Human Rights Act 1998 and promote equal opportunities for all. We embrace the seven staff pledges in the NHS Constitution that represent a commitment by the NHS to provide high-quality working environments for staff. This policy is consistent with these pledges.

This document has been assessed to ensure that no employee or member of the public receives less favourable treatment based on their protected characteristics.

Members of staff, volunteers or members of the public are invited to request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

Equality analysis

This policy has been subject to an Equality Analysis, the outcome of which is recorded below.

		Yes, No or N/A	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	Gender (Men and Women)	No	**TNRF2 027:** Cases of groin hernias in women are not affected by the criteria for inguinal hernia repair, as it is routinely funded. This is because due to anatomical variation, groin hernias are more likely to be femoral in females which are themselves routinely funded. **TNRF2 030:** The policy for female breast reduction is exclusively for female patients and excludes male patients. However, there is a male breast reduction policy. **TNRF2 039:** The policy for male breast reduction is exclusively for male patients and excludes female patients. However, there is a female breast reduction policy. Other than the above, the criteria within TNRF2 apply equally to all patients regardless of gender.
	Race (All Racial Groups)	No	The criteria within TNRF2 apply equally to all patients regardless of race. The prevalence of conditions between races that require treatment restricted by the TNRF2 criteria is not discriminated against by said criteria.
	Disability (Mental, Physical and Carers of Disabled people)	No	**TNRF2 002:** Patients who are immunocompromised are positively impacted as they meet criteria for all viral warts whilst other patients are negatively impacted as they can only meet criteria exclusively for genital / anal warts. **TNRF2 023 A & B:** The criteria requiring patients to have a course of physiotherapy before a total hip replacement, or a total knee replacement could negatively impact patients with disabilities. **TNRF2 032:** Equipment that has been recommended for patients as a result of ACA is not routinely funded.

			There needs to be a clearer justification as to why there was a decision previously not to fund equipment-only assessments. **TNRF2 034 & 035:** Similarly, to TKR, the criteria requiring patients to have a course of physiotherapy before epidural injections for sciatica or therapeutic facet joint injections could negatively impact patients with disabilities. However, if the team receive a physio discharge letter stating that a patient is unable to finish a course, we take that into consideration. **TNRF2 017:** The first half of the criteria for discectomy for lumber disc prolapse (elective) has an impact on patients who are unable to have and MRI or CT due to morbid obesity or claustrophobia. However, this is a neutral impact as these patients can have an open MRI scan under the TNRF2 033A criteria. **TNRF2 020:** If a patient has a disability which prohibits them from engaging with conservative management measures for hallux valgus, this will be taken into account. **TNRF2 022:** Patients with diabetes are impacted by the criteria for the surgical treatment of trigger finger, as they are approved for funding without needing to first attempt conservative management. The reason for this is that diabetes can affect the nervous system, increasing the risk of permanent nerve damage. **TNRF2 27, 28 & 29:** The criteria for the surgical repair of inguinal, umbilical, and incisional hernia only affect adults. This is because hernia repair in children is routinely funded. Other than the above, the criteria within TNRF2 apply equally to all patients regardless of disability.
	Religion or Belief	No	**TNRF2 037:** The criteria for circumcision requires a sound clinical reason for the procedure, therefore it would not be funded for religious reasons. The criteria within TNRF2 apply equally to all patients regardless of religion or beliefs. Decisions of whether a treatment or procedure is not carried out for religious reasons is a decision between the patient and the consultant.

	Sexual Orientation (Heterosexual, Homosexual and Bisexual)	No	The criteria within TNRF2 apply equally to all patients regardless of sexual orientation.
	Pregnancy and Maternity	No	**TNRF2 011:** As geographical differences to female sterilisation *reversal* policies are due to local variations / priorities / clinical judgement; the priorities committee has decided to adhere to NICE guidance for patients seeking female sterilisation *reversal* after having female sterilisation. **TNRF2 012:** The criteria for hysterectomy for heavy menstrual bleeding has a neutral impact on those who are or have been recently pregnant as the requirement is for the uterus to be no larger than a 10-week pregnancy. This is in line with NICE guidance. However, once the patient's uterus returns to a size less than a 10-week pregnancy, the patient is no longer impacted. Also, as with most surgical procedures, a consultant will defer a patient's routine surgery until 6 weeks post-natal. Other than the above, the criteria within TNRF2 apply equally to all patients regardless of pregnancy and maternity.
	Marital Status (Married and Civil Partnerships)	No	The criteria within TNRF2 apply equally to all patients regardless of marriage or civil partnership.
	Transgender	Yes	**TNRF2 031:** Male to female transgender people who had breast implants for cosmetic reasons would be negatively affected by the criteria for breast implant removal and replacement. If their implant(s) need to be removed for a sound clinical reason, removal would be funded but not replacement. This is because replacement is not funded for cosmetic reasons. All other procedures that relate to gender reassignment are carried out under the Gender Dysphoria clinical pathway and are not affected by our criteria.
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	N/A	

4.	Is the impact of the document/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternative is there to achieving the document/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

For advice in respect of answering the above questions, please contact the Corporate Office, of your ICB. If you have identified a potential discriminatory impact of this procedural document, please contact as above.

Names and Organisation of Individuals who carried out the Assessment	**Date of the Assessment**

Contents

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1. Dental

Policy Number	Procedure / Treatment	Guidance Notes
n/a	Impacted third molars	These services are commissioned, and applications are managed by the NHS England
n/a	Dental Extraction of non-impacted teeth	

2. Dermatology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 001A	Removal of benign skin lesions	Please note that where malignancy is suspected, the patient should be referred to an appropriate service under the two-week rule. Benign lesions (excluding lipomas and viral warts; please refer to the separate policy for these lesions). Clinically benign lesions should not be removed for cosmetic reasons and such procedures will not be funded. Details should be provided as to the nature of the lesion, the size and how it is affecting the patient. Removal of benign skin lesions is only available as a treatment option for patients where: • The lesions size or position causes serious functional limitations which severely impair activities of daily living*, as documented by the applicant **OR**

		• There is documented evidence that the lesion is causing recurrent symptoms such as bleeding, infection, or discharge over at least three months and has not responded to appropriate conservative treatment over this period. All clinicians must be prepared to justify to the ICB the criteria applicable for the treatment of any benign skin lesions. Any treatment of skin lesions outside of the criteria will not be funded. * dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing, and eating food) **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 001B	Lipomas	Soft tissue subcutaneous lesions, particularly over 5 cm, which are rapidly enlarging and not clearly longstanding and asymptomatic may be a soft tissue sarcoma. Please refer these patients to the appropriate service under the two-week rule. Removal of lipomatous lesions is permitted where the lesion is associated with at least one of the following criteria: • The lesion is an obvious or proven lipoma that is large (> 5cm) **OR** • The lesion causes serious functional limitation of movement resulting in documented impairment of activities of daily living (details of the impact on daily activities to be included in the application) **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 002	Viral Warts Procedures	Viral warts are usually of aesthetic significance only and surgical removal and / or laser treatment is not routinely funded by the ICB. The ICB will fund removal of viral warts in patients who are immunocompromised. There are no restrictions of genital or anal warts. • The patient is immunocompromised **OR** • Does the patient have genital/anal warts? **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 002A	Liposuction and compression therapy to resolve chronic Lymphoedema	The ICB will **not routinely** fund **cosmetic liposuction**. Liposuction may be funded: • As part of other surgical procedures when indicated for other conditions, e.g., thinning of a transplanted flap. **In lymphoedema patients:** ○ With moderate to severe lymphoedema (International Society of Lymphology stage II/III respectively). **AND** ○ Where all conservative methods (such as MLD and DLT) for treatment have been attempted and have failed.

		[Note- Manual lymphatic drainage (MLD)-Manual lymphatic drainage (MLD) for lymphoedema is currently routinely funded. However, if clinicians wish to provide Complex Decongestive Therapy of which MLD is usually a component, then pre-authorisation will need to be sought. **AND** ○ Patient selection should only be done by a multidisciplinary team as part of a lymphoedema service **AND** ○ Standard arrangements are in place for clinical governance, consent, and audit **Patients should be encouraged to stop smoking prior to treatment, if applicable**

3. Ears, Nose & Throat (ENT)

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 003	Adenoidectomy	Adenoidectomy for Otitis Media in children will not be routinely funded but combined with grommets, will be considered in children who fulfil the criteria (see section on grommets). NICE Guidance on Otitis Media recommends that adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms **Patients should be encouraged to stop smoking prior to treatment, if applicable**
N/A	Bone-anchored hearing aid - unilateral	This service is commissioned, and applications are managed by the NHS England

N/A	Bone-anchored hearing aids - bilateral	There is insufficient evidence to justify the use of bilateral bone anchored hearing aids (i.e., one on each side).
N/A	Cochlear implants	This service is commissioned, and applications are managed by the NHS England
TNRF2 005	Grommets	Grommets for children should be undertaken in accordance with NICE Clinical Guidance 60 (Feb 2008) Surgical Management of Otitis Media with Effusion in Children (Under 12 years old). Grommets will be routinely funded for children with recurrent acute otitis media (rAOM). rAOM is defined as have three or more separate episodes of AOM in the previous 6 months, or four or more episodes in the previous 12 months with at least one episode in the past 6 months. The stated threshold for surgical intervention (under 12s) is: Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention. This procedure is not routinely funded for people over the age of 12 except under the following conditions: • A middle ear effusion causing measured conductive hearing loss and is resistant to medical treatments. The patient must be experiencing disability due to deafness **OR** • Persistent Eustachian tube dysfunction resulting in pain (e.g., whilst flying)

		OR • As one possible treatment for Meniere's disease **OR** • Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma **OR** • Grommet insertion as part of a procedure for the diagnosis or management of head and neck cancer and/or its complications. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 006	Pinnaplasty/Otoplasty	This procedure is not routinely funded for adults on cosmetic grounds. Royal College of Surgeons Commissioning Guidance recommends Pinnaplasty for children aged 5-18. The ICB will consider funding for children when: • The child is aged between 5 and 18 years old **AND** • The surgeon has defined the deformity to the ear(s) as severe enough to require surgical correction **AND** • The child has clearly expressed concerns to the clinician which in their opinion or following a psychological assessment, it is considered that this is likely to be remedied through correction of the ear deformity

		Details of the child's psychosocial concerns must be clearly described in the IFR application. ***Note: there is no clinical evidence to suggest that the degree of prominence has a direct link to psychological distress. It is at the clinician's discretion to treat due to prominence.***
TNRF2 007 A/B/C	Rhinoplasty/Septorhinoplasty/ Septoplasty	The ICB will not routinely fund nasal surgery to correct the following 3 situations: • To stop snoring • Cosmetic appearance of the nose • For patients who are unhappy with the outcome of previous surgeries including immediate post-trauma corrections (whether provided by the NHS or private providers) **A. Rhinoplasty** Patient has: a) Nasal deformity is secondary to congenital cleft lip and/or palate (NB: this should be managed by a specialist cleft team) **OR** b) Chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves), which may be due to trauma, disease, or congenital defect, when **ALL** of the following criteria are met: i. Prolonged, persistent obstructed nasal breathing; ii. Physical examination confirming moderate to severe vestibular obstruction;

		iii. Airway obstruction will not respond to Septoplasty alone; iv. Nasal obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing); v. Conservative management for 6 months or more failed to relieve symptoms; vi. Patient suffers from severe or extreme obstruction of one or both nares. NB: Recommend use of Nasal Obstruction Symptom Evaluation (NOSE) Scale instrument (score 55 or more). **OR** c) Significant distortion of external anatomy subsequent to recent trauma NB: A humped or bent nose is not by itself sufficient evidence of injury **B. Septorhinoplasty** Patient must meet the following 2 criteria: • Patient requires the procedure as an integral part of a medically necessary Septoplasty **AND** • Patient has gross nasal obstruction on the same side as the septal deviation, so that to correct the nasal obstruction the external skeleton will also need correction. **C: Septoplasty** Patient has:

		• Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medical necessary surgical procedures (e.g., Ethmoidectomy) **OR** • Patient has recurrent rhino-sinusitis due to a deviated septum not relieved by appropriate medical and antibiotic therapy after at least 6 months of medical therapy **OR** • Patient suffers from recurrent epistaxis (nosebleeds) related to a septal deformity **OR** • Patient suffers from continuous nasal airway obstruction resulting in nasal breathing difficulty due to obvious and severe septal deviation with no other cause for the patient's apparent breathlessness (e.g., rhinitis, COPD) **OR** • Patient requires this procedure with the association of cleft palate repair **AND (in the case of open Septoplasty)** • Patient has an extremely deviated nasal septum that cannot be corrected adequately with an intranasal Septoplasty. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 008	Tonsillectomy	Tonsillectomy is not routinely funded except in persons who meet the following criteria:

		• Sore throats that are due to acute tonsillitis **AND** • Episodes of sore throat that are disabling and prevent normal functioning **AND** • Seven or more well documented clinically significant, adequately treated sore throats in the preceding year. (It is recognised, however, that not all episodes of tonsillitis will be documented in a face-to-face consultation as many will be treated at home. Significant time off work or school or a hospital admission are examples of situations that would suggest that a definite episode of tonsillitis had occurred). **OR** • Five or more such episodes in each of the preceding two years. **OR** • Three or more such episodes in each of the preceding three years Other indications for referral for tonsillectomy include complications such as peritonsillar abscess (quinsy), pharyngeal obstruction or 2 episodes of emergency hospital admission for tonsillitis or complications (this indicates severity and the SIGN criteria do not apply). **Patients should be encouraged to stop smoking prior to treatment, if applicable** **Tonsillectomy for Tonsil Stones (Tonsilloliths) or halitosis alone is not funded unless the patient meets the criteria above.**

4. Gynaecology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 009	Dilation and Curettage	The ICB will fund dilation and curettage for diagnostic purposes for suspected malignancy and for evacuation of retained products of conception. NICE Heavy Menstrual Bleeding CG 44 states that D&C is not recommended alone as a diagnostic tool or as a therapeutic treatment for heavy menstrual bleeding. Vacuum aspiration is the preferred treatment for removing retained products of conception. D&C for the investigation of abnormal uterine bleeding is appropriate in the following circumstances: • Transvaginal ultrasound with Pipelle endometrial aspirate has failed due to cervical stenosis or pain and facilities for a hysteroscopy with targeted biopsy are unavailable **OR** • Hysteroscopy with targeted biopsy has failed/is not possible due to cervical stenosis, pain, or inability to dilate the cervix **OR** • Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 010	Pelvic Organ Prolapse (surgical management of)	Surgical management of pelvic organ prolapse – this procedure is not routinely funded for asymptomatic or mild pelvic organ prolapse. Referral for specialist assessment with the option of surgical treatment is indicated for:

		• Patients with grade 1-2 POP whose symptoms have not improved with conservative management. This could include:
		  ○ lifestyle modification (losing weight, minimising heavy lifting, preventing/treating constipation)
		  ○ supervised pelvic floor muscle training for at least 16 weeks
		  ○ topical oestrogen
		  ○ pessary fitting
		OR
		• Patients with grade 1-2 POP combined with urethral sphincter incompetence or faecal incontinence
		OR
		• Patients with moderate to severe symptoms of prolapse (for example, grade 3-4, or including urethral sphincter incompetence or faecal incontinence), where conservative management has not improved symptoms, is not appropriate (for example, due to cognitive impairment) or has been declined by the patient.
		Providers are strongly encouraged to ensure shared decision making takes place with women considering surgery for POP.
		Patients should be encouraged to stop smoking prior to treatment, if applicable

TNRF2 011	Female Sterilisation	Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable.

		The ICB will fund this procedure: • Where sterilisation is to take place at the time of another procedure such as caesarean section **OR** • Where there is a clinical contraindication to the use of a Mirena/Implanon **OR** • Where there are severe side effects with the use of Mirena/Implanon **OR** • Where there is an absolute clinical contraindication to pregnancy. These are: • Young women (under 45 years of age) undergoing endometrial ablation for heavy periods • Women with severe diabetes • Women with severe heart disease **AND** • Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 012	Hysterectomy for heavy menstrual bleeding	Hysterectomy and treatments for heavy menstrual bleeding (HMB) will only be funded in line with NICE guidance CG88 and NHS EBI guidance on Hysterectomy (link available at: https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf) Hysterectomy should not be used as first line treatment solely for HMB. If considered when all other treatments have been tried and failed, the woman should be made aware of the risks associated with the procedure, in particular its impact of fertility. When agreeing treatment options, clinicians should consider shared decision-making what matters most to each woman and support their personal priorities and choices. It is advised that patients and clinicians use a decision aid endorsed by NICE: http://www.wisdom.wales.nhs.uk/sitesplus/documents/1183/HMB_Shared_Decision_Making_Aid_Updated_version_Mar-2020.pdf Hysterectomy should be considered only when: • Other treatment options have failed, or are contraindicated; • There is a wish for amenorrhoea (no periods); • The woman (who has been fully informed) requests it; • The woman no longer wishes to retain her uterus and fertility. **Treatment options:** • In women with no identified pathologies and with fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis, an LNG-IUS (levonorgestrel-releasing intrauterine system) should be considered as the first treatment.

		If LNG-IUS is not suitable or declined, clinicians should consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens. 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. Surgical options may include generation endometrial ablation and possibly hysterectomy if appropriate. For women with submucosal fibroids, consider hysteroscopic removal. • In women with fibroids over 3 cm in diameter the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter. Although pharmacological treatment options may be required while investigations and definitive treatment are being organised. Surgical options include second-generation endometrial ablation as the preferred a treatment of choice. Pre-treatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus. • If Ulipristal is considered as a pharmacological option, clinicians should follow Surrey PAD formulary guidance. For further information, please see: ***https://www.nice.org.uk/guidance/ng88*** **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 013	Labiaplasty	Surrey Heartlands ICB will **ONLY** consider commissioning labiaplasty where medically necessary **AND** secondary to another underlying medical condition: • Where the labia are directly contributing to recurrent disease or infection (this could include ulceration/maceration) **OR** • Cancer **OR** • Where the repair of the labia is required after significant trauma (including during childbirth) Surgery will only be considered for adults aged 18 or over (unless medically indicated, e.g., cancer, in under 18s) due to changes in the patient's body during puberty. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 014	Uterine Artery Embolisation for fibroids in woman	UAE may be considered for the treatment of symptomatic large (>3cm) or multiple fibroids and offered as a one-off treatment when: • The patient is symptomatic **AND** • Conservative management at first and second line (including but not limited to; gonadotropin releasing hormone analogues (GnRHas), non-steroidal anti-inflammatory drugs (NSAIDs), hormone replacement therapy (HRT), Levonorgestrel intrauterine system (LNG-IUS), tranexamic acid, other appropriate contraceptives, Ulipristal acetate if clinically appropriate, has been unsuccessful **AND**

		• Women of child-bearing age who wish, or might wish, to become pregnant in the future should only be offered the intervention after fully informed discussion about potential risks to fertility and should be considered on a case-by-case basis • This procedure should only be carried out by radiologists with the appropriate training and competence. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

5. Musculoskeletal (MSK)

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 014	Arthroscopy of the knee	Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag symptoms/signs/conditions) has demonstrated clear evidence of an internal joint derangement due to acute trauma/injury (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective. Knee arthroscopy will not be funded in cases of degenerative knee disease with or without mechanical symptoms (with the exception of cases with true locked knee). Autologous chondrocyte implantation (ACI) will be funded in line with the recommendations under NICE TA477: • The person has not had previous surgery to repair articular cartilage defects

		AND • There is minimal osteoarthritis damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis **AND** • The defect is over 2 cm^2 **AND** • The procedure is done at a tertiary referral centre **Patients should be encouraged to stop smoking prior to treatment, if applicable**
N/A	Arthroscopy of the hand / wrist	Removed from policy as no thresholds are utilised
N/A	Arthroscopy of the elbow	Removed from policy as no thresholds are utilised
TNRF2 015	Carpal Tunnel Syndrome	This intervention will be funded if: • Acute, severe symptoms persist after conservative therapy with either local corticosteroid injection by a trained, competent practitioner, and/or nocturnal splinting **OR** • Mild to moderate symptoms persist for a period of up to 6 months but no less than 4 months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks) **OR**

		• There is neurological deficit e.g., sensory blunting, muscle wasting or weakness of thenar abduction, or proven neurophysiological changes **OR** • Severe** symptoms significantly interfere with daily activities. Patients who are diabetic, and those who are aged 65 and over, should be referred urgently, without first attempting conservative therapies." There are 3 sets of circumstances for which urgent referral should be considered without attempting conservative therapies. **AND** • Patient has been engaged in shared decision making to ensure he/she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration. NB: It is recommended that a Patient Decision Aid is completed. This needs to be recorded in the patient's medical notes, including the written or other materials provided. Nerve Conduction Studies, if available, are suggested for consideration before surgery to predict positive surgical outcomes or where the diagnosis is uncertain. <u>Definition of severe**</u> The ICB will follow the **CTS severity symptoms defined in the BSSH classification**: **<u>Mild:</u>** Intermittent paraesthesia with or without pain that may be nocturnal or occurs with a certain hand position.

		Moderate: Paraesthesia that interferes with activities of daily living or causes constant night waking and/or reversible numbness and/or pain (perhaps by clenching and unclenching of fist or hand shaking). **Severe:** Constant numbness or disabling pain with wasting of thenar muscles, and/or weakness of thumb muscles (Abductor Pollicis Brevis and Opponens Pollicis). **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 016	Balloon kyphoplasty for vertebral compression fractures	NICE Interventional Procedure Guidance 166 supports the use of balloon kyphoplasty if the procedure is undertaken following discussion with a specialist multidisciplinary team that includes a radiologist and a spinal surgeon. The guidance also states that there should be good imaging facilities, arrangements for access to a spinal surgery service and that clinicians reach an appropriate level of expertise before carrying out the procedures. In particular, they must follow the manufacturer's instructions for making the cement, to reduce the risk of embolisation. The ICB expect this service to be provided at centres that fulfil all the conditions stipulated by NICE. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 017	Discectomy for Lumbar Disc Prolapse (elective)	This procedure is not routinely funded unless: • The patient has had appropriate imaging e.g., MRI or CT showing disherniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms

		AND • The patient has radicular pain (below the knee for lower lumbar herniations; into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement **OR** • There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30o and 70o or positive femoral tension sign) **AND** • Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g., analgesia, physiotherapy, bed rest, etc.), provided that analgesia is adequate and there is no imminent risk of neurological deficit **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 018	Dupuytrens contracture – Surgical Treatment / Interventional Procedures, including Needle Fasciotomy	The ICB will only fund surgical treatment/interventional procedures if: • There is a metacarpophalangeal joint contracture of 30° or more **OR** • Any degree of proximal interphalangeal joint contracture **OR** • The patient exhibits the characteristics of Dupuytrens diathesis i.e., earlier age of onset, bilateral disease, or extra-palmar disease. **OR** • The patient shows recurrent symptoms of the disease.

		If an exact measurement is not possible, the clinical assessment should include an evaluation of the extent of disease and an estimate of severity/deformity. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 019	Ganglions: Wrist and surgical techniques for treatment of	This procedure is not routinely funded except in severe cases. Classification: • Mild - Asymptomatic lump • Moderate – 1) Symptomatic lump; long duration of symptoms - pain lasting 3-6 months (2) Occult ganglia – hidden ganglion (3) Cancer-phobia – excessive fear of malignancy • Severe – 1) Nerve or blood vessel compression with restriction of activities of daily living or (2) concern regarding diagnosis. Treatment: • All patients should be informed that most ganglia resolve spontaneously with the passage of time • For mild and moderate cases - reassurance and observation • Aspiration of cancer reassurance - refer for ultrasound / MRI if concerns re diagnosis **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 020	Hallux valgus: Surgical treatment of	• Surgery is offered if symptoms are severe or deteriorating and the risk-benefit ratio is judged favourable

		• Conservative management measures should have been tried and should have failed to resolve the condition before surgery is considered • There should be severe deformity causing significant functional impairment of daily activities **OR** • Severe pain requiring regular painkillers and causing significant functional impairment of daily activities. Conservative management techniques include: • Avoiding high heeled shoes and wearing wide fitting leather shoes which stretch • Exercises specifically designed to alleviate the effects of a bunion and keep it flexible • Applying ice and elevating painful and swollen bunions • Use of bunion pads, splints, insoles, or shields Significant functional impairment is considered as: • Symptoms which prevent the patient fulfilling vital work or educational responsibilities **OR** • Symptoms which prevent the patient carrying out vital domestic or carer activities Before consulting a specialist for surgery, patients must accept that they will be unable to drive for 6 weeks (or 2 weeks after surgery on the left foot if driving an automatic car) and will be off work for 2 weeks for a sedentary job.

		In addition to the above criteria, smoking cessation and weight management should be considered as an integral part of appropriate clinical management prior to consideration of any elective surgery (with referral to appropriate services if indicated). Current evidence on safety and efficacy in relation to the correction of hallux valgus using minimal access techniques is inadequate NICE (IPG 332). **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 021	Spinal fusion for the treatment of lower back pain	This procedure will only be funded in line with NICE guideline (NG59) and the National Low Back Pain Pathway (2017): Spinal fusion **is not offered** to people **with non-specific low back pain** unless as part of a randomised controlled trial. Spinal fusion **may be considered** for patients who: • Have not responded to conservative* management **AND** • Have significant back pain accompanying radicular pain with localised degenerative changes **OR** • Have other specific pathologies and conditions as listed below: - Spondylolysis and significant spondylolisthesis (Grade 2 or greater). - Lumbar deformity in children and adults - Decompression for spinal stenosis with symptoms of claudication - Post-surgical back pain where multiple revision surgery is required

		* Conservative management includes but is not limited to the following: • Self-management and continue with normal activities as much as possible • Exercise and relaxation techniques • Manual therapies (spinal manipulation, mobilisation, soft tissue techniques such as massage) as part of a treatment package • Analgesics • NSAIDS (if not tolerated, ineffective or contraindicated consider weak opioids) • Psychological therapies (as part of a treatment package) • Return to work programme • Low Intensity Comprehensive Combined Physical and Psychological Programmes (CPPPs) if available Consider specialist triage review 12-18 weeks following initial presentation and conservative management. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF22 022	Trigger Finger: Surgical techniques for the treatment of	One in five patients with Trigger Finger will improve without any intervention other than resting the hand and allowing the inflammation time to settle. Surrey CCGs will only fund surgical techniques for the treatment of Trigger Finger when the following criteria are met: • The patient has failed to respond to conservative treatment which includes two corticosteroid injections.

		(Please note: Referral for surgery should only be considered if the patient has failed to respond to both steroid injections. Given steroid injections take time to be effective, any referral or request for funding for surgery must not be made until at least 3 months has elapsed after the second corticosteroid injection). **OR** • The patient has a fixed flexion deformity that cannot be corrected **OR** • The patient has diabetes. In this case the patient should be referred without first attempting conservative management **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 023	Vertebroplasty (Percutaneous)	This procedure will only be funded in line with NICE IPG 12. This procedure should only be undertaken when there are arrangements for good access to a spinal surgery service, and with prior discussion between a specialist multidisciplinary team that includes a radiologist and a spinal surgeon. Clinicians should receive training to reach an appropriate level of expertise before carrying out this procedure. In particular, they must follow the manufacturer's instructions for making the cement, to reduce the risk of embolisation. The procedure should be limited to patients whose pain is refractory to more conservative treatment. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 023A	Total Hip Replacement for Osteoarthritis	The CCG will fund THR for OA **only** when all other treatment options and conservative measures have failed. These include: **a. Medication**: oral/topical NSAIDS and paracetamol-based analgesics **AND** **b. Patient Education:** Shared decision making (SDM) to ensure patients are fully informed about the treatment options available and that their personal preferences and circumstances are taken into consideration. SDM should be supported by the use of a QoL tool to ensure that patients' overall wellbeing is at the centre of decision making. **AND** **c. Physiotherapy and exercise** **AND** **d. Healthy lifestyle improvements:** There is evidence to suggest that a healthy weight is associated with better outcomes pre/post-surgery. Evidence also shows a decline in the need for revision surgery when a patient weight is being kept within healthy parameters. It is anticipated that patients and clinicians in primary and secondary care will discuss options for weight loss where clinically appropriate including referral to weight management service – if available - prior to referral for surgery. Patients who smoke should have been encouraged to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and post-surgery complications.

		Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks. **e. The following criteria must also be met:** • Intense to severe persistent pain which leads to severe functional limitations **OR** • Moderate functional limitation affecting the patient's quality of life despite 3 months of conservative measures **f. <u>Exceptions should include:</u>** • Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 023B	Total Knee Replacement (TKR)	The CCG will only fund TKR for OA in patients meeting the following criteria. It is presumed that all referrals for surgical intervention meet these criteria prior to referral unless exceptional in which case the referral should document explicitly the reason for exceptional circumstances.

		Prior conservative management should have been tried and failed and must include all of the following: **a. Medication** • analgesics • anti-inflammatory medication **b. Physiotherapy** • muscle strengthening • supervised physical therapy **c. Patient education** • benefits of eliminating damaging influences on the knee • benefits of activity modifications • support aids • support 'shared decision making' by discussing treatment options with people offered primary elective knee replacement in accordance with CG177 1.6.2 and NG157 1.1.2 **d. Healthy lifestyle improvements** • There is evidence to suggest that a healthy weight is associated with better outcomes both pre- and post-surgery. It is anticipated that all clinicians involved in the patient's pathway will discuss options for weight loss with the patient – if clinically appropriate - including referral to weight management service if available - prior to referral for surgery • Patients who smoke should have been encouraged to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and post-surgery complications • Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks

		AND When the following criteria have been met: a. Uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of maximal conservative treatment; The above been evidenced by X-Ray/MRI scan showing bone on bone damage **AND** b. Symptom's refractory to at least 3 months conservative management for the condition This policy does not affect criteria for immediate/urgent referral to orthopaedic services in respect of: • Evidence of infection of the knee joint • Symptoms indicating a rapid deterioration of the joint • Persistent symptoms that are causing severe disability *Glucosamine products and hyaluronic acid are not routinely funded. Hyaluronic acid will only be made available on an individual basis for patients whom other pharmacological options have been intolerable, ineffective or have been unable to undergo surgery. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 023C	Hip Impingement Syndrome	Open or arthroscopic femero-acetabular surgery for hip impingement is commissioned if the following criteria are met: • Labral tear or impingement has been confirmed on MRI

		AND • Where hip arthroscopy is supported in the washout of an infected native hip joint in patient's refractory to medical management, patients with underlying disease or patients who are immunosuppressed • Where hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies • The clinician has ensured that the patient understands what is involved, is aware of the serious known complications outlined in NICE patient information and agrees to the treatment knowing that there is only evidence of symptom relief in the short and medium term **AND** • The surgeon must have completed specialist training and have experience of providing arthroscopic hip surgery **AND** • The provider will provide full data on 100% patients undergoing this procedure to the British Hip Society register **AND** • The provider will undertake local review of cases to monitor safety and short-term outcomes **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF02 047	Metal on Metal Hip Resurfacing	Metal on Metal Hip Resurfacing will be funded as per NICE TA304 guidance: • 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. https://www.nice.org.uk/guidance/ta304 **Patients should be encouraged to stop smoking prior to treatment, if applicable**

6. Ophthalmology

Policy Number	Procedure / Treatment	Guidance Notes
N/A	Cataract Surgery	Removed from policy as no thresholds are utilized
TNRF2 025	Excision of Chalazion	This procedure is not routinely funded. Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve. Treatment consists of regular (four times daily) application of heat packs. The ICB will fund excision of chalazia when the following criteria are met: • Chalazion will be removed when it has been present for a minimum of 4 months **AND** • When it is causing blurred vision **OR**

		• When it is a source of regular infection that has required medical attention twice or more The watchful waiting period should usually be between 4 to 6 months at the clinician's discretion as many will resolve with conservative management during that time. In common with all types of lesions, the ICB will fund removal where malignancy is suspected. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 026	Blepharoplasty / ptosis surgery	Blepharoplasty will not be funded for cosmetic reasons. The ICB will consider funding in the following circumstances: **Upper blepharoplasty:** There is documented evidence of interference with vision (such as difficulty reading, driving, looking through the eyelids or seeing the upper eyelid skin) **OR** There is redundant skin overhanging the upper eyelid margin and resting on the eyelashes when gazing straight ahead **OR** There is evidence that where it is not overhanging, the upper lid covers the upper pupil margin **AND** Evidence from visual field testing shows the visual fields are reduced to 120 degrees laterally and/or 20 degrees or less superiorly.

		A degree of interpretation will need to be applied as the area of the visual field where the missing points are concentrated within the 120 to 20 range is crucial to establish the severity of the visual impairment. **AND** Photographic evidence is provided and must show the redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead. Photographs must be taken: • From the front with the camera at eye level with the lid in a relaxed position and the person looking ahead. • The above will need to be supplemented by a picture taken from the side of the patient. NB It is recommended that the test is monocular and that the 120-point Humphrey visual field chart is used." **<u>Lower blepharoplasty:</u>** • Correction of Ectropion or Entropion which threatens the health of the affected eye. **OR** • Removal of lesions of eyelid skin or lid margin causing functional problems **OR** • Rehabilitative surgery for patients with thyroid eye disease. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 026a	Brow Lift and Ptosis Correction	Brow lift and ptosis correction will ONLY be funded for severe cases, where it is established that the patient's visual field is significantly affected, and as a result daily living activities have become restricted, and blepharoplasty alone is inappropriate or insufficient. The same visual field parameters used for Blepharoplasty will be used for Brow-lift and Ptosis correction and it is recommended that the 120-point Humphrey visual field chart is used. Patients will need to meet the following criteria: • There is documented evidence of interference with vision (such as difficulty reading, driving, looking through the eyelids or seeing the upper eyelid skin) **AND** • Evidence from visual field testing shows the visual fields are reduced to 120 degrees laterally and/or 20 degrees or less superiorly. A degree of interpretation will need to be applied as the area of the visual field where the missing points are concentrated within the 120 to 20 range is crucial to establish the severity of the visual impairment • The test used should be monocular • Photographic evidence must be provided and must show the redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead **AND** • Photographic evidence is provided and must show the redundant skin overhanging the upper eyelid margin and resting on the upper eyelashes when gazing straight ahead. Photographs must be taken: • From the front with the camera at eye level with the lid in a relaxed position and the person looking ahead.

		The above will need to be supplemented by a picture taken from the side of the patient. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

7. Other Surgery

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 027	Inguinal hernia in adults (elective surgical repair of)	This procedure is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Patients should be referred for surgical assessment if they meet the following criteria **(These criteria apply to adults only):** • A history of incarceration of, or real difficulty reducing, the hernia **OR** • An inguino-scrotal hernia **OR** • Increase in size month to month **OR** • Pain or discomfort significantly interfering with activities of daily living **OR** • Work related issues e.g., of work/missed work/unable to work/on light duties due to hernia Patients with femoral hernias should be referred for consultation.

		NB: All cases of suspected femoral hernia and groin hernias in women are routinely funded. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 028	Umbilical hernia in adults (elective surgical repair)	Surgical treatment should only be offered when one of the following criteria is met **(These criteria apply to adults only):** • Pain/discomfort interfering with activities of daily living **OR** • Increase in size month on month **OR** • To avoid incarceration or strangulation of the bowel **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 029	Incisional hernia in adults (elective surgical repair)	Surgical treatment should only be offered when both of the following criteria are met **(These criteria apply to adults only)**: • Pain/discomfort interfering with activities of daily living **AND** • Appropriate conservative management has been tried first, e.g., Weight reduction where appropriate **Patients should be encouraged to stop smoking prior to treatment, if applicable**

TNRF2 030	Female Breast Reduction	Breast reduction should only be considered an option for patients who fulfil all of the following criteria: • Documented and ongoing physical symptoms of back, neck and/or shoulder pain due to large breasts (plus documented evidence of treatment for pain) • Requires more than 500g tissue removed from each breast (to be assessed by surgeon*) • BMI of <26kg/m² • Non-smoker GPs should not refer patients into secondary care if they do not fulfil the above outlined criteria (with the exception of estimating the amount of tissue*). This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 031	Breast implant removal and replacement	Removal of implants will be considered, if at least one of the following criteria are met: Please note: Replacement of Breast Implants will not be considered. • Rupture of silicone-filled implant • Implants complication by recurrent infections • Extrusion of implant through skin • Implants with Baker Class IV contracture • Implants with a contracture that interferes with mammography • Intrinsic breast disease

		Surrey Heartlands ICB do not replace breast implants for aesthetic reasons. Re-insertion of implants following removal: (i) Where implants were originally funded by the NHS for non-cosmetic reasons (such as breast cancer or severe trauma) then replacements should be considered in line with the reason for the original funding for implants. (ii) Where implants were originally funded solely for cosmetic reasons they will not be replaced. If implants are bilateral and one implant has to be removed for a sound clinical reason, it will not be replaced so the woman should be given the choice as to whether she wishes only one or both implants to be removed. Privately funded implants: where implants have been previously funded privately and require removal for a sound clinical reason and this has occurred within 12 months of insertion, the applicant should in the first instance approach the private provider to correct the problem rather than pursuing NHS funding. Where cases fall outside of these criteria and there is a possibility that they may be considered either rare or exceptional or both, they can be considered through the usual IFR process. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 040	Hyperhidrosis, treatment of	Botulinum toxin A (BTX-A) and endoscopic thoracic sympathectomy will be funded under the following circumstances: **<u>Botulinum Toxin A for Axillary Hyperhidrosis</u>** **Clinical thresholds;**

1. Patient has **primary axillary hyperhidrosis** which occurs without stimulus of heat or exercise, and which has no other underlying clinical cause such as secondary hyperhidrosis due to hyperthyroidism, menopause, medication, or amphetamines, etc.

AND

2a) The excessive axillary sweating has a significant impact on the patient's personal/professional life i.e., Hyperhidrosis Disease Severity Score* (HDSS) 3 or 4

OR

2b) The patient has complications due to axillary hyperhidrosis such as skin maceration with secondary skin infections

*Hyperhidrosis Disease Severity Scale (HDSS).

HDSS Score	Subjective Score
1. Mild	Sweating is never noticeable and never interferes with daily activities
2. Moderate	Sweating is tolerable but sometimes interferes with daily activities
3. Severe	Sweating is barely tolerable and frequently interferes with daily activities
4. Severe	Sweating is intolerable and always interferes with daily activities

AND

3a) Patient has failed to respond to a six- month trial of topical aluminium chloride or extra strength antiperspirants (i.e., no change in HDSS score)

OR

		3b) Patient is unable to tolerate topical aluminium chloride (e.g., causes a severe rash) **AND** 4. The patient is unresponsive or unable to tolerate oral anti-muscarinic as recommended treatment options by the Area Prescribing Committee: **Oxybutynin (off label for hyperhidrosis)** BLUE on recommendation by the specialist team • Immediate release (IR) preferred choice antimuscarinic treatment option • Modified release (MR) preparation may be used for patients with intolerable side effects to IR preparation. **All other oxybutynin formulations for hyperhidrosis** • Non-formulary **Propantheline (licensed for hyperhidrosis)** BLUE on recommendation from the specialist team • Offered after oxybutynin if intolerable side effects or inefficacy to that treatment **Glycopyrronium oral (off label for hyperhidrosis)** RED traffic light status • Treatment choice after oxybutynin and propantheline if they have not been tolerated or have not been effective • More expensive than other treatment options in primary care, although significantly less costly in secondary care

		AND 5. Patient does not have any contraindications to the use of Botox injections: • Pregnancy or breast feeding • Previous allergy to botulinum toxin • Muscle disorders or use of muscle relaxant therapy • Coagulation disorders, on concurrent aspirin or anticoagulant therapy • Previous surgery to the axilla Please note: BTX-A is unlicensed for the treatment of palmar, plantar, or craniofacial hyperhidrosis. It is not routinely funded and would require application only via the IFR process by the treating clinician. **Surrey Heartlands does not routinely fund iontophoresis for excessive sweating** Primary care advice Although primary care is not directly responsible for requesting prior approval, primary care needs to be aware of the detailed clinical criteria relating to this commissioning policy before referring the patient to the appropriate secondary care service. Primary care treatment options can be found at: Hyperhidrosis | Health topics A to Z | CKS | NICE Surrey PAD Antimuscarinics - Hyperhidrosis

		<u>Endoscopic thoracic sympathectomy</u> Endoscopic Thoracic Sympathectomy surgery for severe palmar or axillary hyperhidrosis will only be funded when all routinely commissioned treatment options have failed. In addition, the patient must be fully informed of the risks, benefits, side effects of the procedure and the characteristics of a patient likely to experience better outcomes. Routinely commissioned treatment options include: a. **Lifestyle** interventions b. **Aluminium chloride** c. **Oral antimuscarinic** see treatment options in previous section d. **Botulinum toxin A** see criteria in previous section. e. **Local surgery** (only for axillary hyperhidrosis) f. **Iontophoresis** is not currently routinely funded due to lack of high-quality evidence on its long-term efficacy. Patients who wish to use Iontophoresis will need to purchase the required equipment privately. Patients should be informed of the risks of serious complications associated with Endoscopic Thoracic Sympathectomy, such as hyperhidrosis elsewhere on the body in around 50% of patients, failure to reduce hyperhidrosis and some patients regret having had the procedure (especially because of subsequent and persistent hyperhidrosis elsewhere) Funding for endoscopic thoracic sympathectomy for craniofacial hyperhidrosis will only be available when it coexists with facial blushing Surrey Heartlands do not routinely fund endoscopic thoracic sympathectomy for plantar hyperhidrosis due to limited evidence on effectiveness.

		Patients should be encouraged to stop smoking prior to treatment, if applicable
TNRF2 042	Gallstones, surgical treatment of	Cholecystectomy will not be funded for asymptomatic gallstones Where patients are asymptomatic, an IFR application is required. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 043	Haemorrhoids, surgical treatment of	Often haemorrhoids (especially early-stage haemorrhoids) can be treated by simple measures such as eating more fibre and drinking more water. When conservative treatments are unsuccessful, many patients will respond to outpatient treatments in the form of rubber band ligation or perhaps injection. Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically: • Recurrent Grade 3 or 4 combined internal/external haemorrhoids with persistent pain or bleeding • Irreducible and large external haemorrhoids Surgery should be performed, according to patient choice and only in cases of: • Persistent Grade 1 or 2 haemorrhoids that have not improved with dietary changes, banding, or injection • Recurrent and symptomatic Grade 3 or 4 haemorrhoids and those with a symptomatic external component **Patients should be encouraged to stop smoking prior to treatment, if applicable**

8. Other Procedures

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 032	Assistive Communication Assessments (ACA) and Equipment	Assessment: The ICB will fund an ACA assessment where it has been recommended by Speech & Language Therapist for patients with ongoing complex communication needs. Equipment recommended as a result of these ACA assessments is not routinely funded by the NHS.
TNRF2 033A	Open MRI Scans	Access to open MRI scans is not routinely funded by the CCG and is subject to this restricted policy. Surrey Priorities Committee has considered the evidence for open/upright MRI scans. Conventional closed MRI scanners are considered to be the gold standard for producing diagnostic images. Open MRI scans provide lower quality images and take longer to produce than those from a conventional scanner. If open/upright MRI scans are to be provided they must be of 0.5 Tesla magnetic strength or above. Surrey Heartlands supports the use of an open MRI scan where at least one of the following criteria are met:

		• Patients who are unable to tolerate conventional MRI due to claustrophobia despite trying a number of conservative measures to manage the anxiety, such as being offered mild sedatives, use of physical measures like noise cancelling headphones, and scanning feet first, and psychological measures such as reassurance and explanation, and specific treatments for anxiety from a therapist. The prescription for the mild sedative should be from a Radiologist. **OR** • Patients who are unable to fit in a conventional MRI scanner, e.g., due to obesity. **OR** • Patients who are unable to lie flat for the duration of a conventional MRI scan due to significant medical reasons, e.g., due to extreme pain. Any patient who requires an Open MRI scan and meets the criteria above should be referred to an appropriate open MRI scanner facility on a Provider-to-Provider basis. **Please note:** Clinicians requesting an open MRI scan for patients with debilitating symptoms which are thought to be due to weight bearing pathology can refer the case for assessment for funding on an individual basis via the Individual Funding Request process. (Potential examples of this include examination of the lumbar spine, neck and spine muscles, knee, and hip joints).
TNRF2 046	Continuous Positive Airway Pressure (CPAP) for the obstructive sleep apnoea/hypo-apnoea syndrome	Evidence shows that weight loss and exercise decrease the severity of obstructive sleep apnoea and that alcohol and smoking increase its severity.

		Based on these findings, lifestyle modifications of weight loss, aerobic exercise, alcohol abstinence and smoking cessation are effective treatments for obstructive apnoea, particularly in patients with mild to moderate symptoms, and where possible should be tried first. (See below for NICE recommendation to assessing severity levels). CPAP should be offered to patients with mild to severe symptoms in line with NICE TA139, with intra-oral devices being offered to patients who do not tolerate CPAP. If all options involving lifestyle changes, CPAP, intra-oral devices have been tried and failed, and in line with NICE NG202, surgical procedures for the treatment of this condition for people with severe OSAS will only be funded if a sleep clinic or respiratory consultant makes a recommendation for a surgical assessment of a patient with sleep apnoea and the subsequent surgical assessment confirms the need for a surgical intervention to address the sleep apnoea.
TNRF2 033B	Referral for Ketogenic diet	Referrals will only be funded for children up to the age of 18 years with: • Epilepsy whose seizures have not responded to appropriate AEDs (Refractory epilepsy) **OR** • Glucose 1 transporter deficiency **OR** • Pyruvate dehydrogenase deficiency Refractory epilepsy is defined as: “a failure of adequate trials of 2 tolerated and appropriately chosen and used anti-epileptic drugs schedules”.

		Children with refractory epilepsy who are candidates for surgery may not be eligible for the diet. The ICB recommend that the classical ketogenic diet (CKD) is used as first line for those who might be considered. However, other variants of the diet may be used if this diet is not tolerated or appropriate for the patient. The ICB does not recommend funding the treatment for refractory epilepsy in adults due to the limited evidence-base or for other neurological conditions such as autism and epilepsy syndromes in children and adults due to the limited evidence-base.

9. Pain Management

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 035	Lumbar Facet Joint injections	Facet joint injections are **NOT** routinely funded for patients with chronic non-specific low back pain and those with sciatica. The ICB will fund medial branch blocks for the diagnosis of lumbar back pain to establish whether the main source of pain is thought to come from structures supplied by the medial branch as follows: • The patient is part of a comprehensive pain management programme **AND** • All non-surgical and conservative management options (physiotherapy treatments and guided exercise programmes, pharmacotherapy including analgesia and muscle relaxants) have been tried and failed. Please provide evidence of robust conservative therapy (e.g., physiotherapy report) within the last 12 months.

		AND The pain has resulted in moderate to significant impact on daily functioning (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral with no evidence of other pathology. No evidence of contraindications is present for the needle placement and injection of local anaesthetics. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 036	Spinal Epidural injections	Epidural injections of local anaesthetic and steroid will only be funded for people with acute and severe sciatica. Epidural injections will not be funded for neurogenic claudication in people who have central spinal canal stenosis. **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 045	Radiofrequency denervation	Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block. Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when: Non-surgical treatment has not worked for them, and the main source of pain is thought to come from structures supplied by the medial branch nerve, and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral. **AND**

		Only perform radiofrequency denervation in people with non-specific low back pain after a positive response to a diagnostic medial branch block. **AND** Do not offer imaging for people with non-specific low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

10. Urology

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 037	Circumcision	Male circumcision in Surrey in not routinely funded. Conservative measures should always be explored prior to referral for surgery. This policy covers men of all ages however it should be noted that for those under 16 consultations should focus on reassurance and education of parents and child. If there is concern that any pathology is evident, or if there is diagnostic uncertainty, referral to a regional centre undertaking paediatric surgery is indicated. The expectation is that this would be a minority of children. For information, the proportion of partially or fully retractable foreskin is only 4% at birth but increases to 99% by the age of 14. Male circumcision will be funded in Surrey for patients with: • Recurrent paraphimosis where conservative treatment has failed (more than 3 clinically significant episodes annually)

		• Malignant or pre-malignant preputial lesion that is confined to the foreskin • Recurrent balanitis where conservative treatment has failed (more than 3 clinically significant episodes annually) • Congenital abnormalities of the urinary tract and in order to prevent urinary tract infection in patients with an abnormal urinary tract • Traumatic foreskin injury where it cannot be salvaged • Pain on arousal or interference with sexual function where conservative measures have been attempted and have failed, including topical steroids and education* *the expectation would be that this would normally be in over 16s **Please note; female circumcision is illegal.** **Patients should be encouraged to stop smoking prior to treatment, if applicable**
TNRF2 044	Surgical removal of Varicocele	Surgical removal of varicocele in adults and children may be funded where the patient meets the following criteria: **Children (under 16):** Grade II or III varicocele **AND** asymmetrical >2 cm^3 **OR** >20% difference

		<u>Adults:</u> Grade II or III varicocele **AND** Symptomatic with persistent pain/significant discomfort despite adequate conservative management **OR** With abnormal semen parameters Men should be informed that surgery for varicoceles as a form of fertility treatment is not advised because it may not improve pregnancy rates. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

11. Vascular Surgery

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 038	Varicose Veins	Patients with symptomatic varicose veins should be offered treatment of their varicose veins. Compression hosiery **is not** recommended if an interventional treatment is possible. 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 they have any of the following; • Symptomatic* primary or recurrent varicose veins • Lower limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency • Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence • A venous leg ulcer (a break in the skin below the knee that has not healed within two weeks) • A healed venous leg ulcer. ***Symptomatic**: Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness, and itching). 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. **Patients should be encouraged to stop smoking prior to treatment, if applicable, if applicable**

12. Weight Management

Policy Number	Procedure / Treatment	Guidance Notes
TNRF2 041	Bariatric Surgery (primary and revision surgery)	**Primary Surgery** The ICB will routinely fund Primary Bariatric Surgery for patients to meet all of the following criteria. • Patient is 18 years or over • Patient has a BMI of 40kg/m2 or more **OR** • A BMI between 35 kg/m2 and 40kg/m2 in the presence of other significant diseases • Patient has undergone a formalised MDT led processes for the screening of comorbidities and the detection of other significant diseases • Morbid/severe obesity has been present for at least five years • The individual has attended a local bariatric surgery information session prior to referral • The individual has followed dietary, and exercise advise for at least 12 months • For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months • The ICB will not commission the removal of excess skin resulting from weight loss following bariatric surgery. Please ensure that the patient is aware of this policy before proceeding with Bariatric Surgery

		<u>Revision Surgery</u> **<u>Group 1:</u>** Patients presenting with a clinical history, symptoms and/or signs that suggest acute/acute on chronic/worsening medical and /or surgical complications related to their primary obesity operation. Patients must be triaged and treated immediately if classified as 'emergency'. Patients are triaged by an MDT and may be assessed as 'clinically urgent' if they are judged to have a subsequent risk of developing emergency complications if they remain untreated. This category will include patients with adverse anatomical complications or the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/or the gastro-jejunal junction. This corrective surgery, or in rare cases reversal surgery, would be as per routine and considered as good clinical practice. Trusts (providers) should triage referral letters from GPs, hospital consultants on this basis. ICBs will routinely fund Group 1 patients. **<u>Group 2:</u>** The patient has failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight. This category will include patients who following a Gastric Bypass develop a dilated gastric pouch or gastro-jejunal anastomotic dilatation. This category will not include patients who have previously had vertical banded gastroplasty. **The ICB will not be routinely funding Group 2 patients. Please submit an IFR application if you feel this patient is rare or clinically exceptional.**

		<u>Group 3:</u> The patient has multiple, severe, and life-threatening co-morbidities which have persisted or re-emerged following primary obesity surgery despite strong evidence that the patient has both attended and engaged with the follow up programmed and multidisciplinary assessment has determined and agreed: • The co-morbidities are potentially life threatening or present a significant risk to health and well – being that is both severe and serious (in the short to medium term) • The presence of clear grounds of clinical exceptionality. **The ICB will not be routinely funding Group 3 patients. Please submit an IFR application if you feel this patient is rare or clinically exceptional.** **<u>Group 4:</u>** Some patients may have had their primary obesity surgery outside of NHS contracts at independent/private providers (including abroad) but subsequently present at NHS facilities as clinical emergencies. The NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment as per Group 1. **Patients should be encouraged to stop smoking prior to treatment, if applicable**

13. Appendix A – Procedural Document Checklist for Approval

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
1.	**Sponsoring Director**		
	Is there a sponsoring director?	Yes	
	Have they approved **this version** of the policy?	Yes	
2.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
3.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
4.	**Development Process**		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
5.	**New or review**		
	Is this a new document?	No	
	Is the ratification date stated on the front cover?	Yes	
	Is the ratification Committee stated on the front cover?	Yes	
	Is the review date stated on the front cover?	Yes	
	Is the version control detailing the version history of the document?	Yes	
	If this is a review document, has the version number been amended throughout?	Yes	
6.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target group clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
7.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	No	Policy developed with evidence reviews agreed

Title of document being reviewed:		Yes/No/ Unsure	Comments/ Details
			by SPC and HCPC
	Are key references cited?	Yes	
8.	**Quality and Equality Impact Assessment**		
	Has a QEIA been completed?	Yes	
	Is the QEIA attached?	Yes	This will be updated to new template at next review
9.	**Style and Format**		
	Is the style and format in line with the *Framework for the Production of Procedural Documents*?	Yes	
	Does the footer include the title, date of ratification and version number?	Yes	
	Are definitions provided for the key terms used in the document?	Yes	
	If applicable, are abbreviations written according to the guidance in *Framework for the Production of Procedural Documents*?	Yes	
10.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
11.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how the document will be disseminated and implemented amongst the target group? Please provide details.	Yes	Policies circulated by SH Contract Team
12.	**Process for Monitoring Compliance**		
	Have specific, measurable, achievable, realistic, and time-specific standards been detailed to monitor compliance with the document? Complete Compliance & Audit Table.	Yes	
13.	**Review Date**		
	Is the review date identified?	Yes	
14.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for implementing and reviewing the documentation i.e., who is the document owner?	Yes	

14. Appendix B – Compliance and Audit Table

Criteria	Measurable	Frequency	Reporting to	Action Plan/ Monitoring
Review of clinical evidence of procedures	N/A	5-year cycle	HCPC	SPC work plan/NICE guidance/EBI thresholds