Lancashire and South Cumbria NHS Clinical Commissioning Groups (CCG)

Level of change document (to align policies with NHS England Evidence-based intervention (NHSE EBI) guidance – May 2019

Policy	CCG	Current CCG policy	Level of change
Policy for the Surgical Release of Trigger Finger	All 8 CCGs (Blackburn with Darwen CCG Blackpool CCG Chorley South Ribble CCG East Lancashire CCG Fylde and Wyre CCG Greater Preston CCG Morecambe Bay CCG West Lancashire CCG)	The CCG will commission the surgical release of trigger finger when one or more of the following criteria are satisfied: • Patient has failed to respond to a single injection of steroid and local anaesthetic or it is contraindicated • Triggering has recurred after injection treatment • Patient has fixed deformity that cannot be corrected	The NHSE EBI guidance criteria includes: - splinting can be used as an alternative to steroids as a conservative management treatment. - Does not require diabetics to try conservative management prior to surgery. - Allows treatment if the patient has had two other digits unsuccessfully treated via conservative management. The criteria above will be added to the current policy criteria.
Policy for Tonsillectomy/Adeno-Tonsillectomy	All 8 CCGs	The CCG will commission tonsillectomy as part of the investigation and management of malignancy or suspected malignancy without a need for prior approval for funding.	THE NHSE EBI guidance criteria includes:

		The CCG will commission tonsillectomy/adeno-tonsillectomy, subject to the judgement of the clinician responsible for managing the patient's condition, when the SIGN[1] criteria are met, as follows: The patient has a sore throat due to acute tonsillitis. **AND** The episodes of sore throat are disabling and prevent normal functioning **AND ONE OF THE FOLLOWING**: The patient has had seven or more well documented, clinically significant, adequately treated sore throats in the preceding year **OR** The patient has had five or more such episodes in each of the preceding two years **OR** The patient has had three or more such episodes in each of the preceding three years. The CCG will also commission tonsillectomy for patients with a confirmed diagnosis of obstructive sleep apnoea who are either: Aged under 16[2] **OR** Aged 16 or over[3] when there is advice from a centre with expertise in sleep apnoea that CPAP has failed to control symptoms and tonsillectomy is the preferred clinical strategy.	a) Acute and chronic renal disease resulting from acute bacterial tonsillitis OR b) Metabolic disorders where a period of reduced oral intake could be dangerous to health OR c) PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis) OR d) Severe immune deficiency that would make episode of recurrent tonsillitis dangerous. The criteria above will be added to the current policy criteria

		The CCG will also commission tonsillectomy after a clinical consideration and assessment, where there has been more than one Peri-Tonsillar Abscess (Quinsy)[2].	
Policy on the Surgical Treatment of Carpel Tunnel Syndrome	All 8 CCGs	The CCG will commission surgical release of the carpal tunnel if all the following criteria are met: • The patient is not pregnant or is at least 12 weeks post-partum. • The patient's symptoms have not resolved despite 3 months of conservative treatment, including activity modification, wrist splinting and, a single steroid injection [9]. • The patient has sleep disturbance and/or limited ability to undertake activities of daily living due to symptom severity. • The diagnosis of carpal tunnel syndrome has been confirmed, either clinically by scored questionnaire or by nerve conduction studies if not possible by examination. • The documented specialist opinion is that the likely benefit from surgery outweighs the risk of harm for the patient. The CCG recognises that the type of surgical procedure undertaken (endoscopic or open surgery) will depend both on clinical factors (including the presence of swelling over the carpal tunnel) and the experience of the surgeon.	The NHSE EBI guidance criteria also includes: - Where there is a permanent reduction in sensation - The patient has muscle wasting/weakness of thenar abduction (moving the thumb away from the hand) The 3 months of conservative treatment mentioned in the second bullet-point (by using splinting, steroid injection) has also been reduced to 2 months (8 weeks) to align with the EBI guidance

		• In severe progressive carpal tunnel syndrome, the CCG will commission surgical release of carpal tunnel syndrome if the documented specialist opinion is that surgery is needed promptly to prevent irreversible median nerve/muscle damage.	
Policy for the Management of Otitis Media with Effusion (OME) using grommets	All 8 CCGs	The CCG will commission the surgical management of OME using grommets when the following criteria are satisfied: The patient is under 12 years of age AND Hearing loss has persisted over a period of at least three months and EITHER The patient has a hearing level in the better ear of 25-30dBHL or worse averaged at 0.5,1,2 and 4kHz OR Exceptionally, where there is well documented evidence that a hearing loss of less than 25-30 dBHL is having a significant impact on the child's developmental, social or educational status	The NHSE EBI guidance includes additional criteria related to children who are unable to undergo standard hearing assessments.
Policy for the Surgical Management of Gynaecomastia	All 8 CCGs	One of the procedures included within the existing Policy for Commissioning Cosmetics Procedures: The policy states that surgical correction of gynaecomastia is not routinely funded	Now forms a separate policy: The CCG will commission this procedure in the following circumstance: Where the gynaecomastia has occurred as a result of medical

			treatment the patient has undergone to manage prostate cancer. This will align the policy with the NHSE EBI guidance.
Policy for Breast Reduction Surgery	All 8 CCGs	One of the procedures included within the existing Policy for Commissioning Cosmetic Procedures: The CCG will commission breast reduction surgery in the following circumstances: a) at least 500 grams of breast tissue will be removed during the procedure. AND b) the patient has maintained a stable BMI of no more than 27.5kg/m^2 during the previous 24-month period. AND EITHER: c) There is inflammation and/or infection of the skin folds (intertrigo) with breakdown of the integrity of the skin. This will be demonstrated by evidence of cellulitis, skin ulceration, abscesses, lymphedema, skin necrosis or equivalent that has been persistent for at least six months despite compliance with nonsurgical treatment (e.g. meticulous skin hygiene; dressings; clothing that minimizes skin fold contact; topical	Now forms a separate policy: Qualifying BMI requirement reduced by 0.5kg/m^2 from the existing 27.5kg/m^2 to 27.kg/m^2. Qualifying period for a stable BMI reduced from 2 years in the existing policy down to 12 months. Soft tissue indentations at the site of bra straps added to the list of functional symptoms Wording around sub-section d on persistent back pain and physiotherapy made simpler and more concise – i.e. ‘Thoracic backache/kyphosis. This will be demonstrated by the presence of a physiotherapy assessment and the patient’s physical symptoms will have continued to persist despite the wearing of a professionally fitted bra.’

		antifungal agents, antibiotics or corticosteroids as clinically appropriate); OR ALL OF THE FOLLOWING d) i) The patient has persistent neck, shoulder or back pain which is disabling and meets the requirements of Appendix 2 of the Statement of Principles ii) The pain has not been relieved by a course of physiotherapy and analgesia iii) A physiotherapy report is provided that describes the treatments that have been tried and failed and the report confirms that the pain is attributable to the size of the breasts iv) The patient's physical symptoms persist despite the wearing of a professionally fitted bra v) The specialist clinical opinion is that the proposed procedure will substantially reduce the pain. Mastopexy will be commissioned when this is required as part of the planned approach for a patient who fulfils the above policy criteria for breast reduction and the intention is to undertake the procedure concurrently.	This will align the policy with the NHSE EBI guidance.

Policy for the Removal of Benign Skin Lesions	All 8 CCGs	One of the procedures included within the existing Policy for Commissioning Cosmetic Procedures: **Removal of skin lesions:** Restricted Removal methods included in this policy section include: - Surgical excision - Cauterisation - Cryosurgery - Cryotherapy - Electrodessication and curettage - Keratolysis - Chemical peeling - Laser destruction - Dermabrasion Skin lesions covered by this section of the policy include but are not limited to: - Lipomata - Epidermoid Cyst - Sebaceous Cyst - Pilar Cyst - Xantheslasmata - Seborrhoeic Keratoses - Dermatofibromata - Milia - Skin tags - Warts- excluding genital warts - Veruccas - Naevi - Vascular naevi (haemangioma, port wine stain, spider naevus,telangiectasia)	Now forms a separate policy: The scope of the policy is now limited to cover benign skin lesions only – no reference to malignant skin lesions is made as this is covered by the cancer care pathway List of skin lesions covered by the policy has been extended to include three further types explicitly listed in the NHSE EBI guidance. These are - Moles - solar comedones - corns/callouses Criteria has been added to include treatment where the lesion is any of the following: - Obstructing an orifice - Impairing visual fields - Significantly impacting on function by restricting joint movement - Is a facial viral wart - Causes pressure symptoms e.g. on nerve or tissue - Repeated infections requiring 2 or more antibiotics a year (a criterion that existed previously

		- Dermal neurofibromas - Molluscum contagiosum lesions - Scars, Keloid Scars - Stretch marks The CCG will commission the removal of skin lesions in the following circumstances: a) When the purpose of the treatment is to exclude or treat malignancy OR b) When the lesion is causing frequent, recurrent bleeding OR c) There is well documented evidence of significant pain that is present all or most of the time, is preventing usual activities and other causes for the pain or discomfort have been excluded OR d) There is well documented evidence of recurrent, clinically significant infections within the last twelve months, requiring treatment with antibiotics (or formal incision and drainage in the case of sebaceous cysts) AND f) The clinical opinion is that the benefit of the procedure in terms of symptom resolution outweighs the risk of harm (scarring	but did not specify the number of antibiotics provided) This will align the policy with the NHSE EBI guidance.