Aligning commissioning policies across north east London – version for clinicians

Creating a single commissioning policy for Barking and Dagenham, City and Hackney, Havering, Newham, Tower Hamlets, Redbridge and Waltham Forest

Clinical version providing rationale behind each proposed policy

Barking and Dagenham, Havering and Redbridge

Contents

New procedures added to the policy

1. Dilation & Curettage (D&C) for heavy menstrual bleeding in women (IFR)
2. Chalazia removal (PA)
3. Surgical treatment of carpal tunnel syndrome (PA)
4. Shoulder Decompression (PA)
5. Interventional treatments for back pain without sciatica (PA)
6. Repair of split ear lobes (IFR)
7. Herbal medicines (IFR)
8. Treatment for scarring and skin hyper- or hypo- pigmentation (IFR)

1. Dilation & Curettage (D&C) for heavy menstrual bleeding in women

What is Dilation & Curettage (D&C)?
Dilation and curettage (D&C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilation) and the lining of the womb is scraped out (curettage).

Recommendation
Dilation & Curettage (D&C) for heavy menstrual bleeding is not routinely funded by NEL CCGs, and therefore funding is only available through an IFR panel where exceptionality can be proven.

D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.

Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy period.

Medication and intrauterine system (IUS) can be used to treat heavy periods.

Rationale for recommendation
Local CCGs have chosen to adopt the National Evidence Based Interventions policy on Dilation & Curettage (D&C) as ensures our local policy is in line with NICE guidance (NG88) and ensures equity of access to treatment for patients.

The rationale for the inclusion of Dilation & Curettage (D&C) as a procedure that is not routinely funded, and therefore only available through an IFR application where exceptionality is proven is as follows:

NICE guidance recommends that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy works better. Complications are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix.

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 13 Dilation & Curettage (D&C) procedures carried out for BHR patients at a cost of £8,139.

2. Chalazia removal

What is Chalazia removal?
This procedure involves incision and curettage (scraping away) of the contents of the chalazion. Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.

Recommendation

With prior approval, NEL CCGs will fund incision and curettage (or triamcinolone injection for suitable candidates) of chalazia when one of the following criteria have been met:

1. Has been present for more than six months and has been managed conservatively with warm compresses, lid cleaning and massage for four weeks

OR

2. Interferes significantly with vision

OR

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

OR

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

OR

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

OR

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

Rationale for recommendation
Local CCGs have chosen to adopt the National Evidence Based Interventions policy for chalazia removal as this ensures our local policy is up to date and based on the latest guidance as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of chalazia removal as a procedure requiring prior approval is as follows:

NICE recommend that warm compresses and lid massage alone are sufficient first line treatment for chalazia. If infection is suspected a drop or ointment containing an antibiotic (e.g. Chloramphenicol) should be added in addition to warm compresses. Only if there is spreading lid and facial cellulitis should a short course of oral antibiotics (e.g. co-amoxiclav) be used.

Where there is significant inflammation of the chalazion a drop or ointment containing an antibiotic and steroid can be used along with other measures such as warm compresses. However, all use of topical steroids around the eye does carry the risk of raised intraocular pressure or cataract although this is very low with courses of less than 2 weeks.

Many chalazia, especially those that present acutely, resolve within six months and will not cause any harm however there are a small number which are persistent, very large, or can cause other problems such as distortion of vision. In these cases surgery can remove the contents from a chalazion.

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-

During 2018/19 there were 171 chalazia removals carried out for BHR patients at a cost of £95,156.

3. Surgical treatment of carpal tunnel syndrome

What is surgical treatment carpal tunnel syndrome?
Carpal tunnel syndrome is pressure on a nerve in the wrist causing pain, tingling or numbness in the fingers. Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time. Non-surgical treatment for carpal tunnel syndrome such as splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. Surgical treatment of carpal tunnel should only be offered under the criteria included below.

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

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

- Corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)
  OR
- Night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

With prior approval, NEL CCGs will fund surgical treatment for carpal tunnel syndrome when one of the following criteria are met:

1. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of eight weeks
   OR
2. A permanent (ever-present) reduction in sensation in the median nerve distribution
   OR
3. Muscle wasting or weakness of thenar abduction (moving the thumb away from the hand)

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

Rationale for recommendation
Local CCGs have chosen to adopt the National Evidence Based Interventions policy for the surgical treatment of carpal tunnel syndrome as this ensures the policy is up to date and based on the latest guidance as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of surgical treatment of carpal tunnel syndrome as a procedure requiring prior approval is as follows:

Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.

In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical effectiveness and long term benefit) should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.

The hand is weak and sore for 3-6 weeks after carpal tunnel surgery but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 513 carpal tunnel syndrome release procedures carried out for BHR patients at a cost of £686,175.

4. Shoulder Decompression

What is Shoulder Decompression?
Shoulder decompression surgery can also be referred to as arthroscopic subacromial decompression surgery. This is surgery to take out small pieces of bone and soft tissue (like tendons) from inside the shoulder by keyhole surgery (arthroscopy).

Recommendation

With prior approval, NEL CCGs will fund arthroscopic subacromial decompression when:

1. The arthroscopic subacromial decompression is for pure subacromial shoulder impingement

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

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

Rationale for recommendation

Local CCGs have chosen to adopt the National Evidence Based Interventions policy for the shoulder decompression as this ensures the policy is up to date and based on the latest guidance as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of shoulder decompression as a procedure requiring prior approval is as follows:

Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.

On the other hand, a more recent prospective randomised trial comparing the long term outcome (10 year follow up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment.

Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails. There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.

A review of the literature identified one further systematic review that looked at the effectiveness of surgery. The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.

Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.

Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 238 shoulder decompression procedures carried out for BHR patients at a cost of £1,090,188.

5. Interventional treatment for back pain without sciatica

What is interventional treatment for back pain without sciatica?

Interventional treatments for back pain without sciatica cover a number of procedures, the procedures are as follows:

Epidurals - an epidural is an injection in the back to stop you feeling pain in part of your body. This specifically involves an injection into the epidural space, these can include interlaminar, transforaminal, caudal approaches.

Spinal decompression - Spinal decompression refers to removal of pressure from the nervous structures within the spinal column. An example would be laminectomy, which may also include foraminotomy/trimming of overgrown facets and or discectomy. Most common cause of spinal canal narrowing is degenerative lumbar disease, otherwise known as spondylosis. Associated symptoms are neurogenic claudication (pain and/or numbness/weakness worse with prolonged standing). Disc prolapse, on the other hand, causes leg pain and sciatica.

Discectomy - A discectomy is the surgical removal of abnormal disc material that presses on a nerve root or the spinal cord. The procedure involves removing a portion of an intervertebral disc, which causes pain, weakness or numbness by stressing the spinal cord or radiating nerves.

Epidurolysis - a minimally invasive form of surgery used to treat people with low back and leg pain caused by epidural adhesions (type of scar tissue in the spine). An endoscope is inserted into the epidural space under fluoroscopic guidance, and used to identify and separate affected nerve roots from scar tissue.

Therapeutic spinal injections (including facet joint injections, intradiscal therapy, prolotherapy, trigger point injections) – are injections which reduce inflammation and lessen or resolve pain.

Spinal Fusion - also called spondylodesis or spondylosyndesis, is a neurosurgical or orthopaedics surgical technique that joins two or more vertebrae. This procedure can be performed at any level in the spine and prevents any movement between the fused vertebrae.

Lumbar Disc Replacement - Lumbar disk replacement surgery involves replacing problematic disks in the lower spine with an artificial disk made of medical-grade metal and/or plastic.

Acupuncture - complementary medicine in which fine needles are inserted into the skin at specific points along lines of energy (meridians).

Ozone Discectomy - is the injection of Ozone inside the problematic intervertebral disc. Ozone is a colourless gas made up of three oxygen atoms.

Recommendation
This policy relates to interventional treatments for back pain only, as described in detail below.

For many patients, consideration of such treatments only arises after conservative management in primary care or specialist musculoskeletal services.

The following exclusions apply:

- Children (aged under 18)
- Patients thought to have/have cancer (including metastatic spinal cord compression)
- Patients with neurological deficit (spinal cord compression or cauda equina symptoms), fracture or infection

In ordinary circumstances, funding for interventional treatments for back pain is available for patients who meet the following criteria.

Section 1: Epidurals

With prior approval, NEL CCGs will fund interventions for epidurals when criteria 1, 2 and either 3(a) or 3(b) are met:

1. The patient has radicular pain consistent with the level of spinal involvement

AND

2. The patient has moderate-severe symptoms that have persisted for 12 weeks or more

AND either one of the following:

3(a). The patient has severe pain and advice, reassurance, analgesia and manual therapy ideally part of community Musculoskeletal (MSK) service has been undertaken. (Evidence that disc prolapses get better on their own)

AND/OR

3(b). The MRI scan (unless contraindicated) shows pathology concordant with the clinical diagnosis.

A maximum of three epidural injections, within a 12 month period with objective with functional benefit demonstrable with each injection, will be funded

For patients with persisting symptoms after three injections, re-approval of treatment with epidural injections will be needed through the IFR panel. This may be older/frailer patients who derive medium term benefit but are unsuitable for or unwilling to have surgery.

Medial branch blocks, sacroiliac joint injections and subsequent medial branch radiofrequency lesioning (facet joint denervation) or sacroiliac joint radiofrequency denervation are only funded if performed in a Pain Service with a multidisciplinary team approach, only to be performed by doctors trained in Biopsychosocial Assessment.

Section 2: Spinal decompression

With prior approval, NEL CCGs will fund interventions for spinal decompression when all of the following criteria are met:

1. The patient has radicular/claudicant leg pain consistent with the level of spinal involvement

AND

2. The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is concordant with the clinical diagnosis

   AND

3. The patient has shown no sign of improvement despite conventional therapy for one year

Section 3: Discectomy

With prior approval, NEL CCGs will fund interventions for discectomy when both of the following criteria are met:

1. The patient has radicular pain consistent with the level of spinal involvement
   AND
2. The patient has shown no sign of improvement despite conventional therapy for 12 weeks

Section 4: Epidurolysis (See also NICE IPG 333)

With prior approval, NEL CCGs will fund interventions for epidurolysis when all of the following criteria are met:

1. The patient has late onset radiculopathy post spinal surgery
   AND
2. MRI Gadolinium-enhanced or dynamic epidurogram (unless contraindicated) findings are concordant to show adhesive radiculopathy
   AND
3. Conservative management and epidural injections have failed

The specialist applying for funding must confirm that they are trained in the technique.

Subsequent epidurolysis treatments will require an IFR approval, including information about the nature and duration of benefit from initial treatment.

Therapeutic spinal injections (including facet joint injections, intradiscal therapy, prolotherapy, trigger point injections)
Therapeutic spinal injections are not routinely funded

Spinal Fusion
Spinal fusion surgery is not routinely funded for non-radicular back pain

Lumbar Disc Replacement
Lumbar disc replacement surgery is not routinely funded

Acupuncture
Acupuncture for back pain is not routinely funded

Ozone Discectomy
Ozone discectomy is not routinely funded

Rationale for recommendation

Local CCGs have chosen to adopt the London Choosing Wisely policy for interventional treatments for back pain without sciatica as this ensures the policy is up to date and based on the latest guidance as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of interventional treatments for back pain within the policy is as follows:

Epidurals:

NICE and NHSE guidance in agreement:

- Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.
- Consider epidural injections of local anaesthetic + steroid in those with acute and severe sciatica.
- Acute sciatica population (symptoms <3months), multiple injections would not be performed in such a short time.

Lancet:

- Recognises there may be limited use in selected patients with persistent low back pain >12 weeks.

Therapeutic spinal injections:

NICE and NHSE guidance in agreement:

- Do not offer spinal injections for managing low back pain.

Lancet:

- Recent guidelines do not recommend spinal epidural injections or facet joint injections for low back pain
- Epidural injections of local anaesthetic and steroid for severe radicular pain may have a role (as above)

Spinal Fusion

NICE and NHSE guidance in agreement:

- Do not offer spinal fusion for people with low back pain unless as part of a randomized control trial.

Lancet:

- Insufficient evidence for acute non-radicular low back pain with degenerative disc findings (<6 weeks) and role uncertain for persistent non-radicular low back pain with degenerative disc

- Benefits of spinal fusion for non-radicular low back pain thought to originate from degenerated lumbar discs are similar to those of intensive multidisciplinary rehabilitation and only modestly greater than standard non-surgical management. Surgery is also more costly and carries a greater risk of adverse events than non-surgical management.

Spinal decompression

NICE and NHSE are in agreement:

- Consider spinal decompression for people with sciatica when nonsurgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

Lancet:

- Spinal decompression surgery can be considered for radicular pain when non-surgical treatments have been unsuccessful and clinical and imaging findings indicate association of symptoms with herniated discs or spinal stenosis.
- For a herniated disc, early surgery is associated with faster relief of radiculopathy than with initial conservative treatment with the option of delayed surgery, but benefits diminish with longer (>1 year) follow-up.
- For symptoms associated with lumbar spinal stenosis, benefits of surgery over conservative care are not clear but some beneficial effects have been shown. However, patients tend to improve with or without surgery and, therefore, non-surgical management is an appropriate option for patients who wish to defer or avoid surgery.

Lumbar disc replacement

NICE and NHSE are in agreement:

- Do not offer disc replacement in people with low back pain.

Lancet:

- The UK guidelines recommend that patients do not have disc replacement or spinal fusion surgery for low back pain, and instead recommend offering fusion surgery only as part of a randomised trial.

Acupuncture

NICE and NHSE guidance in agreement:

- Do not offer acupuncture for managing low back pain with or without sciatica.
- NHSE further recommends to decommission treatments which are recommended against by NICE 2016, such as acupuncture.

Lancet:

- Recommends acupuncture for acute low back pain (<6 weeks) and persistent low back pain (>12 weeks) as a second line or adjunctive treatment.

For detailed review of rationale and evidence review of all procedures: https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

During 2018/19 there were 2976 interventional treatments for back pain procedures carried out for BHR patients at a cost of £1,815,337.

6. Repair of split ear lobes

What are split ear lobes?

The earlobes are appendages of the ears made of soft skin and a small amount of fatty tissue. Excessive weight or trauma can easily overcome the strength of the earlobe tissues leading to a tear in the gentle earlobe tissues.

Recommendation

Surgical procedures conducted to repair split ear lobes (whether the earlobe is totally or partially split) are not routinely funded by NEL CCGs, and therefore funding is only available through an IFR panel where exceptionality can be proven.

Rationale for recommendation

Repair of split ear lobes is generally considered to be an aesthetic procedure and is normally only available where the ear lobes have split as a result of direct trauma.

No activity and cost activity identified in SUS as coding not specific enough to identify repair of split ear lobe procedures.

7. Herbal Medicines

What are Herbal medicines?
Herbal medicines are those with active ingredients made from plant parts, such as leaves, roots or flowers.

Recommendation
Herbal medicines are not routinely funded due to the lack of evidence of clinical effectiveness and the risk of toxicity from non-quality assured therapies.

Rationale for recommendation

- They may cause problems if you're taking other medicines. They could result in reduced or enhanced effects of the medicine, including potential side effects.
- You may experience a bad reaction or side effects after taking a herbal medicine.
- Not all herbal medicines are regulated. Remedies specially prepared for individuals don't need a licence, and those manufactured outside the UK may not be subject to regulation.
- Evidence for the effectiveness of herbal medicines is generally very limited. Although some people find them helpful, in many cases their use tends to be based on traditional use rather than scientific research.
- Certain groups of people should be particularly wary of taking herbal medicines.

No activity and cost activity identified in SUS as coding not available to identify herbal medicines.

8. Treatment for scarring and skin hyper- or hypo- pigmentation

What is scarring and skin hyper- or hypo- pigmentation?

A scar is a mark left on the skin after a wound or injury has healed. A scar can be a fine line or a pitted hole on the skin, or an abnormal overgrowth of tissue. Hyperpigmentation is excessive pigmentation of the skin which causes dark spots. Hypopigmentation is inadequate pigmentation of the skin which causes light spots.

Recommendation
Surgical procedures conducted to improve the appearance of skin affected by scarring, hyperpigmentation or hypopigmentation are not routinely commissioned by NEL CCGs, and therefore funding is only available through an IFR panel.

Rationale for recommendation

Improving the appearance of skin affected by scarring, hyperpigmentation or hypopigmentation is generally considered to be an aesthetic procedure. There are a number of alternatives to surgery to help with the appearance of skin affected by these conditions. For example there are a range of specially made skin camouflage make-up products designed to hide scars and marks.

No activity and cost activity identified in SUS.

Procedures where clinical criteria has changed

We are proposing to change the clinical criteria for the following procedures:

1. Trigger Finger (PA)
2. Sympathectomy for severe hyperhidrosis (PA)
3. Pinnaplasty/ Otoplasty (PA)
4. Rhinoplasty/Septoplasty/Rhinoseptoplasty (PA)
5. Dupuytren's contracture release (PA)
6. Cataract Surgery (PA)
7. Bariatric surgery (PA)
8. Female breast reduction (PA)
9. Grommets for glue ear in children (PA)

1. Trigger Finger

What is Trigger Finger?
Trigger finger occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

Summary of change from previous policy
Surgical treatment for trigger finger was previously not routinely funded and could only be accessed by making an individual funding request. This change would move trigger finger from being IFR to being funded if certain criteria are met. It has also been made clear that this policy does not apply to children. This exclusion was previously not stated. These changes would make access to trigger finger procedures easier for patients and categorically clear that trigger finger surgery for children will be routinely funded.

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

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

- one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics
  OR
- splinting of the affected finger for 3-12 weeks (weak evidence)

With prior approval, NEL CCGs will fund trigger finger surgery when one of the following criteria are met:

1. The triggering persists or recurs after one of the above measures (particularly steroid injections)
   OR
2. The finger is permanently locked in the palm
   OR
3. The patient has previously had two other trigger digits unsuccessfully treated with appropriate nonoperative methods
   OR

4. Patients with diabetes

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

Rationale for recommendation

Local CCGs have chosen to adopt the National Evidence Based Interventions policy for trigger finger release as this ensures our local policy is up to date and based on the latest guidance as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of trigger finger release as a procedure requiring prior approval is as follows:

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

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 39 trigger finger procedures carried out for BHR patients at a cost of £52,043.

2. Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)

What is sympathectomy for severe hyperhidrosis (palmar, plantar, axillary)?
Endoscopic thoracic sympathectomy (ETS) is a surgical procedure in which a portion of the sympathetic nerve trunk in the thoracic region is destroyed. ETS is used to treat excessive sweating in certain parts of the body.

Summary of change from previous policy
This would now require a prior approval form to be completed before the procedure can be carried out to ensure clinical criteria are met. Previously this was not routinely funded and would have required exceptionality to be proven via an IFR application. This would make access to treatment easier for patients.

Recommendation

With prior approval, NEL CCGs will fund sympathectomy when criteria 1(a) and 2 are met or 1(b) and 2 are met:

1(a). Significant focal hyperhidrosis and a one to two month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition
OR
1(b). Significant focal hyperhidrosis and intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone
AND
2. All of the following conservative therapies have been tried and found to be unsuitable or unsuccessful:

- treatment of underlying anxiety if it is an exacerbating factor

- referral to a dermatologist for modified topical therapy
- prescription of oral anticholinergics (which block the effect of the nerves that stimulate the sweat glands)
- iontophoresis (for palmar or plantar hyperhidrosis) or botulinum toxin injections (for axillary hyperhidrosis)

Sympathectomy is an established intervention for this condition BUT should be considered only after all other non-invasive non-surgical treatment options have been tried and failed.

Compensatory sweating following sympathectomy is common and can be worse than the original problem. Patients should be made aware of this risk.

Rationale for recommendation

- To align policy to NICE IPG 487 (2014)
- There is a risk of serious complications
- Hyperhidrosis elsewhere on the body is usual after the procedure: this can be severe and distressing and some patients regret having had the procedure (especially because of subsequent and persistent hyperhidrosis elsewhere)
- The procedure sometimes does not reduce upper limb hyperhidrosis.
- In view of the risk of side effects this procedure should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been non-responsive to other treatments.

During 2018/19 there were 7 sympathectomy procedures for severe hyperhidrosis carried out for BHR patients at a cost of £3,770.

3. Pinnaplasty/Otoplasty

What are Pinnaplasty/ Otoplasty?

Pinnaplasty (sometimes called otoplasty) is an operation used to correct prominent ears. The surgery is performed through a cut behind the ear and is carried out under general anaesthetic.

Summary of change from previous policy

The criteria of having ‘significant’ ear deformity is now defined as having ‘prominence measuring >30mm’. This provides clarity to the clinicians on the definition of significance as this was previously undefined. The criteria for the patient to be aged between 5 and 18 has been relaxed to under 18. This procedure was previously treated as an IFR due to the need for high quality clinical photographs with the criteria listed in the policy taken into consideration. This is no longer required as the procedure will be classed as prior approval and provided as long as the criteria is met rather than an IFR application needing to be made. This will improve the turnaround time for pinnaplasty applications making access to treatment for patients faster.

Recommendation

With prior approval, NEL CCGs will fund pinnaplasty/otoplasty when all of the following criteria are met:

1. The patient is under the age of 18 at the time of referral for significant prominent or bat ears
   AND
2. Where the prominence measures >30mm (using the measuring guide below)

Measuring guide

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

Measure from the posterior aspect of the Helix.

Prominence = H-M distance > 20mm

Pinnaplasty/otoplasty will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids. In which case an IFR application would be required clearing setting out the patient's clinical exceptionality.

Rationale for recommendation

The correction of prominent ears is an aesthetic procedure; however, for some people with a greater degree of prominence there is a greater impact on their wellbeing. Consequently, corrective pinnaplasty surgery is commissioned in certain circumstances. Note there is no NICE guidance on this at present.

The addition of a definition for significance was required as without this definition it left clinicians feeling uncertain as to what would be classed as significant. Prominence has been defined as being greater than 30mm, with prominence being measured by the helix to mastoid distance. This is based on other London CCG policies where they have also defined significance to ensure equity of access to treatment for patients.

No activity and cost data identified in SUS.

4. Rhinoplasty, Septoplasty and Rhinoseptoplasty

What is Rhinoplasty, Septoplasty and Rhinoseptoplasty?

Rhinoplasty is a facial cosmetic procedure, usually performed to enhance the appearance or reconstruct the nose. During rhinoplasty, the nasal cartilages and bones are modified, or tissue is added, to improve the visual appeal of the nose. Rhinoplasty is also frequently performed to repair nasal fractures. When rhinoplasty is used to repair nasal fractures, the goal is to restore pre-injury appearance of the nose. Rhinoseptoplasty is a related procedure performed for patients who also have nasal obstruction. Rhinoseptolasty not only improves the appearance of the nose, but it removes any internal obstructions and stabilizes structures that may be blocking nasal breathing. Rhinoplasty is a procedure listed as requiring prior approval in the current BHR policy. In the new policy this procedure will remain as requiring prior approval.

Summary of change from previous policy
Clarified that the existing rhinoplasty policy includes septoplasty and rhinoseptoplasty as was previously unclear as only rhinoplasty was specified, causing confusion for clinicians as to whether this would also encompass septoplasty. The criteria that conservative treatments need to be tried for at least 3 months has been altered to stating a need for all conservative treatments to have been exhausted without a time limit being placed on this. This allows for flexibility if all conservative treatments are tried inside of 3 months, but also for conservative treatments to be tried for longer based on clinical judgement as to the appropriateness. The previous criteria for significant symptoms to be confirmed by an ENT consultant as resulting from nasal obstruction has been removed as under prior approval the clinician requesting funding has to confirm that there is documented evidence of medical problems caused by an obstruction of the nasal airway mitigating the need for this additional criteria.

Recommendation

a) Rhinoplasty; Septoplasty and Septorhinoplasty are not routinely commissioned for cosmetic reasons.

b) Rhinoplasty; Septoplasty and Septorhinoplasty are restricted for non-cosmetic/other reasons.

The CCG will fund this treatment if the patient meets the eligibility criteria below:

- Documented medical problems caused by obstruction of the nasal airway **AND** all conservative treatments have been exhausted.
  OR
- Correction of complex congenital conditions e.g. Cleft lip and palate

For the purposes of this eligibility criteria, a medical problem is defined as a medical problem that continually impairs sleep and/or breathing.

This means (for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG

Rationale for recommendation
Rhinoplasty is a procedure contained within the existing policy and will remain as requiring prior approval. This update was needed to clarify that the policy includes septoplasty and rhinoseptoplasty as it was previously unclear whether these were covered by the rhinoplasty policy as only rhinoplasty was generically stated, causing confusion for clinicians as to whether prior approval needed to be sought.

During 2018/19 there were 71 rhinoplasty, septoplasty or rhinoseptoplasty procedures carried out for BHR patients at a cost of £169,211.

5. Dupuytren's contracture release

What is Dupuytren's contracture release?

Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient's life. However none cure the condition which can recur after any intervention so that further interventions are required.

Splinting and radiotherapy have not been shown to be effective treatments of established Dupuytren's contractures.

Several treatments are available: collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others. The need for, and choice of, intervention should be made on an individual basis and should be a shared decision between the patient and a practitioner with expertise in the various treatments of Dupuytren's contractures.

No-one knows which interventions are best for restoring and maintaining hand function throughout the rest of the patient's life, and which are the most cost-effective in the long term. Ongoing and planned National Institute for Health Research studies aim to address these questions.

Summary of change from previous policy
This remains prior approval. Main change is that treatment will now be funded if patient has a loss of finger extension of 20 degrees or more at the proximal interphalangeal joint, this was previously 30 degrees under the existing policy. The threshold is therefore lower and so more patients will be able to access this treatment.

Recommendation

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

With prior approval, NEL CCGs will fund intervention/treatment in the form of (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) when one of the following criteria are met:

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

OR

2. Severe thumb contractures which interfere with function

With prior approval, NEL CCGs will fund, in line with NICE Guidance, collagenase when 1 or 2(a) and 2(b) of the following criteria are met:

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

OR

2. Adult patients with a palpable cord if:

(a) there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints
AND
(b) needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

Rationale for recommendation
Local CCGs have chosen to adopt the National Evidence Based Interventions policy for the dupuytren's contracture release as this ensures the policy is up to date and based on the latest guidance (NICE IPG 43 & NICE TA 459), as well as ensuring equity of access to treatment for patients.

The rationale for the inclusion of dupuytren's contracture release as a procedure requiring prior approval is as follows:

Contractures left untreated usually progress and often fail to straighten fully with any treatment if allowed to progress too far. Complications causing loss, rather than improvement, in hand function occur more commonly after larger interventions, but larger interventions carry a lower risk of need for further surgery.

Common complications after collagenase injection are normally transient and include skin breaks and localised pain. Tendon injury is possible but very rare. Significant complications with lasting impact after needle fasciotomy are very unusual (about 1%) and include nerve injury. Such complications after fasciectomy are more common (about 4%) and include infection, numbness and stiffness.

This policy has been adopted from the National Evidence Based Interventions policy to ensure equity of access for all patients.

For full details on rationale and evidence based used please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 98 dupuytren's contracture procedures carried out for BHR patients at a cost of £283,722.

6. Cataract surgery

What is Cataract surgery?
Cataract is the presence of an opacity in the lens of an eye or its capsule, resulting in changes in the transparency and refractive index of the eye and in turn affecting vision. Cataract may occur in one or both eyes. Risk factors for cataract include increasing age, diabetes mellitus, corticosteroid use, female gender, socio-economic status, ethnicity, smoking and alcohol.

Cataract surgery, whereby the natural lens is replaced by an implant, is the only effective treatment for cataract. The benefits are lifelong unless negated by other eye disease. Phacoemulsification (removal of the cataractous lens using ultrasound) is the standard surgical technique and used in over 99.7% of cataract operations in the NHS.

Summary of change from previous policy
Cataract surgery is contained within the existing BHR policy and remains as requiring prior approval. The main change to the clinical criteria is that the patients visual acuity must now be 6/9 or worse in either the first or second eye for treatment to be approved via prior approval. Under the existing BHR policy the patients visual acuity must be 6/12 or worse in either the first or second eye. This change would allow access to this procedure for more patients. It has also been made explicitly clear that children are excluded from requiring prior approval to access cataract surgery, under the existing BHR policy children were not excluded.

Recommendation

This policy relates to cataract surgery only, as described in detail below.

The policy does not apply to:

- Patients with confirmed or suspected malignancy
- Patients with acute trauma or suspected infection
- Children under the age of 18

With prior approval, NEL CCGs will fund cataract surgery when both of the following criteria are met:

1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye
   AND
2. Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls

Additional information
All patients should be given the opportunity to engage with shared decision making at each point in the pathway to cataract surgery (e.g. optometrists, GPs, secondary care), to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

- Surgery is also indicated for management of cataract with coexisting ocular comorbidities. A full list of these ocular comorbidities can be found below.*
- Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a clear clinical indication or symptoms affecting lifestyle. For NHS treatment to be provided, there needs to be mutual agreement between the provider and the responsible (i.e. paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure).

*List of ocular comorbidities:

- Glaucoma
- Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening
- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- 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)
- Severe anisometropia in patients who wear glasses
- Posterior subcapsular cataracts

Rationale for recommendation

The clinical benefits and cost-effectiveness of cataract surgery are well established. Cataract surgery has a high success rate in improving visual function, with low morbidity and mortality. NICE suggests, whilst improvements in visual symptoms and function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better, the risk of worse visual acuity after surgery also increases. Where the preoperative visual acuity is very good, surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms that are clearly attributable to cataract.

For Barking & Dagenham, Havering and Redbridge patients, adopting the London cataract policy means that the visual acuity requirement has been relaxed which would allow access to this procedure for more patients. The London cataract policy also makes clear that children are excluded from requiring prior approval, whereas previously, prior approval also needed to be sought for children. These changes ensure equity of access to treatment for patients and bring our local policy in line with other CCGs in London.

For full details of the London Choosing Wisely cataract surgery policy review and recommendations, please see:
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-9a-Cataract-Surgery-Policy.pdf

During 2018/19 there were 1675 cataract surgery procedures carried out for BHR patients at a cost of £1,273,095.

7. Bariatric surgery

What is Bariatric Surgery?
Bariatric surgery is an operation that helps you lose weight by making changes to your digestive system. Some types of bariatric surgeries make your stomach smaller, allowing you to eat and drink less at one time and making you feel full sooner. Other bariatric surgeries also change your small intestine - the part of your body that absorbs calories and nutrients from foods and beverages.

Bariatric surgery may be an option if you have severe obesity and have not been able to lose weight or keep from gaining back any weight you lost using other methods such as lifestyle treatment or medications. Bariatric surgery also may be an option if you have serious health problems, such as type 2 diabetes or sleep apnoea, related to obesity. Bariatric surgery can improve many of the medical conditions linked to obesity, especially type 2 diabetes.

Summary of change from previous policy
Bariatric surgery remains as a procedure requiring prior approval in the proposed policy. It is proposed to update the existing bariatric surgery policy to ensure the clinical criteria mentioned aligns with the latest NICE guidance (NICE CG 189) on bariatric surgery. The existing BHR bariatric surgery policy states that surgery will be funded

when the patient has type 2 diabetes AND a BMI of greater than 35 kg/m2. The proposed policy alters this criteria to adhere to latest NICE bariatric surgery guidance as follows. Criteria altered to state 'the patient has a BMI of 40 kg/m2 or more' which would remove the additional requirement for the patient to have type 2 diabetes in the existing policy. This would make access easier for some patients.

Criteria altered to state 'the patient has a BMI of between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight. This allows patients with a wider range of significant diseases that can be improved by weight loss to be considered for bariatric surgery. There is also additional criteria which has been added that requires all non-surgical measures to have been tried, that intensive management is provided in a tier 3 service, that the person is generally fit for anaesthesia and surgery; and the person commits to long term follow up. These encourage bariatric surgery to be used as a last resort.

Recommendation

With prior approval, NEL CCGs will fund bariatric surgery when all of the following criteria are met:

- They have a BMI of 40 kg/m2 or more, **OR** between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight
  AND
- All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss
  AND
- The person has been receiving or will receive intensive management in a tier 3 service
  AND
- The person is generally fit for anaesthesia and surgery
  AND
- The person commits to the need for long term follow up

Rationale for recommendation

The purpose of updating the existing bariatric surgery policy is to ensure the clinical criteria mentioned in our local policy aligns with the latest NICE guidance (NICE CG 189) on bariatric surgery

For full details on NICE CG 189 see:
https://www.nice.org.uk/guidance/cg189/chapter/1-recommendations

During 2018/19 there were 90 bariatric surgery procedures carried out for BHR patients at a cost of £590,241.

8. Female breast reduction surgery

What is female breast reduction surgery?
Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.

Summary of change from previous policy
Female breast reduction surgery remains as a procedure requiring prior approval. The clinical criteria for bilateral breast reduction surgery that previously stated the cup size must be H or larger has been removed. This criteria removal would allow patients with a smaller cup size to access breast reduction surgery as previously they would not have met the requirement for the cup size to be H or larger and would have had to request funding via an IFR application.

The previous criteria requirement for bilateral breast reduction surgery that stated the breast reduction planned should be 500gms or more per breast or at least 3 cup sizes has been updated to state the breast reduction planned should be 500gms or more per breast or at least 4 cup sizes. This may therefore require women to have more of a breast reduction than before.

The previous criteria for bilateral breast reduction surgery that stated the patient has a BMI equal to or below 27 kg/m2 for at least two years (documented) has been updated to state the patient has a BMI below 27 kg/m2 for at least 12 months. This reduces the time the patient has to keep their BMI below 27 kg/m2 before they can access breast reduction surgery, though BMI must now be below 27 kg/m2 rather than equal to.

The previous criteria for bilateral breast reduction surgery that stated the evidence must be submitted to demonstrate pain symptoms persist as documented by the physician despite a six month trial of therapeutic measures has been removed. This would make access to breast reduction surgery easier as this criteria is no longer mentioned in the policy.

Additional clinical criteria that was not previously contained in the bilateral breast reduction policy has been added. The patient must now receive a full package of supportive care from their GP in the form of advice on weight loss and pain management. If the patient has thoracic or shoulder girdle discomfort a physiotherapy assessment has to be provided. The patient must receive written information of the risks and benefits involved with bilateral breast reduction surgery. Patients must be advised that smoking increases complications and should be advised to stop smoking. Patients should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

The previous criteria for unilateral breast reduction surgery that stated there must be gross asymmetry (defined as a difference in size of at least three cup sizes) has been altered to a difference of 150 - 200gms size as measured by a specialist. This ensures the measurement is carried out by a specialist.

The previous criteria that required the patient to demonstrate that there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra). This has been removed. This would make access to this procedure for patients easier.

The previous criteria that required the woman’s breasts to be fully developed i.e. there has been no change in the size of either breast over the previous 18 months has been removed. This will make access to this procedure easier for patients.

A requirement for the body mass index (BMI) to be <27 and stable for at least 12 months has been added. This promotes a healthy weight prior to surgery being undertaken and encourages maintenance of a healthy weight.

Recommendation

Section 1: Bilateral breast reduction

With prior approval, NEL CCGs will fund bilateral breast reduction when all of the following criteria are met:

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

AND

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

AND

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

AND

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

AND

5. Body mass index (BMI) is <27 and stable for at least 12 months

AND

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

AND

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

AND

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

Section 2: Unilateral breast reduction

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

With prior approval, NEL CCGs will fund unilateral breast reduction when all of the following criteria are met:

1. A difference of 150 - 200gms size as measured by a specialist

AND

2. Body mass index (BMI) is <27 and stable for at least 12 months

Additional information

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

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

Rationale for recommendation

One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery.

Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).

Local CCGs propose to adopt the national policy for breast reduction to ensure equity of access to treatment for patients and to ensure local policies are in line with national recommendations and latest guidance.

For further details please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 19 female breast reduction procedures carried out for BHR patients at a cost of £49,503.

9. Grommets for glue ear in children

What are grommets for glue ear in children?
This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid buildup (glue ear) when it is affecting hearing in children.

Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing. Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems.

Summary of change from previous policy
Grommets for glue ear in children remains as a procedure requiring prior approval. The previous criteria that the child should be aged between three and twelve has been removed. This opens up access to this treatment for children outside of that age range. The additional previous criteria that stated the child must have documented persistent hearing loss on two occasions at intervals of three months or more has been changed to one episode of at least three consecutive months. This allows grommets for glue ear to be considered earlier as only one episode of three months required to be demonstrated rather than two.

The previous criteria that stated grommets for glue ear in children can be funded via prior approval if the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma has been removed from the new policy. This ensures that the cholesteatoma is treated before a new grommet is fitted.

Previous criteria that stated grommets for glue ear in children can be funded via prior approval if the child has five or more episodes of acute otitis media has been removed. This would allow access to treatment when there are fewer episodes of acute otitis media provided other clinical criteria are met.

An additional criteria has been added to one of the options for approving funding for grommets for glue ear in children via prior approval which states that all children must have had a specialist audiology and ENT assessment. This ensures that any audiology and ENT assessments are carried out be a specialist prior to the fitting of a grommet for glue ear.

Recommendation

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

With prior approval, NEL CCGs will fund grommets for glue ear when criteria 1, 2 and 3 are met. Or exclusively when either 4(a) or 4(b) are met:

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

AND

2. Persistent bilateral otitis media with effusion for at least three consecutive months

AND

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

OR exclusively in one of the following circumstances:
4(a). Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral otitis media with effusion (OME) with a hearing loss

less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant

OR

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

Additional information

This guidance does not apply to children with Down's Syndrome or Cleft Palate, who may be offered grommets after a specialist Multi-Disciplinary Team (MDT) assessment in line with NICE guidance. It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

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

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

Rationale for recommendation

Local CCGs have chosen to adopt the National Evidence Based Interventions policy on grommets for glue ear in children as this brings the policy in line with NICE guidance (CG60) and ensures equity of access to treatment for patients.

The rationale for the inclusion of grommets for glue ear in children as a procedure requiring prior approval is as follows:

In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities.

The NHS should only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit.

NICE guidance: https://www.nice.org.uk/Guidance/CG60

For full details on rationale please see:
https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

During 2018/19 there were 253 grommets for glue ear in children procedures carried out for BHR patients at a cost of £220,785.