Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

South Yorkshire and Bassetlaw Commissioning for Outcomes Policy

Governing Body meeting

11 January 2018

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Purpose of Paper

South Yorkshire and Bassetlaw (SY&B) Accountable Care System (ACS) commissioners, Rotherham, Barnsley, Doncaster, Sheffield and Bassetlaw CCGs, are working together to develop a joint commissioning approach for procedures not routinely commissioned and those subject to clinical thresholds.

In August 2017, Governing Body formally approved the principle of converging approaches to commissioning policies and also the development of a common South Yorkshire and Bassetlaw policy covering a consistent set of procedures, criteria by which they are commissioned and approach to ensuring compliance.

Following a region wide clinical review process this work has culminated in the development of a South Yorkshire and Bassetlaw Commissioning for Outcomes Policy.

The Commissioning for Outcomes Policy brings together existing policies in a single document and also introduces a number of additional policies (both clinical thresholds and procedures not routinely commissioned).

Key Issues

This paper seeks Governing Body approval for a revised clinical commissioning policy covering clinical thresholds and procedures not routinely commissioned. This policy introduces number of new clinical thresholds for referral for specified interventions as part of a strategic approach to improve the health and wellbeing of the CCG population. The policy includes clinical threshold policy changes to align the policies of the Clinical Commissioning Groups across South Yorkshire and Bassetlaw.

The aim of the policy is to reduce variation in existing practice and ensure consistent referral guidance across the South Yorkshire and Bassetlaw area. Adopting this policy will enable GP's to look for alternatives to surgery for certain procedures where clinical thresholds apply, by using a combination of the evidence provided by national clinical thresholds and procedures of limited clinical value. This will ensure that procedures are only undertaken where there is agreed evidence of benefit to the patient, and therefore, patient safety and outcome will be improved.

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by Governing Body

The Governing Body is asked to:

1. Approve the draft SY&B Commissioning for Outcomes Policy, noting proposed amendments to be made for NHS Sheffield CCG and delegate authority to the Accountable Officer and Chair to approve the final amendments as described.
2. Approve the proposed process for future review and approval of amendments to the Policy by SCCG.
3. Approve the proposed implementation of the policy in February 2018.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?
To ensure there is a sustainable, affordable healthcare system in Sheffield.

Are there any Resource Implications (including Financial, Staffing etc)?

No

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not
SY&B Commissioners have produced a joint equality impact assessment and this is attached at appendix 3.

Have you involved patients, carers and the public in the preparation of the report?

Details are included in the report.

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Sheffield
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1. Introduction

NHS Sheffield Clinical Commissioning Group (SCCG) is committed, through the Sheffield Place Based Plan and commissioning intentions to deliver high quality, patient centred, efficient healthcare for patients living in the City, when it is needed and as close to their own home as possible. We aim to do this by commissioning high quality and evidenced based care. SCCG seeks to ensure that commissioning decisions are fully informed and based on the best evidence available.

This paper seeks Governing Body approval for a revised clinical commissioning policy, the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy, attached at Appendix 2, with a summary of the policy at Appendix 1. This policy covers clinical thresholds and procedures not routinely commissioned and introduces number of new clinical thresholds for referral for specified interventions as part of a strategic approach to improve the health and wellbeing of the CCG population. The policy includes clinical threshold policy changes to align the policies of the Clinical Commissioning Groups across South Yorkshire and Bassetlaw.

2. Overarching Context

In common with other CCGs across South Yorkshire and Bassetlaw, Sheffield Clinical Commissioning Group's (SCCG) vision is to achieve the best health and wellbeing for everyone. In light of the current financial pressures on the NHS we believe that to get the best value from NHS resources the CCG should try to prevent any unnecessary use of NHS resources.

Through the Accountable Care System (ACS) a working group of commissioners from across South Yorkshire and Bassetlaw (SY&B) was established to review align similar commissioning policies across the region and to develop additional polices, with the aim of reducing variance between individual CCG policies by producing a standardised policy.

In August 2017, Governing Body formally supported the principle of converging approaches to commissioning policies and the development of a common South Yorkshire and Bassetlaw policy that covers a consistent set of procedures, criteria by which they are commissioned and approach to ensuring compliance. Following a region wide clinical review process this work has now concluded in a South Yorkshire and Bassetlaw Commissioning for Outcomes Policy which is presented for approval (Appendix 2).

3. Requirement for a Commissioning for Outcomes Policy

In order to improve quality of care and outcomes for patients and to ensure the best value for money from the services commissioned, most CCGs have in place commissioning policies to identify procedures that are with not routinely commissioned or where they are commissioned for patients meeting specific thresholds

These policies cover interventions where either there is significant risk that patients undergoing them will gain little health benefit or where the procedures have low rather than no clinical value. Some may be effective, but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others. Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.

SCCG already has in place a number of policies, based upon published evidence base, guidance, or best practice that either identify clinical thresholds that should be met for access to particular interventions or identify procedures where SCCG believe there is insufficient evidence base e.g. NICE guidance (April 2017). The rationale for the adoption of these clinical thresholds is to improve the quality of care provided for all patients.

4. The South Yorkshire and Bassetlaw Commissioning for Outcomes Policy

The aim of the development of a SY&B Commissioning for Outcomes Policy (appendix 2) is to reduce variation in existing practice and ensure consistent referral guidance across the South Yorkshire and Bassetlaw area. Adopting this policy will enable GP's to look for alternatives to surgery for certain procedures where clinical thresholds apply, by using a combination of the evidence provided by national clinical thresholds and procedures of limited clinical value. This will ensure that procedures are only undertaken where there is agreed evidence of benefit to the patient, and therefore, patient safety and outcome will be improved.

The Commissioning for Outcomes Policy brings together existing policies and also introduces a number of additional policies. The policy includes:

- context for the adoption of clinical thresholds and commissioning policies;
- a consistent set of procedures;
- criteria and clinical evidence by which they are commissioned;
- an approach to ensuring compliance;
- a process for agreeing future commissioning policies.

This will ensure that decisions are robust, rational and justifiable. In addition to offering more equitable access for patients, the policy will reduce the number of policies providers are required to operate and support consistent implementation.

4.1. Policy Areas

The South Yorkshire and Bassetlaw Commissioning for Outcomes policy covers the following:

- Clinical thresholds across a range of procedures to ensure that when patients do receive treatment, they achieve the best possible outcomes
- Procedures which are not routinely commissioned and therefore require prior approval through the Individual Funding Request Panel.
- The SY&B Plastics Policy (Commissioning Guidelines for Specialist Plastic Surgery Procedures) has been reviewed and incorporated into the policy.
- The Y&H Fertility Policy (as approved in January 2017) has also been incorporated into this policy.

Once adopted the policy will replace all individual policies and thresholds currently in place for SCCG. The policy will not replace guidelines and pathways included on the PRESS portal.

4.1.1 Clinical thresholds

The interventions indicated as clinical thresholds, reflect the areas identified within NICE or other guidance as having limited clinical value. Clinical thresholds are a predetermined set of criteria that must be met before some procedures are considered. Within this there may be procedures of limited clinical value which are procedures that medical experts have suggested have only limited or temporary benefit.

Where a clinical threshold applies, clinicians will be required to complete a referral checklist to accompany any referral. A referral will only be accepted if the patient meets the clinical threshold.

It must be emphasised that if a GP or consultant feels that a patient's circumstances are exceptional and the patient may benefit from any of these treatments then they must be referred to the IFR Panel.

4.1.2 Procedures not routinely commissioned

Procedures which are not routinely commissioned require prior approval through the Individual Funding Request Panel.

4.3 Individual Funding Requests (IFR)

This policy works in conjunction with the Individual Funding Request Policy. In some circumstances GPs, Consultants or other clinicians may think that individuals who do not meet the policy or specific threshold have exceptional clinical circumstances and may therefore benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by the clinician. This request will then be considered and approved or rejected by an independent panel.

4.4 Deviations from the SY&B Policy

While the aim of the project has been to develop a common policy and process, there are several areas where complete consensus could not be achieved. In these cases individual CCG positions are indicated within the Policy.

There is one further area where SCCG proposes to deviate from the policy. SCCG propose that for orthopaedic interventions referrals continue to be made using the

existing MSK referral form and that a clinical decions is made by the receiving consultant on a case by case basis. These interventions are indicated in the table in appendix 1.

4.5 Key Changes to Process

Within the existing SCCG commissioning policies, treatments where thresholds apply, e.g. varicose veins, insertion of grommets, tonsillectomy and reversal of sterilisation require prior approval through the Individual Funding Request (IFR) process before referral to secondary care.

Under the new SY&B Commissioning for Outcomes Policy, this requirement would be removed. If the referring clinician considers that a patient meets the criteria for treatment then they may make a referral, completing the appropriate referral checklist.

The receiving provider will confirm that the referring provider will confirm the necessary information is provided and treat accordingly

5. Engagement and Consultation

5.1 Public and Patient Engagement

Public, patient and clinical engagement is an integral part of the commissioning process. In this case, this has been built on the principles of appropriate, proportionate and targeted engagement to enable clear understanding of the impact of future service provision and referral pathways.

Formal consultation is not required for the changes proposed within the policy however, patient group representatives from the SCCG Practice Participation Group Network were asked to provide views and input into the proposed approach and processes.

While the majority understood and accepted the rationale behind the development of the Policy a number of key issues were raised in their responses and actions taken to address these are as follows:

- Concerns about approaches that limit treatment on the basis of age – with the exception of the Fertility Policy which is based on NICE guidance, SY&B polices do specify an upper age limit for access to interventions.

- Policies will limit access to effective treatments for patients – as set out at section 3, the policy covers treatments where the evidence demonstrates that patients are likely to derive no or limited value form the intervention. Clinicians may use the IFR process if they feed a patient is likely to derive benefit from a treatment not routinely commissioned.

- Patients require clear information on the process and possible outcomes – an information leaflet for patients will be developed and made available to GPs. The network will be asked to provide comments and feedback on the patient leaflet and supporting information. to ensure there is consistent information for all South Yorkshire and Bassetlaw patients, the aim is to have a link on the CCG's website to a South Yorkshire and Bassetlaw website where the policy documents and supporting information will be held.

- Patients may experience delays or other problems if GPs do not follow the thresholds and process – a full communications and awareness plan is being developed for GPs and practices to minimise any confusion. This will be supported with information to secondary care and the CASES peer review process.

Prior notification to NHS England has also been provided on a SYB footprint to ensure colleagues are aware of developments regarding the South Yorkshire and Bassetlaw Commissioning for Outcomes policy.

5.2 Clinical Engagement

Local clinical engagement has been built into the development of this policy, see table below.

August 2017	**Agreement to Converge Approach** Governing Body agreement to develop a shared South Yorkshire and Bassetlaw policy and support the principle of joining approaches to commissioning policies
October – December 2017	**Provider Engagement** - draft policy and proposed clinical evidence shared with main providers (STHFT and SCH) for review and comment. Further engagement to be planned as part of mobilisation.
September - October 2017	**SYB Clinical Convergence Meeting -** clinicians from the involved CCG's met to discuss any local differences and how these will be represented in the policy document.
December 2017 – January 2018	**Clinical Reference Group** – draft policy reviewed by SCCG clinical reference group
January 2018	**LMC engagement** **CASES Peer Review** – confirm policies and process with reviewers
January – March 2018	**GP and practice engagement** – confirm policy, process and information for patients Secondary Care - mobilisation meetings, confirm process

6. Risks and Benefits

Adopting the South Yorkshire and Bassetlaw Commissioning for Outcomes Policy is expected to deliver the following benefits:

- Improved quality of care based on evidence based care for patients. Evidence shows that the outcomes from alternative treatments such as conservative management are as good as if procedures have taken place.
- Improved patient autonomy, experience and safety.
- Improved equality - reduced variance in access to interventions and ensuring patients are offered consistent treatment options across SY&B.
- More simpler and consistent advice for patients.
- Improved use of resources.

The following risks apply to this programme of work:

- Primary Care clinicians are not suitably engaged in the programme then this could result in low confidence of adherence to the policy.
- lack of compliance and adherence of the clinical thresholds by both Primary and Secondary Care.
- insufficient engagement takes place then the programme is unable to progress within stated timescales. There is also a subsequent risk to the CCG's reputation.

7. Impact of Implementing the Policy

Work is underway across SY&B ACS to quantify the possible financial impact of the additional thresholds and policies. Once concluded this will included within the CCG Quality, Improvement, Productivity and Prevention (QIPP Plan for 2018/19)

The Policy will be included in secondary care provider contracts and the process for monitoring adherence is set out in the SY&B Commissioning for Outcomes Policy. SCCG will establish benchmark data and monitor procedures throughout 2018/19 to confirm compliance and identify changes in referral and treatment practice.

The CASES Peer Review service, operating across seven specialties will support the process primary care with the process of implementation.

SCCG will put in place a process to monitor patient experience and outcomes form the policy changes to support future development and amendment of the Policy.

8. Supporting Primary Care Implementation

The CCG is clear that these changes should not impose significant additional workload on primary care and SCCG will liaise with the Local Medical Committee on the implementation of this Policy.

This policy includes the implementation of additional clinical thresholds that require the completion of referral checklists and procedures not routinely commissioned which require approval through the IRF process. These could place additional requirements on primary care. The table at Appendix 1 identifies the number of new interventions included in the policy that will require the completion of an additional referral form and the number of existing procedures where the process for approval has changed.

In total 15 new policies are implemented. A number of these sit within MSK where referral will continue to be by the existing MSK referral form so, in total there will be 6 new procedures that require the completion of a referral checklist or IFR request. In addition there are 8 existing interventions where the process will change from IFR application to referral checklist.

To support practices with the application of the Policy the SY&B CCGs are working together to make the referral checklists available on both SystmOne and EMIS, SCCG will also work closely with localities and neighbourhoods on the implementation of the policy.

9. Next Steps and Timescales for Implementation in Sheffield

Having developed a SY&B final draft of the policies, these have been circulated to SCCG Clinical Reference Group for review. Subject to Governing Body approval, final

amendments will be made and, subject to Governing Body approval, signed off by the Chair and Accountable Officer on behalf of the Governing Body in January 2018. SCCG will work with Primary Care, the LMC and secondary care providers to implement the Policies in February 2018.

10.Review and Update of the Policy

The policy will be subject to an annual review. However, it is recognised that as clinical guidelines are updated some elements may require a review prior to this date. SY&B CCGs have agreed that additional amendments may be required during the implementation process.

Subject to approval of Governing Body it is proposed a process is established whereby future amendments are approved through CRG and then Quality Assurance Committee. There is also a process outlined in section 3 of the policy for agreeing changes across the South Yorkshire and Bassetlaw footprint. Changes will be published on the CCGs website and disseminated to primary care and secondary care providers.

10. Recommendations

The Governing Body is asked to:

1. Approve the draft SY&B Commissioning for Outcomes Policy, noting proposed amendments to be made for NHS Sheffield CCG and delegate authority to the Accountable Officer and Chair to approve the final amendments as described.
2. Approve the proposed process for future review and approval of amendments to the Policy by SCCG.
3. Approve the proposed implementation of the policy in February 2018.

Paper prepared by:	Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning
On behalf of:	Brian Hughes, Director of Commissioning and Performance

December 2017

Summary of SY&B Commissioning for Outcomes Policy APPENDIX 1

Procedure	New or Existing Policy	Process
Cholecystectomy	New	Checklist
Cataract Surgery	New	Checklist
Hysterectomy for Heavy Menstrual Bleeding	New	Checklist
Chalazion/Meibomian Cyst	New	Checklist
Blepharoplasty	New	Checklist
Acupuncture	New	IFR
Hallux Valgus	New	MSK referral form
Arthroscopic Decompression of the shoulder	New	MSK referral form
Spinal Joint Injections	New	MSK referral form
Carpal Tunnel	New	MSK referral form
Dupuytren's Disease	New	MSK referral form
Trigger Finger	New	MSK referral form
Ganglion	New	MSK referral form
Hip and Knee replacement	New	MSK referral form
Ingrowing Toe Nail in secondary care	New	MSK referral form/podiatry
Assisted Conception	Existing	As policy
Benign Skin Lesions	Existing	Checklist
Hernia Repair	Existing	Checklist
*Grommets	Existing	Checklist
*Tonsillectomy	Existing	Checklist
*Varicose Veins Surgery	Existing	Checklist
Male Circumcision	Existing	Checklist
Benign Perianal skin tags	Existing	Checklist
Haemorrhoidectomy	Existing	Checklist
Vasectomy Under General Anaesthetic	Existing	IFR
Reversal of Female Sterilization	Existing	IFR
Reversal of Male Sterilization	Existing	IFR
Face and Brow Lift	Existing	IFR
Abdominoplasty	Existing	IFR
Buttock, thigh and arm lift	Existing	IFR
Breast augmentation	Existing	IFR
Breast reduction	Existing	IFR
Male gynaecomastia	Existing	IFR
Breast asymmetry	Existing	IFR
Breast lift	Existing	IFR
Correction of nipple inversion	Existing	IFR

Hair removal	Existing	IFR
Hari transplantation	Existing	IFR
Acne scarring	Existing	IFR
Pinnaplasty	Existing	IFR
Rhinoplasty	Existing	IFR
Rhinophyma	Existing	IFR
Revision of surgical scars	Existing	IFR
Congenital vascular abnormalities	Existing	IFR
Thread veins	Existing	IFR
Tattoo removal	Existing	IFR
Reduction of labia minora	Existing	IFR
Liposuction	Existing	IFR

Health and care working together in South Yorkshire and Bassetlaw

Appendix 2

South Yorkshire and Bassetlaw - Commissioning for Outcomes Policy

Draft 14

Version Control

Version	Date	Author	Changes
v1.0	01/04/2015	Dr Sarah Lever	
v1.1	19/06/2015	Hilary Porter	Added wording specifically excluding tonsillectomy as part of cancer treatment/management
V1.2	24/08/2015	Rebecca Chadburn	Change of email address
V2	28/07/16	Dr Sarah Lever	Renamed Clinical thresholds policy with 7 additional clinical thresholds added. Changes to process for referral and approval for treatment. Prior approval only required when deemed exceptional
V3		Dr Sarah Lever	Renamed South Yorkshire and Bassetlaw Commissioning for Value policy. Additional clinical thresholds added and commissioning policy made expressly clear for all procedures including, cosmetic, plastic and fertility procedures.
V8	4/9/17	Jack Harding	Formatting

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1. Executive Summary

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

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

Section 1

2. Introduction

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

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

This policy links with our strategic plan and commissioning intentions available at the STP plan LINK

3. Decision Making and Prioritisation Approach

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

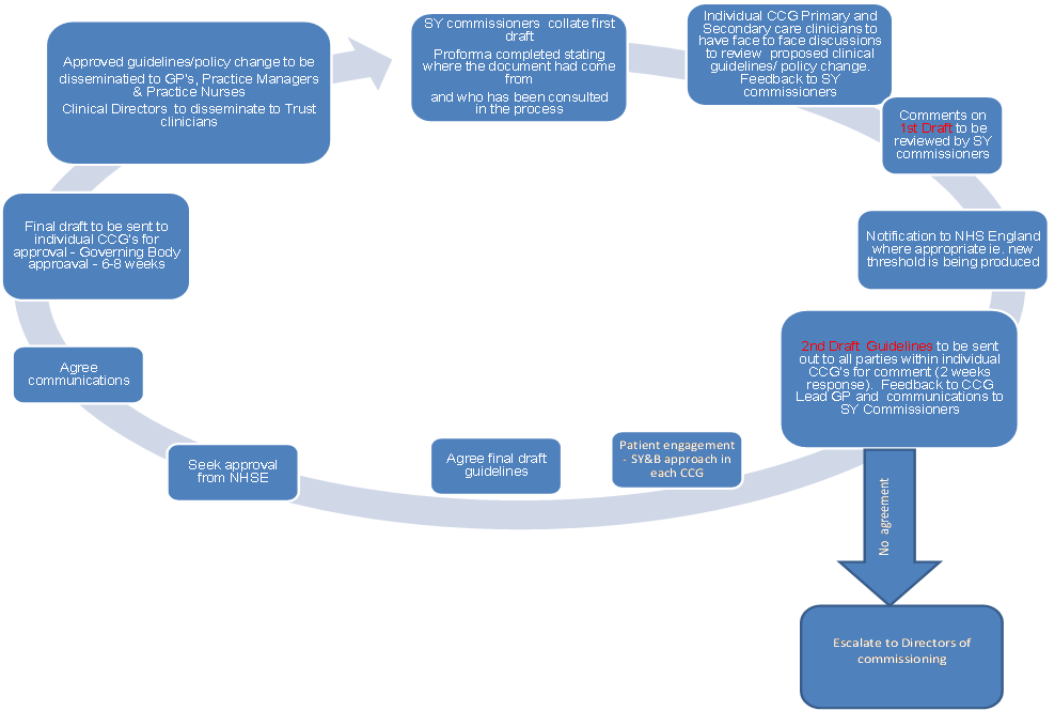
- business cases for investment in services
- value for money reviews
- performance monitoring of services or specific treatments where they no longer provide evidenced clinical value, outcomes and best value for money or are a lower priority than services we need to fund within our affordability envelope (including proposal for new Individual Funding Request (IFR) policies)

- Decisions required outside of our planning process on funding outside existing commissioned services and exceptionality for individual cases. This may apply in the following circumstances:

    - A new intervention is made available that is of significant importance
    - A new treatment or service is made available that provides such significant health or financial benefits
    - A proposal is submitted by an external body that provides benefits

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

Figure 1 SY&B process for decision making



4. Priorities for Annual Resource Allocation

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

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

5. Service Developments

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

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

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

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

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

6. Scope of Document

SY&B Commissioning for Outcomes Policy covers the following:

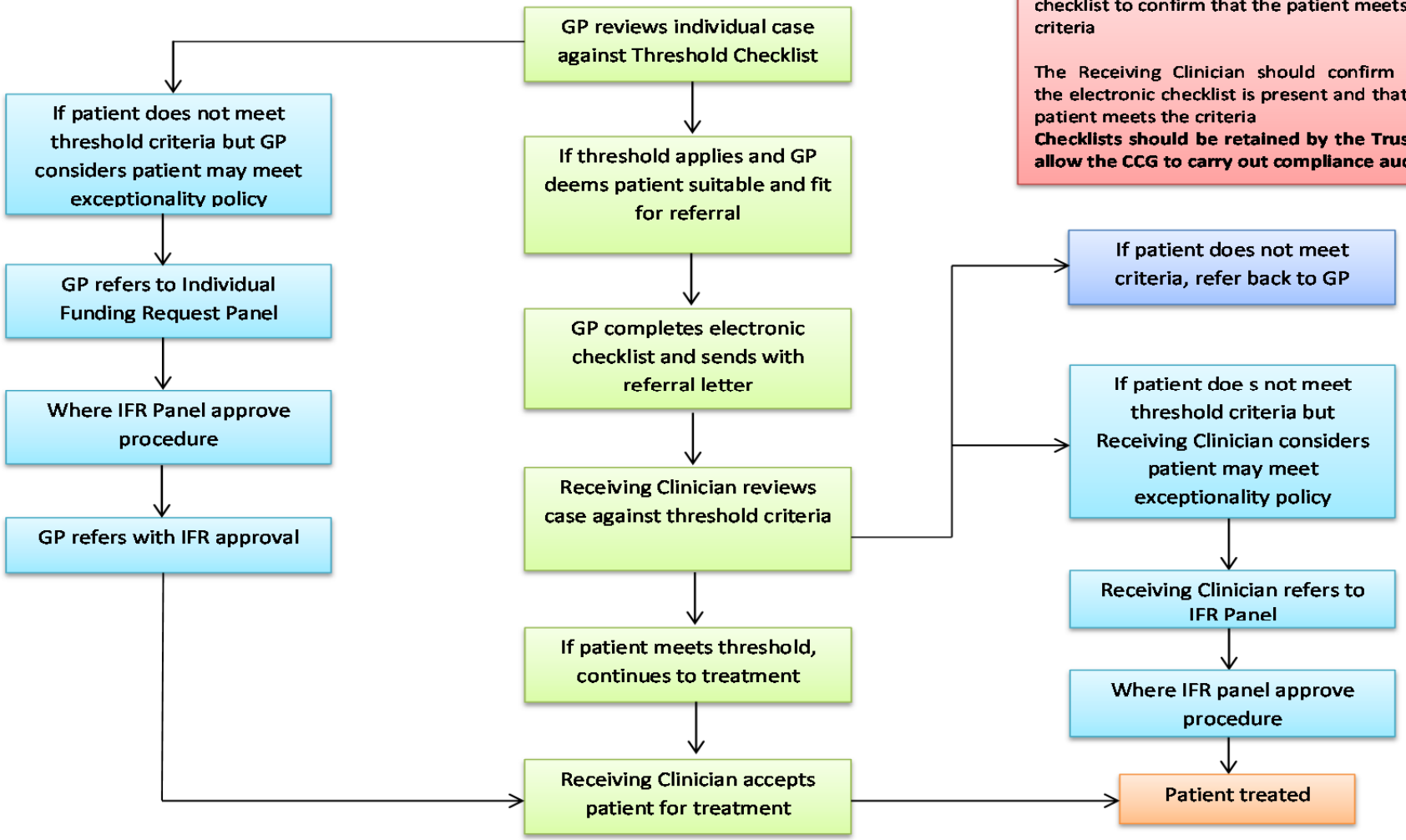
- Clinical thresholds across a range of procedures to ensure that when patients do receive treatment, they achieve the best possible outcomes (7.1)
- Procedures which are not routinely commissioned and therefore require prior approval through the Individual Funding Request Panel (8.1)
- The SY&B Commissioning Guidelines for Plastic Surgery Procedures have been incorporated into this document
- The Y&H Fertility Policy has been incorporated into this document

This document sets out:

- The procedures covered by this policy
- The referrals process including the use of the IFR process where prior approval is required or there is a case for exceptionality
- The procedures and threshold for treatment
- Monitoring arrangements
- Rules around payment
- Referral checklists
- Patient information sheet

SECTION 2

CLINICAL THRESHOLDS REFERRAL PROCESS



7. Procedures of Limited Clinical Value and Clinical Thresholds

The table below lists the procedures to which clinical thresholds apply and the responsibilities of the accepting and referring clinician

All threshold procedures require a referral checklist to accompany the referral where the criteria for treatment are met.

Table 1: Responsibilities of accepting and referring clinician in operation of the clinical thresholds policy

Procedure	Referring clinician responsibility	Accepting clinician responsibility
Carpal Tunnel	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Dupuytren's Disease	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Trigger Finger	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Ganglion	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Hip and Knee replacement	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Benign Skin Lesions	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Cholecystectomy	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Hernia Repair	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Cataract Surgery	Optometrist completes and signs checklist Checklist from GP not usually required	Check and electronically sign/accept the checklist
*Grommets	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
*Tonsillectomy	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
*Hysterectomy for Heavy Menstrual Bleeding	Checklist from GP not required	Complete and sign checklist
*Varicose Veins Surgery	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Male Circumcision	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Benign Perianal skin tags	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Haemorrhoidectomy	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Ingrowing Toe Nail	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Chalazion	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Blepharoplasty	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Hallux Valgus	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist
Arthroscopic Decompression of the shoulder	Complete the checklist and attach to referral letter	Check and electronically sign/accept the checklist

***** *Checklist does not apply to Barnsley CCG*

7.1 Making a Referral

Where a clinical threshold applies, GPs/optometrists/MSK service is required to complete the referral checklist, attaching the document with the referral. Referrals without a completed checklist should be returned to the referral source indicating the reason for rejection. The provider will confirm that the electronic checklist is present and that the patient meets the threshold, criteria. The secondary care element of the referral checklist will be completed (where this applies to a condition or procedure) and electronically signed/accepted by the receiving clinician to evidence that the patient meets the criteria. The document will be included within the patient notes.

A referral should only proceed to treatment if the patient meets the clinical threshold and a completed and compliant referral checklist is in place.

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

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

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

Where patients do not meet the criteria for referral they should be advised to seek review by their GP or other appropriate health care professional should their condition change. Likewise where patients are on a pathway for elective care, clinical review should be available where necessary should a patient's condition require earlier intervention.

Table 1 shows the responsibilities of the GP/Optometrist/Consultant for each condition.

8. Procedures not routinely commissioned

There are a number of services not routinely commissioned unless NICE Guidance applies. These include:

- Vasectomy under General Anaesthetic
- Spinal Joint injections
  (i) Therapeutic substance into spinal facet or sacroiliac joints
  (ii) Spinal injection as a diagnostic tool
- Acupuncture (except for those conditions which are NICE approved)

8.1 Process for IFR Referral

If a GP or consultant feels that a patient's circumstances are exceptional and may benefit from any of these treatments then they must be referred to the IFR Panel (10).

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

9. Prior approval for treatment outside of this policy

Table 1 makes clear the requirements of the referring and accepting clinician for clinical threshold procedures. Clinicians will seek prior approval for treatment where patients are to be treated outside of these policies. Where a GP or Consultant believes that a patient might benefit from a procedure but where they do not meet the clinical threshold, the Clinician may apply to the IFR Panel to make the case for exceptionality. In these circumstances clinicians will be required to evidence the reasons for exceptionality. Where a procedure has a BMI restriction, patients whose high BMI is due to bulk muscle should be referred to the IFR panel as an exception.

10. Exceptionality

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

Responsibility for demonstrating exceptionality rests with the requesting clinician.

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

He/she is different to the general population of patients who would normally be refused the healthcare intervention, **and**

There are good grounds to believe that the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

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

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

The IFR policy is shown here: https://www.healthandcaretogethersyb.co.uk/

Where prior approval is required it should be sought from the CCG in advance of the treatment being provided.
All requests should be sent to:

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

or sent electronically to:

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

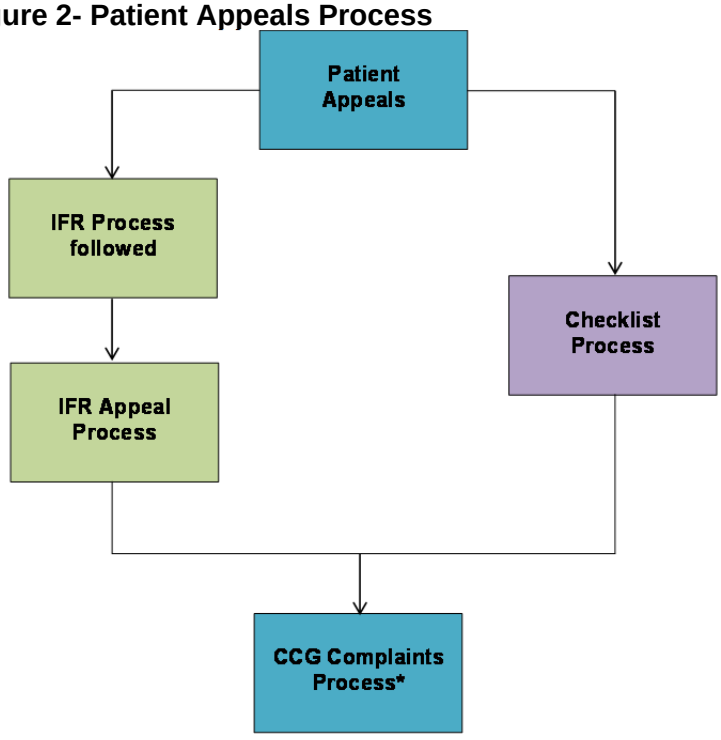
SC 29.26 of the contract makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat. The IFR team aims to process requests through the panel within 13 days and request further information from the GP where required.

11. Appeals

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

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

Figure 2- Patient Appeals Process



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

12. Monitoring and payment

CCGs will audit adherence to the clinical thresholds policy. Where there is no evidence that the patient meets the clinical threshold, CCGs will not pay for the patient's treatment. SC 29.22 of the contract makes clear that the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed prior approval schemes.

CCGs will monitor activity and finance levels on a monthly basis through the Contract Performance Meeting. A baseline will be established and activity monitored against the following OPCS codes listed in Table 2

13. Review

This policy will be reviewed on an annual basis.

Date of next Review: **December 2018**

14. List of Treatments and Services where low priority procedures/clinical thresholds apply

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review

ENT	Myringotomy/ Grommets	The CCG will **only** fund grommet insertion in children (age under 18 for Barnsley/Doncaster/ Bassetlaw/Rotherham or 16 and under for Sheffield) when one or more of the following criteria are met:
		• Recurrent otitis media – 5 or more recorded episodes in preceding 12 month period
		• Suspected hearing loss at home or at school / nursery following 3 months of watchful waiting
		• Speech delay, poor educational progress due to hearing loss
		• Abnormal appearance of tympanic membrane
		• Persistent hearing loss for at least 3 months with hearing levels of:
		  • - 25dBA or worse in both ears on pure tone audiometry **OR**
		  • - 35dHL or worse on free field audiometry testing **AND**
		  • - Type B or C2 tympanometry
		• Suspected underlying sensorineural hearing loss
			ENT UK 2009 OME/Adenoid and Grommet Position Paper http://www.bapo.org.uk/tonsillectomy_position_papers_09.pdf
			
			NICE guidelines – CG60 Surgical management of otitis media with effusion in children. https://www.nice.org.uk/guidance/cg60/chapter/1-Guidance
			
			Perera R. Autoinflation for hearing loss associated with otitis media with effusion.(Cochrane review). In: Cochrane database of systemic reviews, 2006. Issue Chichester: Wiley Interscience. http://www.cochrane.org/CD006285/ENT_autoinflation-for-hearing-loss-associated-with-otitis-media-with-effusion-glue-ear
			
			Evidence note. QIS. Number 22, January 2008. The clinical and cost effectiveness of surgical insertion of grommets for otitis media with effusion (glue ear) in children. file:///C:/Users/janet.sinclair-pinde/Downloads/EN22_Grommets.pdf
				Clinical threshold – refer using checklist. IFR for exceptionality Barnsley CCG require prior approval through IFR for this procedure	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		• Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk • OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down Syndrome, cleft palate • Persistent OME (more than 3 months) with fluctuating hearing but significant delay in speech, educational attainment or social skills. **Adults** should meet at least one of the following criteria. • Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry **or** • Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period **or** • Eustachian tube dysfunction causing pain **or** • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **or** • Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk **or**	Fickelstein Y. et al. Adult-onset otitis media with effusion. Archives of Otolaryngology -- Head & Neck Surgery, May 1994, vol./is. 120/5(517-27). Dempster J.H. et al. The management of otitis media with effusion in adults. Clinical Otolaryngology & Allied Sciences, June 1988, vol./is. 13/3(197-9) Yung M.W. et al. Adult-onset otitis media with effusion: results following ventilation tube insertion. Journal of Laryngology & Otology, November 2001, vol./is. 115/11(874-8). Wei W.I. et al. The efficacy of myringotomy and ventilation tube insertion in middle-ear effusions in patients with nasopharyngeal carcinoma. Laryngoscope, November 1987, vol./is. 97/11(1295-8) Ho W.K. et al. Otorrhea after grommet insertion for middle ear effusion in patients with nasopharyngeal carcinoma. American Journal of Otolaryngology, January 1999, vol./is. 20/1(12-5) Chen C.Y. et al. Failure of grommet insertion in post-irradiation otitis media with effusion. Annals of Otology,	Clinical threshold – refer using checklist. IFR for exceptionality Barnsley CCG require prior approval through IFR for this procedure	

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		• As a conduit for drug delivery direct to the middle ear • In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician. • Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy	Rhinology & Laryngology, August 2001, vol./is. 110/8(746-8) Ho W.K. et al. Randomized evaluation of the audiologic outcome of ventilation tube insertion for middle ear effusion in patients with nasopharyngeal carcinoma. Journal of Otolaryngology, October 2002, vol./is. 31/5(287-93) Park J.J. et al. Meniere's disease and middle ear pressure - vestibular function after transtympanic tube placement. ACTA OTOLARYNGOL, 2009 Dec; 129(12): 1408-13 Sugaware K. et al. Insertion of tympanic ventilation tubes as a treating modality for patients with Meniere's disease: a short- and long-term follow-up study in seven cases. Auris, Nasus, Larynx, February 2003, vol./is. 30/1(25-8) Montandon P. et al. Prevention of vertigo in Meniere's syndrome by means of transtympanic ventilation tubes. Journal of Oto-Rhino-Laryngology & its Related Specialties, 1988, vol./is. 50/6(377-81)		
ENT	Tonsillectomy	The CCG will **only** fund tonsillectomy when one or more of the following criteria have been met: • Recurrent attacks of tonsillitis as defined by: - Sore throats are due to acute tonsillitis which is disabling	Burton MJ, Glasziou PP. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD001802. First published online: July 26 1999. Available from:	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		and prevents normal functioning **AND** - 7 or more well documented, clinically significant *, adequately treated episodes in the preceding year **OR** - 5 or more such episodes in each of the preceding 2 years **OR** - 3 or more such episodes in each of the preceding 3 years • Two or more episodes of Quinsy (peritonsillar abscess) • Severe halitosis secondary to tonsillar crypt debris • Failure to thrive secondary to difficulty swallowing caused by enlarged tonsils • Sleep disordered breathing or obstructive sleep apnoea diagnosed by an overnight pulse oximetry or polysonography • Biopsy/removal of lesion on tonsil • * A Clinically significant episode is characterised by at least one of the following: o Oral temperature of at least 38.30C requiring antibiotic treatment o Tender anterior cervical lymph nodes. o Tonsillar exudates.	http://www.cochrane.org/reviews/en/ab001802.html (accessed 2016) Paradise JL, Bluestone CD, Bachman RZ. Efficacy of tonsillectomy for recurrent throat infection in severely affected children. Results of parallel randomized and non-randomized clinical trials. N England J Med 1984:310(11):674-83 SIGN. Management of sore throat and indications for tonsillectomy. A National clinical Guideline. April 2010 http://www.sign.ac.uk/pdf/sign117.pdf (accessed 2016)	Barnsley CCG require prior approval through IFR for this procedure	
Vascular	Varicose	The CCG will only fund Varicose Vein surgery if	National Institute for Health and Care	Clinical	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
Surgery	Veins	the patient meets the following criteria: • BMI ≤ 30 **AND** • Intractable ulceration secondary to venous stasis. **OR** • Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity.) **OR** • Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral). **OR** • Recurrent thrombophlebitis (more than 2 episodes) associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living*. **OR** If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply: • Symptoms must be caused by varicosity and cannot be attributed to any other co-morbidities or other disease affecting the lower limb. • There must be a documented unsuccessful six month trial of conservative management.**	Excellence (NICE). 2013. *Varicose veins in the legs: the diagnosis and management of varicose veins.* CG168. London: National Institute for Health and Care Excellence. https://pathways.nice.org.uk/pathways/varicose-veins-in-the-legs#content=view-node%3Anodes-information (Accessed 2017) Foti D & Kanazawa L. Activities of daily living. In: Pendleton H & Shultz-Krohn (*eds)* Pedretti's Occupational Therapy: Practice Skills for Physical Dysfunction. 7th edition. United states. Elsevier Mosby; 2008 p157-159. NHS England Interim Clinical Commissioning Policy for Varicose Veins November 2013 https://www.england.nhs.uk/commissioning/wpcontent/uploads/sites/12/2013/11/N-SC035.pdf	threshold – refer using checklist. IFR for exceptionality Barnsley CCG require prior approval through IFR for this procedure	

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		• Evidence that symptoms are affecting activities of daily living and or Instrumental activities of daily living. • In the opinion of a vascular specialist, these symptoms can be reversed or significantly improved with treatment. * Activities of daily living include: functional mobility, eating, bathing and personal care. They can be measured using the Barthel activities of daily living index. Instrumental activities of daily living include more complex tasks such as care of others, community mobility, health management and meal preparation. ** Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss if appropriate. Compression stockings should only be used where interventional treatment is unsuitable or the patient fails to meet the criteria			
Dermatology	Benign Skin lesions	The CCG will only offer funding if one or more of the eligibility criteria has been met. • Diagnostic uncertainty exists and there is suspicion of malignancy. GPs are reminded to refer to the 7 features suspicious of malignancy, as per NICE guidance on skin cancer* • The lesion is painful or impairs function	http://www.nice.org.uk/nicemedia/live/10968/29814/29814.pdf (p35) Kerr OA, Tidman MJ, Walker JJ *et al.* The profile of dermatological problems in primary care. *Clin Exp Dermatol*. 2010; (4):380-3 http://www.patient.co.uk/doctor/minor-	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

<table>
<tr><th>Speciality</th><th>Procedure</th><th>Criteria for treatment</th><th>Evidence Base</th><th>Process</th><th>Date of review</th></tr>
<tr><td></td><td></td><td>and warrants removal, but it would be unsafe to do so in primary care/community setting, for example because of large size (>10mm), location (e.g. face or breast) or bleeding risk. Removal would not be purely cosmetic.
• Viral warts in the immunosuppressed.
• Patient scores >20 in Dermatology Life Quality Index administered during a consultation with the GP or other healthcare professional.

*NICE recommend GPs use the following checklist, with major features scoring 2 and minor features scoring 1. A score of 3 indicated high suspicion of malignancy. If there is a strong clinical suspicion, the patient may be referred on the basis of one feature alone.
<table><tr><th>Major features</th><th>Minor features</th></tr><tr><td>Change in size</td><td>Diameter ≥ 7mm</td></tr><tr><td>Irregular in shape</td><td>Inflammation</td></tr><tr><td>Irregular in colour</td><td>Oozing</td></tr><tr><td></td><td>Change in sensation</td></tr></table></td><td>surgery-in-primary-care

George S, Pockney P, Primrose J et al. A prospective randomised comparison of minor surgery in primary and secondary care. The MiSTIC trial. Health Technology Assessment 2008;12(23):iiiiv, ix-38.

Mazzotti E, Barbaranelli C, Picardi A et al. Psychometric properties of the Dermatology Life Quality Index (DLQI) in 900 Italian patients with psoriasis.Acta Derm Venereol 2005;85(5):409-13

http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html</td><td></td><td></td></tr>
<tr><td>Gynaecology</td><td>Hysteroscopy and Hysterectomy for menorrhagia</td><td>Hysteroscopy for HMB will only be funded if one of the following criteria is met:

Trans vaginal ultrasound scan provided inconclusive results.
Trans vaginal ultrasound scan was suggestive of an endometrial pathology (e.g. polyp or submucous fibroid).
As part of an ablative procedure.</td><td>https://www.nice.org.uk/guidance/cg44/chapter/1-Guidance (accessed 2016)
https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/advice-for-hmb-services-booklet.pdf (accessed 2016)
http://www.patient.co.uk/doctor/intrauterine-system-pro (accessed 2016)
Lethaby AE, Cooke I, Rees M.</td><td>Clinical threshold – refer using checklist.
IFR for exceptionality
The hysteroscop</td><td>Dec 2018</td></tr>
</table>

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		Inter-menstrual bleeding over the age of 40yrs Scan suggests thickened and cystic appearance/hyperplasia *Funding **will not** be provided for dilatation and curettage (D & C) as a standalone diagnostic or a therapeutic tool in the management of HMB.* Hysterectomy for HMB will only be funded if **all** the following criteria are met: A levonorgestrel intrauterine system or LNG-IUS (e.g. Mirena) has been trialled for *at least 6 months* (unless contraindicated) and has not successfully relieved symptoms. A trial of *at least 3 months each* of **two** other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include: NSAIDs e.g. mefenamic acid Tranexamic acid Combined oral contraceptive pill Oral and injected progestogens Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE) have either been ineffective or are not appropriate,	Progesterone/progestogen releasing intrauterine systems for heavy menstrual bleeding. (Cochrane Review). In: *Cochrane Database of Systematic Reviews* 2005; Issue 4 Stewart A, Cummins C, Gold L, *et al*. The effectiveness of the levonorgestrelreleasing intrauterine system in menorrhagia: a systematic review. *BJOG: an International Journal of Obstetrics and Gynaecology* 2001;108(1):74–86. Hurskainen R, Teperi J, Rissanen P, *et al*; Quality of life and cost-effectiveness of levonorgestrel releasing intrauterine system versus Hysterectomy for treatment of menorrhagia: a randomised trial. *Lancet*. 2001;357(9252):273-7. Marjoribanks J, Lethaby A, Farquhar C; Surgery versus medical therapy for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2006;(2):CD003855 http://www.nice.org.uk/nicemedia/live/11002/30401/30401.pdf - table 8.1, pg 56	y element of this Threshold does not apply to Doncaster CCG. Normal referral process applies	
General	Cholesystect	The CCG will **only** support the funding of	Sanders G, Kingsnorth AN. Gallstones.	Clinical	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
Surgery	omy	cholecystectomy in mild or asymptomatic gallstones if **one or more** of the following criteria are met: High risk of gall bladder cancer, e.g. *gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer). (**Annual USS for smaller asymptomatic polyps)* Transplant recipient (pre or post transplant). Diagnosis of chronic haemolytic syndrome by a secondary care specialist. Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones smaller than 3mm with a patent cystic duct, presence of multiple stones. Acalculus cholecystitis diagnosed by a secondary care specialist. **Exclusion Criteria:** The CCG **will not** support the funding of cholecystectomy for patients in the following scenarios: Patients with gallstones who experience one episode of mild abdominal pain only which can safely be managed with oral analgesia in primary care/community setting. Such patients should be advised to follow a low fat diet and only require referral if they have further episodes, OR their pain is not controlled by oral	*BMJ*. 2007;335:295-9. Sakorafas GH, Milingos D, Peros G. Asymptomatic cholelithiasis: is cholecystectomy really needed? A critical reappraisal 15 years after the introduction of laparoscopic cholecystectomy. *Dig Dis Sci*. 2007;52:1313-25. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones (Accessed 2016) Behari A and Kapoor VK. Asymptomatic Gallstones (AsGS) – To Treat or Not to? *Indian J Surg*. 2012;74: 4–12. Tsirline VB, Keilani ZM, El Djouzi S *et al*. How frequently and when do patients undergo cholecystectomy after bariatric surgery? *Surg Obes Relat Dis* 2013;1550-7289(13)00335-3. Taylor J, Leitman IM, Horowitz M. Is routine cholecystectomy necessary at the time of Roux-en-Y gastric bypass? *Obes Surg*. 2006;16:759-61. Caruana JA, McCabe MN, Smith AD *et al.* Incidence of symptomatic gallstones after gastric bypass: is prophylactic treatment really necessary? *Surg Obes*	threshold – refer using checklist. IFR for exceptionality The threshold in respect of mild (one episode of mild abdominal pain) does not apply to Doncaster, Bassetlaw or Sheffield CCG	

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		analgesia OR is associated with other symptoms, i.e. vomiting Asymptomatic gallstones in patients with diabetes mellitus. Asymptomatic gallstones in patients undergoing bariatric surgery, unless intra-operatively the gall bladder is found to be abnormal or the presence of calculi are very apparent. In such cases it is worth considering concurrent cholecystectomy. All patients with asymptomatic gallstones who do not meet any of the above criteria	*Relat Dis*. 2005;1(6):564-7; discussion 567-8.		
General Surgery	Hernia Repair (Ingiunal, femoral, Umbilical, para-umbilical, incisional)	*Inguinal:* Surgical treatment should only be offered when one of the following criteria is met: Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living **OR** The hernia is difficult or impossible to reduce, **OR** Inguino-scrotal hernia, **OR** The hernia increases in size month on month *Femoral:* All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation *Umbilical/Paraumbilical and midline ventral hernias:* Surgical treatment should only be offered when one of the following criteria is met: pain/discomfort interfering with Activities of Daily	National Institute for Health and Care Excellence (2004) laprascopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ta83 (Accessed 2016) Medscape: *Hernias.* Available from: http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 2016) McIntosh A. Hutchinson A. Roberts A & Withers, H. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice, 2000;17(5), 442-447. GP notebook: *Paraumbilical hernias*. Available from: http://www.gpnotebook.co.uk/simplepage.cfm?ID=-	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		Living **OR** Increase in size month on month **OR** to avoid incarceration or strangulation of bowel where hernia is ≥ 2cm *Incisional:* Surgical treatment should only be offered when of the following criteria are met: Pain/discomfort interfering with Activities of Daily Living	1811546097&linkID=17862&cook=n (accessed 2016) Friedrich M. Müller Riemenschneider F. Roll S. Kulp W. Vauth C. Greiner W & von der Schulenburg JM. Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. *GMS health technology assessment*. 2008;*4*. Dabbas. Frequency of abdominal wall hernias: is classical teaching out of date. JRSM *Short Reports*: 2011;2/5. Fitzgibbons. Watchful waiting versus repair of inguial hernia in minimally symptomatic men, a randomised controlled trial. *JAMA*: 2006;295, 285-292 Purkayastha S. Chow A, Anthanasiou T, Tekkis P P & Darzi A. Ingunal hernias. *Clinical evidence, 2008;*0412, 1462-3846 Rosenberg J. Bisgaard T. Kehlet H. Wara P. Asmussen T. Juul P & Bay-Nielsen M. Danish Hernia Database recommendations for the management		

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
			of inguinal and femoral hernia in adults. *Dan Med Bull*, 2011;*58*(2), C4243. Simons M P. Aufenacker T. Bay-Nielsen M. Bouillot J L. Campanelli G. Conze J & Miserez, M. European Hernia Society guidelines on the treatment of inguinal hernia in adult patients. *Hernia*, 2009;*13*(4),343-403. Primatesta P & Goldacre MJ. Inguinal hernia repair: incidence of elective and emergency surgery, readmission and mortality. *International journal of epidemiology*, 1996;*25*(4), 835-839. Patient Care Committee, & Society for Surgery of the Alimentary Tract. Surgical repair of incisional hernias. SSAT patient care guidelines. Journal of gastrointestinal surgery: official journal of the Society for Surgery of the Alimentary Tract. 2004;8(3), 369. The Society for Surgery of the Alimentary Tract. *Surgical Repair of Groin Hernias. Available from: http://www.ssat.com/cgi-bin/hernia6.cgi* (accessed 2016)		
Orthopaedics	Hip/Knee Replacement for osteoarthritis	The CCG will **only** fund hip/knee replacement for osteoarthritis when conservative measures have failed (listed below) or its successor AND the following criteria have been met:	http://pathways.nice.org.uk/pathways/musculoskeletal-conditions (accessed 2016)	Clinical threshold – refer using checklist.	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures: (If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required. Patients DO NOT require referral back to the GP for re referral) Referral to the Hip or Knee Pathway **AND** Patient has a BMI of less than 35 (Patients with BMI>35 should be referred for weight management interventions and upon 6 months of documented weight loss attempt with dates and intervention types- if the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process.) **AND** Intense to severe persistent pain (defined in table one and documentation to support is required) which leads to severe functional limitations (defined in table two and documentation to support is required), ***OR*** Moderate to severe functional limitation (defined in table two and documentation to support is required) affecting the patients quality of life despite 6 months of conservative measures including referral to the local hip pathway or its successor.	National Institute of Health. Consensus development program. Dec 2003 https://consensus.nih.gov/2003/2003totalkneereplacement117html.htm (accessed 2016) The musculoskeletal services framework – A joint responsibility: doing it differently. Department of Health. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf Namba, R., Paxton, L., Fithian, D., and Stone, M. Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50. Hawkeswood MD, J.,Reebye MD, R. Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles. College of General Practitioners. 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip	IFR for exceptionality	

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		Exceptions include: Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. Rapid onset of severe hip pain ****Conservative measures:*** Patient education such as elimination of damaging influence on hips/knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND** Physiotherapy **AND** Oral NSAIDS a minimum of 3 weeks and paracetamol based analgesics (COX-2 Inhibitor of NSAIDS). Documentation of dates and medication types is required.	Procedures criteria. 2013. NICE. TA44 Metal on Metal Hip Resurfacing. 04 January 2013. https://www.nice.org.uk/guidance/TA2/documents/appendix-b-proposal-paper-presented-to-the-institutes-guidance-executive2 NHS England. Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC019.pdf Kandala NB, Connock M, Pulikottil-Jacob R, Sutcliffe P, Crowther MJ, Grove A,Mistry H Clarke A. Setting benchmark revision rates for total hip replacement: analysis of registry evidence. BMJ 2015;350:h756 doi: 10.1136/bmj.h756 (Published 9 March 2015)		
Orthopaedics	Carpal Tunnel Syndrome	The CCG will only fund Carpal Tunnel Surgery when **either** of the following criteria is met: Severe symptoms at presentation (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms significantly interfere with daily activities)*, **OR**	Bickel, K. (2010). Carpal Tunnel Syndrome. *Journal of Hand Surgery*, 35 (1), pp. 147-151285-1295 Massy-Westropp. N, Grimmer.K and Bain. G, (2000). A systematic review of the clinical diagnostic tests for carpal tunnel syndrome, *J Hand Surgery,* 25A,	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		If there is no improvement in mild-moderate symptoms after 6 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required) *This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms.	pp. 120–127. Gerritsen. A, de Krom. M, Struijs. M, Scholten. R, de Vet.H, Bouter. L. (2002) Conservative treatment options for carpal tunnel syndrome: a systematic review of randomised control trials. *Journal Neurology*, 249, pp.272-80 Bland, J.(2007). Carpal Tunnel Syndrome. *BMJ*, 335:343-6 Kruger. V, Kraft.G, Deitz.J, Ameis.A, Polissar.L. (1991). Carpal tunnel syndrome: objective measures and splint use. *Arch phys Med Rehabil*, 72, pp.517-20 Manente. G, Torrieri. F, Di Blasio. F, Staniscia. T, Romano. F, Uncina. A. (2001). An innovative hand brace for carpal tunnel syndrome: a randomised controlled trial. *Muscle Nerve*, 24, pp. 1020-5. Gerritsen, A.A., Uitdehaag, B.M., van Geldere, D. et al. (2001) Systematic review of randomized clinical trials of surgical treatment for carpal tunnel syndrome. *British Journal of Surgery,* 88(10), pp.1285-1295 Wong. S, Hui. A, Tang. A, Ho. P, Hung. L, Wong. K. (2001). Local vs systematic corticosteroids in the treatment of carpal tunnel syndrome. *Neurology*, 56, pp.1565-7. Marshall, S., Tardif, G. and Ashworth, N. (2007) *Local corticosteroid injection*		

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
			for carpal tunnel syndrome (Cochrane Review). The Cochrane Library. Issue 2. John Wiley & Sons, Ltd. British Society for Surgery of the Hand. BSSH Evidence for Surgical Treatment (BEST) 1: Carpal Tunnel Syndrome. http://www.bssh.ac.uk/patients/conditions/21/carpal_tunnel_syndrome		
Orthopaedics	Common Hand Conditions (Dupuytren's, Trigger Finger, Ganglion)	*Dupuytren's Disease:* Referral should **only** be considered when the patient is having **at least one** of the following functional difficulties: Moderate to severe form of the disease with notable functional impairment **or/and** *30 degrees or more fixed flexion at the metacarpophalangeal joint **or** *30 degrees or more fixed flexion at the proximal interphalangeal joint *(*Inability to flatten fingers or palm on table)* *Ganglions:* Referral should only be undertaken when one of the following criteria are met: Painful seed ganglia **OR** Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) **OR** If diagnosis is in doubt There is no indication for the routine excision of	British Society for Surgery of the Hand. BSSH Evidence for Surgical Treatment (BEST) 1: Dupuytren's Disease. http://www.bssh.ac.uk/patients/conditions/25/dupuytrens_disease Davis, T. et al. Surgery for dypuytren's contractures of the fingers. Cochrane Musculoskeletal Group. Published online 17 Oct.2012. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010143/epdf NICE Clinical Knowledge Summaries. Dupuytren's disease. http://cks.nice.org.uk/dupuytrens-disease	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		simple wrist ganglia and these should not be routinely referred except where there is ND deficit or severe pain. *Trigger Finger:* Referral should only be undertaken when the following criteria have been met including patient record documentation of conservative treatment interventions: Triggering with difficulty actively extending finger/need for passive finger extension **or** Loss of complete active flexion **or** Failure to respond to conservative treatment (up to 2 corticosteroid injections)			
Ophthalmology	Cataract Surgery	All requests for the surgical removal of cataract(s) will **only** be supported by the CCG when the following applies: All requests for the surgical removal of cataract in the first eye will **only** be supported by the CCG when the total assessment score is 7 or above as per the cataract assessment and referral form ***For second eye surgery:*** If vision in the first operated eye is better than 6/10 (0.20 logMAR) corrected postoperatively then the patient will need to have sufficient cataract to cause blurred or dim vision with a monocular distance acuity of 6/18 (0.40	Department of Health. National Eye Care Plan (2004) The Royal College of Ophthalmologists: Cataract Surgery guidelines (2004) NHS Executive. Action on Cataracts; Good Practice Guidance (2000). Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S. Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older people in the community. *Br J Ophthalmol* 2002; 86: 795-800	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		logMAR) or worse in the second eye to qualify for cataract surgery. If vision in the first eye does not correct to better than 6/10 then second eye cataract surgery can be offered only if the binocular corrected vision is 6/10 or worse or the second eye vision is monocularly worse than 6/18 corrected. ***Exceptions*** The only exceptions to the above referral criteria are as follows: Anisometropia (a large refractive difference between the two eyes, on average about dioptres) which would result in poor binocular vision or disabling diplopia which may increase falls. Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	NICE February 2014. Eye conditions pathway http://pathways.nice.org.uk/pathways/eye-conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209.February 2007. http://guidance.nice.org.uk/IPG209		

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) Corneal or conjunctival disease where delays might increase the risk of complications (e.g.cicatrising conjunctivitis) Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) Post Vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia. Cataracts progress fairly rapidly following vitrectomy and are age dependent. Patients over the age of 50, especially those over 60 can have a rapid increase in the density of a cataract.			
Phase 2					
Urology	Male circumcision	Circumcision will **only** be commissioned for the following indications as confirmed by an appropriate clinician: • Phimosis (inability to retract the foreskin	NHS Choices. Circumcision in adults: http://www.nhs.uk/conditions/Circumcision/Pages/Introduction.aspx (Accessed 16 January 2017)	Clinical threshold – refer using checklist.	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		due to a narrow prepucial ring) • Recurrent paraphimosis (inability to pull forward a retracted foreskin) • Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin) • Balanoposthitis (recurrent bacterial infection of the prepuce) • Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	Royal College of Surgeons. Commissioning guide: Foreskin conditions. 2013. Available from: http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions Moreno G, Corbalán J, Peñaloza B, Pantoja T. Topical corticosteroids for treating phimosis in boys. Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD008973. DOI: 10.1002/14651858.CD008973.pub2 Liu, Yang, Chen et al. Is steroids therapy effective in treating phimosis? A meta-analysis. Int Urol Nephrol. 2016 Mar; 48(3):335-42. doi: 10.1007/s11255-015-1184-9 Zhu, Jia, Dai et al. Relationship between circumcision and human papillomavirus infection: a systemic review and meta-analysis. Asian J Androl. 2016 March. http://www.ajandrology.com/article.asp?issn=1008-682X;year=2017;volume=19;issue=1;sp	IFR for exceptionality	

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
			age=125;epage=131;aulast=Zhu Singh-Grewal D,Macdessi J, Craig J. Circumcision for the prevention of urinary tract infection in boys: a systematic review of randomised trials and observational studies. Arch Dis Child. 2005 Aug;90(8):853-8 Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. The Lancet. 2007;369 (9562): 643–56		
General Surgery	Benign Perianal Skin Tags	Referral should only be undertaken when the following criteria have been met: There is doubt about the benign nature of the skin lesion Viral warts in immunocompromised patients where underlying malignancy may be masked. Recommended by GU Med when conservative treatment has failed	NHS England. Interim Clinical Commissioning Policy: Anal Kin Tag Removalhttps://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC002.pdf McKinnell and Gray, 2010, QIPP Programme Right Care: Value Improvement Identifying Procedures of Low Value, Public Health Commissioning Network. Lumps and swellings NHS Choices http://www.nhs.uk/conditions/lumps-swellings/Pages/Introduction.aspx (accessed January 2017)	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
	Haemorrhoidectomy	Haemorrhoidectomy is not routinely funded for Grades I and II. The CCG will fund Haemorrhoidectomy when the following criteria are met: Recurrent third or fourth degree combined internal/external haemorrhoids **OR** Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR** Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct current electrotherapy.)	SSAT Patient Care Guidelines, Surgical Management of Hemorrhoids. http://www.ssat.com/cgi-bin/hemorr.cgi (accessed 16/04/17) [Haemorrhoids CKS]. 2016 [cited 23 May 2016]. Available from: http://cks.nice.org.uk/haemorrhoids Reese, G.E., von Roon, A.C. and Tekkis, P.P. (2009) Haemorrhoids. Clinical Evidence BMJ Publishing Group. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907769/pdf/2009-0415.pdf (accessed 16/04/17) Kaidar-Person, O., Person, B. and Wexner, S.D. (2007) Hemorrhoidal disease: a comprehensive review. Journal of the American College of Surgeons 204(1), 102-117. Cataldo, P., Ellis, C.N., Gregorcyk, S. et al. (2005) Practice parameters for the treatment of hemorrhoids (revised).Diseases of the Colon & Rectum48(2), 189-194. Northwest London collaboration of clinical commissioning group. Haemorrhoidectomy. http://www.hounslowccg.nhs.uk/media/40064/21-Haemorrhoidectomy-v33.pdf (accessed 16/04/17) Wakefield Clinical commissioning group. Clinical compact for	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
			haemorrhoids. https://www.wakefieldccg.nhs.uk/wp-content/uploads/2015/06/Clinical-Compact-for-Haemorrhoids-procedures-v0.3-final.pdf (accessed 16/04/17) Herefordshire Clinical Commissioning Group Low Priority Treatment Policy 2015 http://tinyurl.com/h7a28ov (accessed 16/04/17) Nottingham North East CCG http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2014/04/10.-Policy-for-Procedures-of-Low-Clinical-Value-PLCV-Version-D-March-2011-NNE.pdf (accessed 16/04/17		
Orthopaedics	Ingrowing Toe Nail in secondary care	Referral to secondary care should only be undertaken when: the patient is in clinical need of surgical removal of ingrowing toe nail, has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed. **OR** People of all ages with infection and/or recurrent inflammation due to ingrown toenail **AND** who have high medical risk*. **Medical risk is determined by the referring clinician*	Eekhof JAH, Van Wijk B, Knuistingh Neven A, van der Wouden JC. Interventions for ingrowing toenails. Cochrane Database of Systematic Reviews 2012, Issue 4. Art. No.: CD001541. DOI: 10.1002/14651858.CD001541.pub3 Nice.org.uk. (2016). Clinical Assessment Service: foot and ankle pathway | QP Case Study | Local practice | NICE. [online] Available at: https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f959489%2fattachment%3fniceorg%3dtrue	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
	Hallux Valgus	This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus. Surgery for hallux valgus will be funded if the following criteria are met and evidenced in clinic letters: Significant and persistent pain when walking **AND** conservative measures tried for at least six months (e.g. Toe spacers, bunion pads, medication or altered footwear) do not provide symptomatic relief **OR** ulcer development at the site of the bunion or the sole of the foot **OR** evidence of severe deformity (overriding toes) **OR** Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Patient Info – Hallux valgus http://patient.info/doctor/hallux-valgus NICE Clinical Knowledge Summaries – Bunions https://cks.nice.org.uk/bunions		Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
Opthalmology	Meibomian Cyst (Chalazion)	Referral should only be made for the following indications Where conservative treatment has been tried for 3 months and has failed **AND** Where the meibomian cyst/chalazion is on the upper eyelid and interferes with vision **OR** Is causing persistent inflammation and pain.	Clinical Knowledge Summaries: Management of Meibomian cyst (accessed April 2017) https://cks.nice.org.uk/meibomian-cyst-chalazion#!scenariorecommendation Paper A, Tuttle DJ, Mahar TJ. Differential diagnosis of the swollen red eyelid. Am DFam Physician. 2007 Dec 15;76(12):1815-24 http://www.ncbi.nlm.nih.gov/pubmed/12399770 McKinnell and Gray, 2010, QIPP Programme Right Care: Value Improvement Identifying Procedures of Low Value, Public Health Commissioning Network http://www.aafp.org/afp/2007/1215/p1815.pdf Cottrell D. G., Bosanquet R. C., Fawcett I. M. Chalazions: the frequency of spontaneous resolution. *British Medical Journal*. 1983;287(6405, article 1595) doi: 10.1136/bmj.287.6405.1595. [PMC free article]	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018
	Blepharoplasty	Referral should only be made for the following indication: To relieve symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue. **OR** Following skin grafting for eyelid reconstruction	Minhas A, Ronoh J., Badrinath P., 2008. "Upper Eyelid Blepharoplasty for the Treatment of Functional Problems: A Brief to the Suffolk PCT Clinical Priorities Group". Suffolk PCT. Hacker H.D. and Hollsten D.A, 1992.	Clinical threshold – refer using checklist. IFR for exceptionali	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		OR Following surgery for ptosis For all other individuals, the following criteria apply: Documented patient complaints of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND** There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND** Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly.	"Investigation of automated perimetry in the evaluation of patients for upper lid blepharoplasty". Ophthalmic, Plastic & Reconstructive Surgery 8 (4) pp. 250-255. Purewal B.K. and Bosniak S., 2005. "Theories of upper eyelid blepharoplasty". Ophthalmology Clinics of North America 18 (2) pp 271-278. American Academy of Ophthalmology, 1995. "Functional Indications for Upper and Lower Eyelid Blepharoplasty". Ophthalmic Procedures Assessment American Journal of Ophthalmology 102 (4) pp. 693-695. Kosmin A.S., Wishart P.K., Birch M.K., 1997. "Apparent glaucomatous visual field defects caused by dermatochalasis". Eye 11 pp. 682-686	ty	
Orthopaedics	Arthroscopic Subacromial decompression of the shoulder (ASAD)	• Patient has had symptoms for at least 3 months from the start of treatment • The patient has been assessed by Musculoskeletal Services and undertaken a minimum of six weeks of conservative treatment, as advised by and documented in primary care, such as education, rest, cessation of painful activity, a course of physiotherapy, NSAIDs and analgesia without improvement of symptoms (Saltychev M, 2015). • Symptoms are intrusive and debilitating	NICE guidance NG59 November 2016	Clinical threshold – refer using checklist. IFR for exceptionality	Dec 2018

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
		• Patients have received one steroid injection from a trained physiotherapist or GP without improvement; (Normally, only one injection should be considered as repeated injections may cause tendon damage (Dean B, 2014). A second injection is occasionally appropriate after 6 weeks, but should only be administered in patients who received good initial benefit from their first injection and who need further pain relief to facilitate their structured physiotherapy treatment). • Patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with conservative management • At least 8 weeks following steroid injection • Symptoms are severe and cause significant functional impairment. Significant functional impairment is defined by the BNSSG Health Community as: 1. Symptoms preventing the patient fulfilling routine work or educational responsibilities 2. Symptoms preventing the patient carrying out routine domestic or carer activities			

Speciality	Procedure	Criteria for treatment	Evidence Base	Process	Date of review
Not routinely Commissioned					
Orthopaedics	Spinal Joint injections for low back pain	**Not routinely Commissioned**	NICE Guidance NG 59 does not recommend offering spinal injections for low back pain https://www.nice.org.uk/guidance/ng59	Refer through IFR for exceptionality	
	Acupuncture	**Not Routinely Commissioned except for chronic tension type headaches and migraine**	NICE Guideline NG59 https://www.nice.org.uk/guidance/ng59 NICE CKS – Migraine https://cks.nice.org.uk/migraine CG 150 Headaches in over 12s – Diagnosis and Management https://www.nice.org.uk/guidance/cg150/chapter/recommendations	Refer through IFR for exceptionality	
	Vasectomy under General Anaesthetic	**Not Routinely Commissioned** Needle phobia is no longer an exception for this procedure		Refer through IFR for exceptionality	

15. Plastics and fertility procedures

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
Obstetrics & Gynaecology	Reversal of Female Sterilisation	**Not Routinely Commissioned**	**National supporting evidence** NHS England Interim Commissioning Policy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC028.pdf	Refer through IFR for exceptionality	

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

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
Plastic and Cosmetic surgery	Facelift Browlift	**Facelift procedures and Botulinum toxin will not be routinely commissioned by the NHS for cosmetic reasons** Cases may be considered on an exceptional basis, for example in the presence of an anatomical abnormality or a pathological feature which significantly affects appearance.	Policy for specialist plastic surgery procedures Link	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Abdominoplasty/ apronectomy (tummy tuck)	**Abdominoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Abdominoplasty may rarely be considered on an exceptional basis, for example where the patient: • has lost a significant amount of weight (moved down two levels of the BMI SIGN guidance) and has a stable BMI, which would normally be below 27 for a minimum of 2 years, **and** • is experiencing severe difficulties with daily living, for example ambulatory or urological restrictions. Other factors may be considered: • recurrent severe infection or ulceration beneath the skin fold • significant abdominal wall deformity due to surgical scarring or trauma		Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
Plastic and Cosmetic surgery	Buttock, thigh and Arm lift surgery	**Not Routinely Commissioned** Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • has an underlying skin condition, for example cutis laxa or • has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living **and** • has a normal BMI in the range18.5 - 27 for a minimum of 2 years	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Breast Augmentation	**Breast augmentation will not be routinely commissioned by the NHS for cosmetic reasons, for example for small normal breasts or for breast tissue involution (including post-partum changes).** Breast augmentation may rarely be considered on an exceptional basis, for example where the patient: • has a complete absence of breast tissue either unilaterally or bilaterally or • has suffered trauma to the breast during or after development and • has a BMI within the range 18.5 - 27 and • has completed puberty as surgery is not routinely commissioned for individuals who are below 19 years of age	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
		Patients who have received feminising hormones for an adequate length of time as part of a recognised treatment programme for gender dysphoria will only be considered when they meet the above criteria. Revision surgery will only be commissioned for implant failure or for other physical symptoms, for example capsule contracture associated with pain, and not for aesthetic indications. Implant replacement will only be considered if the original procedure was performed by the NHS.			
Plastic and Cosmetic surgery	Breast Reduction	**Not Routinely Commissioned** Breast reduction will not routinely be commissioned by the NHS for cosmetic reasons. Breast reduction may rarely be considered on an exceptional basis, for example where the patient: • has a breast measurement of cup size G or larger **and** • has a BMI in the range 18.5 - 27 **and** • is 19 years of age or over **and** • has significant musculo-skeletal pain causing functional impairment which in the opinion of the referrer is likely to be corrected or significantly improved by surgery **and** • has tried and failed with all other advice and support, including a professional bra fitting and assessment by a physiotherapist where relevant	**National supporting evidence** NHS England Interim Commissioning Policy for Breast Reduction November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC005.pdf	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
Plastic and Cosmetic surgery	Breast Reduction for male gynaecomastia	**Not Routinely Commissioned** Surgery to correct gynaecomastia will not routinely be commissioned by the NHS for cosmetic reasons. Surgery may be considered on an exceptional basis, for example where the patient: • has more than 100g of sub areolar gland and ductal tissue (not fat) **and** • has a BMI in the range 18.5 - 27 **and** • has been screened prior to referral to exclude endocrinological and drug related causes o if drugs have been a factor then a period of one year since last use should have elapsed **and** • has completed puberty - surgery is not routinely commissioned below the age of 19 years **and** • has been monitored for at least 1 year to allow for natural resolution if aged 25 or younger	**National supporting evidence** NHS England Interim Commissioning Policy for Breast Reduction for Gynaecomastia (male) November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC006.pdf	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Breast Asymmetry	**Not Routinely Commissioned** Surgery to correct breast asymmetry will not routinely be commissioned by the NHS for cosmetic reasons. Surgery may rarely be considered on an exceptional basis, for example where the patient: • has a difference of at least 2 cup sizes and • has a BMI in the range 18.5-27 and • has tried and failed with all other advice and treatment, including a professional bra fitting and • has completed puberty - surgery is not	**National supporting evidence** NHS England Interim Commissioning Policy for Breast Asymmetry November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC003.pdf	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
		normally commissioned below the age of 19 years			
Plastic and Cosmetic surgery	Breast lift mastopexy	**Not Routinely Commissioned** Mastopexy will not be routinely commissioned by the NHS for cosmetic reasons, for example post lactation or age related ptosis but may be included as part of the treatment to correct breast asymmetry.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Correction of Nipple inversion	**Not Routinely Commissioned** Surgical correction of benign nipple inversion will not be routinely commissioned by the NHS for cosmetic reasons.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Hair removal	**Not Routinely Commissioned** Hair removal will not be routinely commissioned by the NHS for cosmetic reasons. Hair removal may be considered on an exceptional basis, for example where the patient: • has had reconstructive surgery resulting in abnormally located hair bearing skin or • has a pilonidal sinus resistant to conventional treatment in order to reduce recurrence risk	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Hair transplantation	**Not Routinely Commissioned** Hair transplantation will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
		Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma.			
Plastic and Cosmetic surgery	Acne scarring	**Procedures to treat facial acne scarring will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Pinnaplasty	**Not Routinely Commissioned** Surgical correction of prominent ears will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern **and** • has very significant ear deformity or asymmetry	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Rhinoplasty	**Not Routinely Commissioned** Rhinoplasty will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example in the presence of severe functional problems.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
		Post traumatic airway obstruction or septal deviation does not need funding approval.			
Plastic and Cosmetic surgery	Rhinophyma	**Not Routinely Commissioned** Surgical/laser treatment of rhinophyma will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an individual basis, for example where the patient has functional problems and where conventional medical treatments have been ineffective.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Revision of Surgical Scars	**Not Routinely Commissioned** Revision surgery for scars will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • has significant deformity, severe functional problems, or needs surgery to restore normal function or • has a scar resulting in significant facial disfigurement.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Congenital vascular abnormalities	**Not Routinely Commissioned** Procedures for congenital vascular abnormalities will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

Speciality	Procedure	Commissioning Position	Evidence Base	Process	Date of Review
		only.			
Plastic and Cosmetic surgery	Thread vein/telangectasia	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Tattoo removal	**Tattoo removal will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example where the patient: • has suffered a significant allergic reaction to the dye and medical treatments have failed • has been given a tattoo against their will (rape tattoo)	**National supporting evidence** NHS England Interim Commissioning Policy for Tattoo Removal November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC032.pdf	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Reduction of labia minora (Labioplasty)	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018
Plastic and Cosmetic surgery	Liposuction	**Not Routinely Commissioned** Liposuction will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient has significant lipodystrophy.	Policy for specialist plastic surgery procedures	Refer through IFR for exceptionality	Updated May 2016 Review May 2018

16. Clinical Threshold Checklists

Please send this form with the referral letter.

Grommets for Otitis Media with Effusion in Children

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund Grommets for Otitis Media with Effusion in children (age under 18 years) when the following criteria are met:

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

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

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

Please send this form with the referral letter.

Grommets in Adults

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund Grommets for Adults (Aged 18 and over) when the following criteria are met:

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

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

Please send this form with the referral letter.

Tonsillectomy

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund Tonsillectomy when the following criteria have been met:

A six month period of watchful waiting is recommended prior to referral for tonsillectomy to establish a pattern of symptoms and to allow the patient time to fully consider the implications of the operation

In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria when presenting in a Primary Care setting:	***Delete as appropriate***	
Recurrent attacks of tonsillitis • 7 or more well documented, clinically significant**, adequately treated sore throats in the preceding year **OR** • 5 or more such episodes in each of the preceding 2 years **OR** • 3 or more such episodes in each of the preceding 3 years	Yes	No
Two or more episodes of quinsy (peri-tonsillar abscess)	Yes	No
Severe halitosis secondary to tonsillar crypt debris	Yes	No
Failure to thrive secondary to difficulty swallowing caused by very enlarged tonsils.	Yes	No
In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria when presenting in a Secondary Care setting:	***Delete as appropriate***	
Sleep disordered breathing or obstructive sleep apnoea diagnosed on overnight pulse oximetry or polysomnography.	Yes	No
Biopsy / removal of lesion on tonsil	Yes	No

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

****** A Clinically significant episode is characterised by at least one of the following:
- Oral temperature of at least 38.30C requiring antibiotic treatment
- Tender anterior cervical lymph nodes.
- Tonsillar exudates.

Please send this form with the referral letter.

Varicose Veins

Instructions for use: Please refer to the full policy for details.

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

Diagnosis of varicose veins and truncal reflux must be confirmed on duplex ultrasound to be eligible for treatment. According to the NICE clinical guideline 168, treatment is to be offered in a stepwise approach. Endothermal ablation must be offered first and if it is unsuitable, the patient should then be offered ultrasound guided foam sclerotherapy as a second line option. Should sclerotherapy also be unsuitable then surgery may be offered as a third line option.

Patients can be referred to secondary care as a third line option if the first and second line options (above) are unsuitable and they meet the following criteria:	Please tick one
Patient's BMI is 30 or less **AND**	
Bleeding varicose vein or if the patient is at high risk of re-bleeding. (i.e. there has been more than one episode of minor haemorrhage or one episode of significant haemorrhage from a ruptured superficial varicosity.) **OR**	
Significant and or progressive lower limb skin changes such as Varicose eczema, or lipodermatosclerosis with moderate to severe oedema proven to be caused by chronic venous insufficiency (itching is insufficient for referral). **OR**	
Recurrent thrombophlebitis (more than 2 episodes) associated with severe and persistent pain requiring analgesia and affecting activities of daily living and or instrumental activities of daily living*. **OR**	
If the patient is severely symptomatic affecting activities of daily living and or instrumental activities of daily living. - **ALL** below must apply:	
• Symptoms must be caused by varicosity and cannot be attributed to any other comorbidities or other disease affecting the lower limb.	
• There must be a documented unsuccessful six month trial of conservative management.**	
• Evidence that symptoms are affecting activities of daily living and/or Instrumental activities of daily living.	
• In the opinion of a vascular specialist, these symptoms can be reversed or significantly improved with treatment.	

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

** Conservative management should include advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation whenever sitting and weight loss if appropriate. Compression stockings should only be used where interventional treatment is unsuitable or the patient fails to meet the criteria

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

Please send this form with the referral letter.

Management of Benign Skin Lesions

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

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

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

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

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

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

Please send this form with the referral letter.

Hysterectomy and Hysteroscopy for Management of Heavy Menstrual Bleeding

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

The CCG will only fund Hysterectomy or Hysteroscopy when the following criteria are met:
Patients **WILL NOT** receive a D&C:

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

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

*Hysteroscopy for HMB will only be funded if ONE of the following criteria is met:

Trans vaginal ultrasound scan provided inconclusive results	Yes	No
Trans vaginal ultrasound scan was suggestive of endometrial pathology (e.g. polyp or submucous fibroid).	Yes	No
As part of an ablative procedure	Yes	No
Inter-menstrual bleeding over the age of 40yrs	Yes	No
Scan suggests thickened and cystic appearance/hyperplasia	Yes	No

*The hysteroscopy element of this Checklist does not apply to Doncaster CCG. Normal referral process applies.

Hysterectomy for HMB will only be funded if ALL the following criteria are met:

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

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

Please send this form with the referral letter.

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

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the form prior to referral.

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

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

** (Annual USS for smaller asymptomatic polyps)*

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

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

***** The threshold in respect of mild (one episode of mild abdominal pain) does not apply to Doncaster, Bassetlaw and Sheffield CCG***

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

Please send this form with the referral letter.

Surgical Repair of Hernias

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit. (This policy only applies to patients aged over 16 years)
PATIENTS WITH DIVERIFICATION OF THE RECTI SHOULD NOT BE REFERRED FOR SURGICAL OPINION
The CCG will only fund ***inguinal*** hernia surgery when the following criteria are met:

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

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

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

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

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

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

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria.*	Delete as appropriate	
Pain or discomfort interfering with Activities of Daily Living	Yes	No

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

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

Please send this form with the referral letter.

Hip Replacement

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

*Conservative measures = oral NSAIDs, physiotherapy or referral to the Hip Referral Pathway, and paracetamol based analgesics and patient education (e.g. activity / lifestyle modification). Documentation of dates and types of conservative measures required to be included with this form.

Table 1: Classification of pain level

Pain level	
Slight	Sporadic pain.(May be daily but comes and goes 25% or less of the day) Pain when climbing/descending stairs. Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house) Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects
Moderate	Occasional pain.(May be daily and occurs 50-75% of the day) Pain when walking on level surfaces (half an hour, or standing). Some limitation of daily activities.(Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects.
Intense/Severe	Pain of almost continuous nature.(Occurs 75-100% of the day) Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour or pain when resting Daily activities significantly limited. (unable to maintain home, cook, bathe or dress

	without difficulty or assistance) Continuous use of NSAIDs or narcotics for treatment to take effect or no response Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

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

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

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

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

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

Please send this form with the referral letter.

Knee replacement

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further details.
*Conservative measures =, oral NSAIDs, physiotherapy or referral to the Knee Referral Pathway and paracetamol based analgesics, intra-articular corticosteroid injections and patient education (e.g. activity / lifestyle modification). See policy for further details.

Table 1: Classification of pain level

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

	Requires the use of support systems (walking stick, crutches).

Table 2: Functional Limitations

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

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

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

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

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

Please send this form with the referral letter.

Carpal Tunnel Syndrome Surgery.

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.
To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

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

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

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

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

*** plus CTS score of 5 or more for Doncaster, Bassetlaw and Sheffield

Please send this form with the referral letter.

Common Hand Conditions – Dupuytren's Disease

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria.*	Delete as appropriate	
Moderate to severe form of the disease with notable functional impairment **or/and**	Yes	No
30 degrees or more fixed flexion at the metacarpophalangeal (MCPJ)joint **or	Yes	No
**30 degrees or more fixed flexion at the proximal interphalangeal (PIPJ) joint	Yes	No

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

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

Please send this form with the referral letter.

Common Hand Conditions – Trigger Finger

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Triggering with difficulty actively extending finger/need for passive finger extension **or**	Yes	No
Loss of complete active flexion **or**	Yes	No
Failure to respond to conservative treatment (up to 2 corticosteroid injections)**	Yes	No

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

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

Please send this form with the referral letter.

Common Hand Conditions – Ganglions

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

There is no indication for the routine excision of simple wrist ganglia and these should not be routinely referred except where there is ND deficit or severe pain. (Refer through IFR)

To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.
The CCG will only fund correction of Ganglion(s) when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Painful seed ganglia	Yes	No
Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint)	Yes	No
If the diagnosis is in doubt	Yes	No

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

Cataract Surgery

Instructions for use:

First Eye Surgery: Referring Optometrist or GP completes checklist. **Please complete Part 1**
Second Eye Surgery: Please complete Part 2

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

Part 1 First Eye Cataract Surgery

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

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

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

	Circle Score	**Yes**	**No**
Any difficulties for patient with mobility *(including aspect of travel, e.g. driving, using public transport)*?		2	0
Is the patient affected by glare in sunlight or night (*car headlights)*?		1	0
Is the patient's vision affecting their ability to carry out daily tasks?		2	0

TOTAL ASSESSMENT SCORE (*VA AND LIFESTYLE SCORE*)

NB: ***THE PATIENT MUST HAVE A TOTAL ASSESSMENT SCORE OF 7 TO MEET THE THRESHOLD FOR FIRST EYE SURGERY***

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

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

Part 2
To be completed by Hospital Consultant

For second eye surgery	Delete as appropriate	
If vision in the first operated eye is better than 6/10 (0.20 logMAR) corrected postoperatively then the patient will need to have sufficient cataract to cause blurred or dim vision with a monocular distance acuity of 6/18 (0.40 logMAR) or worse in the second eye to qualify for cataract surgery. If vision in the first eye does not correct to better than 6/10 then second eye cataract surgery can be offered only if the binocular corrected vision is 6/10 or worse or the second eye vision is monocularly worse than 6/18 corrected.	Yes	No
The only exceptions to the referral criteria above are as follows:		
Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls.	Yes	No
Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma	Yes	No
Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.	Yes	No
Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery	Yes	No
Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)	Yes	No
Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)	Yes	No
Other glaucoma's (including open-angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography	Yes	No
Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)	Yes	No
Post vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia.	Yes	No

Please send this form with the referral letter.

Male Circumcision

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*
This policy does not apply to

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

Please send this form with the referral letter.

Treatment of benign perianal skin lesions in secondary care

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

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

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:

To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

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

Please send this form with the referral letter.

Surgery for Ingrown Toenails

Instructions for use:

To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

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

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

Please send this form with the referral letter.

Hallux Valgus Surgery

Instructions for use:

To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

In ordinary circumstances, referral should not be considered unless the patient meets **one** of the following criteria.*	Delete as appropriate	
Significant and persistent pain when walking **AND** conservative measures tried for at least six months (e.g. Toe spacers, bunion pads, medication or altered footwear) do not provide symptomatic relief **OR**	Yes	No
Ulcer development at the site of the bunion or the sole of the foot **OR**	Yes	No
Evidence of severe deformity (overriding toes) **OR**	Yes	No
Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Yes	No

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

Please send this form with the referral letter.

Meibomian cyst/chalazion

Instructions for use:

To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

In ordinary circumstances, referral should not be considered unless the patient meets **two or more** of the following criteria*	Delete as appropriate	
Conservative treatment has been tried for at least 3 months **AND**	Yes	No
Interferes with vision **OR**	Yes	No
Is causing persistent inflammation and pain	Yes	No

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

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

Please send this form with the referral letter.

Upper Eyelid Blepharoplasty

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

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

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

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

Please send this form with the referral letter.

Arthroscopic Subacromial Decompression of the Shoulder (ASAD)

Instructions for use:

To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

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

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

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

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

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

17. Patient Information Sheet

Patient information sheet
Procedures of limited clinical value and clinical thresholds

How do we choose the best treatment for your health problems?

By using a combination of the evidence provided by national **clinical thresholds** and **procedures of limited clinical value** South Yorkshire & Bassetlaw CCG are able to choose the best treatment for your health problems. This leaflet briefly explains where those ideas came from and how they are used.

What is a procedure of limited clinical value?

Procedures of limited clinical value are procedures which medical experts have suggested have only limited or temporary benefit and which are not felt to be necessary to maintain good health

What is a clinical threshold?

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

Your GP will look for alternatives to surgery for certain procedures where clinical thresholds apply.

Assessing what people in South Yorkshire & Bassetlaw need

Our aim is to provide both value for money alongside quality services based on the whole population of SY&B. We aim to do this in a way that is fair so that different people with equal need have equal opportunity to access services.

What is SY&B CCG's approach to procedures of limited clinical value?

Some treatments will only be considered if specific predetermined and evidence based criteria have been met; these are the clinical thresholds for treatment as set out in SY&B CCG's Commissioning for Outcomes policy.

Examples

- Research has shown that around 80% of individuals with carpal tunnel syndrome initially respond to non-surgical treatment, especially among young people or pregnant women
- Gallstones are often seen on scans but do not cause any symptoms or only mild symptoms which can be controlled by diet.
- Research has shown that obese patients suffer significant complications following hip/knee surgery, such as joint infections and poor healing.
- Medical treatment for heavy menstrual bleeding is very successful and in many circumstances prevents the need for hysterectomy and complications of surgery.

This approach is not new. These clinical thresholds are already in place at many other CCGs.

Clinical thresholds apply to the following:

- Benign Skin Lesions
- Carpal Tunnel Surgery
- Cataract Surgery
- Cholecystectomy (Gall Bladder surgery)
- Dupuytren's Disease
- Ganglion Surgery
- Grommets
- Hernia Repair
- Hip and Knee Replacement
- Hysterectomy for Heavy Menstrual Bleeding
- Tonsillectomy
- Trigger Finger
- Varicose Vein Surgery
- Upper Eye Lid Blepharoplasty
- Chalazion
- Surgery for ingrown Toe Nail in Secondary care
- Bunions
- Haemorrhoidectomy
- Benign perianal skin lesions
- Male Circumcision

What are the implications for you?

This may mean that your doctor is not able to offer you a certain treatment because it would not be funded by the local NHS. Your doctor has to observe the policy because it is the policy of the local NHS, and is the best way to ensure that local NHS funds are spent on the things that will bring greatest overall health benefit to local people.

In some circumstances, your GP, Consultant or NHS clinician may think you have exceptional clinical circumstances and may benefit from a treatment which is not routinely provided. Requests for such treatments must be made through an Individual Funding Request (IFR) by your clinician. This request will then be considered and approved or rejected by an independent panel.

Where you do not meet the criteria for referral you should see your GP or other appropriate health care professional should your condition change. Likewise if you are on a pathway for elective care, you should request a clinical review if your condition changes.

If you are considered to be a vulnerable patient (those with mental health issues, learning disability or cognitive impairment) you should be clinically assessed and given the opportunity to improve your lifestyle by referral for appropriate interventions.

Further information in respect of the Commissioning for Outcome Policy can be found on the internet at: https://www.healthandcaretogethersyb.co.uk/

How can you raise a concern/complaint about this policy?

Information regarding how to raise concerns or make a complaint to your CCG can be found at:

BARNSLEY

Write to: Quality Team, Barnsley CCG' Hillder House, 49 – 51 Gawber Road, Barnsley, S75 2PY
or alternatively you can telephone**:** 01226 433716
or Email: safehaven.riskmanagement@nhs.net

For further advice you can also contact Healthwatch at: The Core, County Way, Barnsley, S70 2JW or Tel: 01226320106

BASSETLAW

Write to: Complaints Department, Retford Hospital, North Road, Retford, Notts, DN22 7XF
or alternatively you can telephone**:** 01777 863321
or Email: BASCCG.CommunicationOffice@nhs.net

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

DONCASTER

Write to: Patient Experience Manager, Doncaster CCG, Sovereign House, Heaven's Walk, Doncaster, DN4 5HZ
Or alternatively you can telephone 01302 566228
Or Email: Donccg.enquiries@nhs.net

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

ROTHERHAM

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

For further advice you can also contact Healthwatch at: 22-30 High St, Rotherham S60 1PP or Tel: 01709717130

SHEFFIELD

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

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

18. Table 2 OPSC Codes

Procedure	Primary Procedure Codes	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
Carpal Tunnel Syndrome	A651, A659			G560	
Hip and Knee Replacement for Osteoarthritis (Hips)	W371, W378, W379, W381, W388, W389, W391, W398, W399, W931, W938, W939, W941, W948, W949, W951, W958, W959			M15, M16, M17	
Hip and Knee Replacement for Osteoarthritis (Knees)	W401, W408, W409, W411, W418, W419, W421, W428, W429, O181, O188, O189			M15, M16, M17	
Asymptomatic gallstones	J181, J182, J183, J184, J185, J188, J189, J211, J212, J213, J218, J219			K802, K805	
Cataract Surgery	C711, C712, C713, C718, C719, C721, C722, C723, C728, C729, C741, C742, C743, C748, C749, C751, C752, C753, C754, C758, C759				
Asymptomatic inguinal hernias in adults	1) T191, T192, T198, T199, 2) T20, T21, T25, T26, T27 3) T24	1) <> N132 2) NOT IN (G693, H111, G762, H175)		1) K402, K409, K439, K469 2) K402, K409, K439, K469 3) K429	1) Age >= 18 2) Age >= 18 3) Age >= 18
Dupuytren's Contracture	1) T521, T522, T525, T526, T541 2) T528, T529, T548, T549, T558, T559, T561, T562, T571, T574, T578, T579		2) Z894	1) M720 2) M720	
Ganglion	T591, T592, T593, T594, T598, T599, T601, T602, T603, T604, T608, T609, T611, T613, T618, T619				
Trigger Finger	T691, T692, T698, T699, T701, T702, T718, T719, T723, T728, T729			M653	

Procedure	Primary Procedure Codes	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
Adenoidectomy	E201, E204				
Anal Skin Tags	H482				
Botulinum Toxin Type A (Botox) for Spasticity or Hyperhidrosis	1) X851 2) Any 3) X851 4) Any	2) X851 4) X851		1) G80 or R61 2) G80 or R61 3) Any 4) Any	3) 1st Secondary Diagnosis G80 or R61 4) 1st Secondary Diagnosis G80 or R61
Bunions	W791, W792, W799, W151, W152, W153, W154, W155, W156, W158, W159, W591, W592, W593, W594, W595, W596, W597, W598, W599			M201	
Chalazion	Is not blank			H001	
Dilatation & Curettage	Q103, Q108, Q109			N920, N921, N922, N924	
Eyelid Surgery (excluding Chalazion)	C121, C122, C123, C124, C125, C126, C128, C129, C131, C132, C133, C134, C138, C139, C161, C162, C163, C164, C165, C168, C169			<> H001	
Haemorrhoidectomy	H511, H512, H513, H518, H519, H521, H522, H523, H528, H529, H531, H532, H533, H538, H539				
Ingrowing toe nail	1) S641, S642, S681, S682, S683, S701 2) S641, S642, S681, S682, S683, S701	1) Z906, Z907, Z506 2) S641, S642, S681, S682, S683, S701	2) Z906, Z907, Z506		
Male Circumcision	N303				
Shoulder Arthroscopy	Is not blank			M750, M751, M754	
Vasectomy	N171				

Procedure	Primary Procedure Codes	First Secondary Procedure Codes	Second Secondary Procedure Codes	Primary Diagnosis Codes	Other Criteria
Benign Skin Lesions	1) S063, S064, S065, S081, S082, S083, S088, S089, S101, S102, S103, S104, S105, S108, S109, S111, S112, S113, S114, S115, S118, S119 2) Is not blank			1) Any 2) D17, L82	
Hysterectomy	Q072, Q074, Q075, Q082			N920, N921, N922, N924	
Hysteroscopy	Q181, Q188, Q189			N920, N921, N922, N924	
Myringotomy / Grommets	D151, D153				
Tonsillectomy	F341, F342, F343, F344, F349				
Varicose Veins	L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888, L889				

Appendix 2

19. Definitions

Definition of Procedures of Limited Clinical Value
Procedures of limited clinical value are those that deliver a relatively poor output/outcome to the population. This schedule sets out those procedures of limited clinical value that are not routinely commissioned or only commissioned when certain criteria are met.

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

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

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

Definition of Exceptionality
In order to demonstrate exceptionality the patient

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

Appendix 3

NHS
Sheffield Clinical Commissioning Group

Equality Impact Assessment

Title of policy or service:	**Commissioning for Outcomes Policy**	
Name and role of officer/s completing the assessment:	Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning	
Date of assessment:	28 December 2017	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Through 'Shaping Sheffield' the Sheffield Place Based Plan, NHS Sheffield Clinical Commissioning Group's (SCCG) strategic objectives for elective care focuses on the management of demand for planned care in secondary care. To date, quality improvements have been made through the development of CASES peer review and whole journey pathways together with the ongoing development of key community services. However, the scale of the CCG's financial challenge is significant and demands further action to ensure that commissioned services are as effective as possible. Accordingly, the CCG has worked with the other CCGs within the South Yorkshire and Bassetlaw Accountable Care System (ACS), its main provider, GPs and the public to review current commissioning policies and thresholds and to introduce clinical thresholds across a range of procedures with low or limited clinical value to ensure that when patients do receive treatment, they achieve the best possible clinical outcomes. The Commissioning for Outcomes Policy will provide a consistent and comprehensive policy across the ACS. Clinical thresholds apply to the following: • Carpal Tunnel • Dupuytren's disease

	• Trigger finger • Ganglion • Hip and knee replacement • Benign skin lesions • Cholecystectomy • Hernia repair • Cataract surgery • Grommets • Tonsillectomy • Hysterectomy for heavy menstrual bleeding • Varicose veins surgery • Circumcision • Vasectomy under General Anaesthetic • Anal Skin Tags • Haemorrhoidectomy • In-growing Toe Nail • Chalazion • Blepharoplasty • Acupuncture for Low Back Pain • Joint Injections - (i) therapeutic substance into spinal facet or sacroiliac joints - (ii) Spinal Injection as a diagnostic tool • Shoulder Arthroscopy • The evidence that the CCG has used in preparing the clinical thresholds policy can be found within the policy document. **Benefits to patients and staff** This process will allow prioritisation of cost effective, clinically evidenced care. It may improve services and staff experience through reduced waiting times for commissioned services. Support for clinicians to focus on delivering evidence based care The policy supports the elimination of discrimination in all equality strands. All equality groups

	have the same access to the treatment and the policy aims to ensure equity of access to treatment across SCCG. The Policy exists to bring clinical consistency to referral and therefore decisions about an individual's cases will be free from bias. All interventions carry potential for risk/harm and the policy supports patients and clinicians decision making where the intervention may also deliver limited clinical benefit. This may be particularly relevant for more vulnerable patients.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐	Positive Impact The consistent application of the NICE guidance in this policy by doctors and consultants will reduce unwarranted variation and enable equality of services. Negative Impact There is a possibility that people	Consistent application for everyone across Sheffield will ensure individuals can get the best clinical outcomes. Exception criteria exist and clinicians are expected to discuss approaches with patients to review the benefits they can derive from different

				perceive this negatively and as an infringement of their rights to access services, however the clinical evidence supports this process through the application of the criteria and exceptions. The CCG will continue to review evidence based practice and good practice from elsewhere.	treatments and what would work before the individual. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Age	☐	☒	☐	<u>Hip / Knee</u> Older people are more likely to require hip or knee replacement. In particular older people who have participated in certain sports which put pressure on their joints or who have had certain occupations such as lifting heavy objects. The level of the impact would be likely increased in an older person is living on his/her own. <u>Cataracts</u> Ageing is by far the most common cause of cataracts in adults. A gradual accumulation of yellow–brown pigment develops in the lens of the eye as a result of ageing. Most cataracts occur in people over the age of 60 years <u>Grommets</u> Children/Younger people are more likely to suffer from Otitis media with effusion. <u>Tonsillitis</u> Tonsillitis is more prevalent in Children/Younger people.	The policy applies to all ages. The CCG would promote self-management and education of both of patients and clinicians to enable individuals to make informed choices. In addition there are clear exceptions that would make a patient suitable for referral. In addition to the exception criteria there is inclusion within the process for patients to revisit GPs should the presenting symptoms worsen e.g. serve pain, severe disability. Note these procedures are deemed to have low clinical value regardless of age. Patients meeting the set criterion will continue to receive surgical treatment and therefore it is anticipated there will be limited impact. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates

					exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities.
Carers	☐	☒	☐	Positive Impact Elderly people and their carers may prefer alternative treatments that do not require repeated hospital visits However there is also potential for elderly people and their carers may take longer to adjust to self-care treatments and may require additional support. Negative Impact The potential that people do not have the surgery when they feel they require it negatively impacting on their self-care abilities and thus the dependency on carers may potentially increase.	Same as in age, however reasonable adjustments may need to be made for individual needs. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Disability	☐	☒	☐	Dependency on carers may potentially increase (see carers). The policy provides a consistent clinically based criteria for decision making, benefitting patients by providing consistency and equity of service provision. Patients meeting the set criterion will continue to receive surgical treatment and therefore it is anticipated there will be limited impact.	The policy applies to the whole population of Sheffield The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Sex	☐	☒	☐	None Anticipated For some conditions women / men have a higher risk factor for example: □ Women have a higher risk factor for Cholecystitis than men □ Men are more likely to develop Dupuytren's and to have more severe contractures than women.	The policy will apply to both men and women. There is no evidence that either sex is more impacted. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates

				However there are objective clinical symptoms that would allow any patient to be referred regardless of sex.	exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Race	☐	☒	☐	Language barriers my pose difficulties, the patient leaflet and IFR Policy leaflet will be made available in an accessible format in the common languages for Sheffield <u>Circumcision</u> There are some cultural reasons why circumcision may take place more prevalently in some groups than other however the commissioning stance is clinically focused. The Department of Health website states that this intervention is not funded where it is requested for non-medical reasons. An NHS funded service will remain in place for those who have a clinical need.	The policy transcends race and will meet the clinical needs of individuals regardless of their race. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Religion or belief	☐	☒	☐	<u>Circumcision</u> Circumcision of infant males (for non-clinical reasons) is established religious practice within Judaism, Islam, Coptic Christianity and the Ethiopian orthodox church. The Department of Health website states that this intervention is not funded where it is requested for non-medical reasons. An NHS funded service will remain in place for those who have a clinical need.	The policy will ensure that clinically eligible patients are able to access treatment regardless of their religion or belief. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities

Sexual orientation	☐	☒	☐	None Anticipated	The policy will ensure that clinically eligible patients are able to access treatment regardless of their sexual orientation. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Gender reassignment	☐	☒	☐	None Anticipated	The policy will ensure open access to transgender patient. The Individual Funding Request process is available in all cases where a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities
Pregnancy and maternity	☐	☒	☐	None Anticipated Varicose Veins - Prevalence of varicose veins rises in pregnancy Hernia - Pregnant women are at higher risk of developing inguinal/umbilical hernia due to increased pressure in the abdomen from the growing foetus Gallstones - Gallstones are more common during pregnancy due to decreased gallbladder motility and increased cholesterol saturation of bile Carpal Tunnel Syndrome - Carpal Tunnel Syndrome is more prevalent in	Patients meeting the set criterion will continue to receive surgical treatment and therefore it is anticipated there will be limited impact. It is unlikely that planned surgery would be undertaken during pregnancy. It is unlikely that planned surgery would take place in the immediate post-natal period The Individual Funding Request process is available in all cases where

				pregnancy	a patient does not meet the criteria for an intervention but demonstrates exceptionality and would be more likely to benefit from a procedure, this may be particularly relevant where patients have other co-morbidities.
Marriage and civil partnership (only eliminating discrimination)	☐	☒	☐	None Anticipated	
Other relevant groups	☐	☒	☐	None Anticipated	
HR Policies only: Part or Fixed term staff	☐	☒	☐	Not applicable	

IMPORTANT NOTE: *If any of the above results in '* ***negative'*** *impact, a 'full' EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.*

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan				
Issues/impact identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication				
When will the proposal be reviewed and by whom?	**Lead / Reviewing Officer:**	**Abigail Tebbs, Deputy Director of Strategic Commissioning and Planning**	**Date of next Review:**	**December 2018**

Once completed, this form **must** be emailed to Richard Kennedy for sign off:

signature:	