Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	19 September 2018
Reporting Member /Officer of Strategic Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**GREATER MANCHESTER RESPONSE TO NHS ENGLAND CONSULTATION ON EVIDENCE BASED INTERVENTIONS**
Report Summary:	This report summarises the NHS England (NHSE) consultation on evidence based interventions and proposes a Greater Manchester response that will be submitted on behalf of Tameside and Glossop and other GM Clinical Commissioning Groups. The NHSE proposal is stop routinely funding the following interventions: • Surgery for simple snoring i.e. in the absence of obstructive sleep apnoea; • Dilation and curettage as a diagnostic or treatment option for heavy menstrual bleeding; • Knee arthroscopy for patients with osteoarthritis; • Injections for non-specific low back pain without sciatica. Set qualifying criteria for a further thirteen: 1. Breast reduction (includes asymmetry and gynaecomastia; 2. Benign skin lesions; 3. Grommets for glue ear; 4. Tonsillectomy for recurrent tonsillitis; 5. Haemorrhoid surgery; 6. Hysterectomy for heavy menstrual bleeding; 7. Chalazion removal; 8. Arthroscopic shoulder decompression for subacromial shoulder pain; 9. Carpal tunnel syndrome release; 10. Dupuytren's contracture release; 11. Ganglion excision; 12. Varicose Vein surgery; 13. Trigger finger release. The proposed response indicates general agreement whilst suggesting the additional intervention of cataracts and removal of Varicose Veins. It also suggests amendments to the clinical criteria
Recommendations:	The Strategic Commissioning Board is recommended to: 1. Note the report and implications; 2. Confirm agreement with the proposed response to NHS England set out in section 6.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	N/A
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	This paper provides the views of Tameside and Glossop to inform a GM response to an NHSE consultation. The purpose of the consultation is to ensure clinical effectiveness and value for money so this is inherent in the proposals.
Additional Comments The implementation of zero tariff for category one would result in reduced expenditure than is currently the case to comply with EUR processes. However, if the criteria as outlined in the NHSE consultation were adopted, additional costs could be incurred which would present budgetary pressures.	

Legal Implications:

(Authorised by the Borough Solicitor)

Before making their decision Board Members should ensure they fully understand the equality and financial implications of the proposals in order to comply with their equality and fiduciary duties to the public and public purse.

How do proposals align with Health & Wellbeing Strategy?

Focussing on clinically effective interventions will help ensure all patients are able to access the care needed to promote a long Healthy Life Expectancy.

How do proposals align with Locality Plan?

The delivery of clinical effective treatments supports improve patient outcomes and cost effectiveness.

How do proposals align with the Commissioning Strategy?

The NHSE consultation is regarding a proposal to reduce the number of clinically ineffective interventions which will ensure that commissioning resources focus on evidence based treatments that support people to live well.

Recommendations / views of the Health and Care Advisory Group:

The response developed by GMSS was reviewed and the Health and Care Advisory Group confirmed agreement with the response to NHS England set out in section 6.

Public and Patient Implications:

This report sets out our response to a national public consultation the outcome of which will then be implemented locally in line with other national directives and guidance.

Quality Implications:

The proposal focuses on improving clinical outcomes through reducing ineffective treatments.

How do the proposals help to reduce health inequalities?	NHSE in developing their proposal have given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities
What are the Equality and Diversity implications?	The NHSE document includes the following Equality Impact Assessment. 1. Throughout the development of the policies and processes cited in this document, we have: • Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic[1] (as cited under the Equality Act 2010) and those who do not share it; and • Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities 2. We are completing a full Equality and Health Inequalities Assessment (EHIA) as part of this consultation which we will publish alongside the consultation response and other guidance documents. As part of the EHIA we will be engaging with representatives from relevant protected characteristics and asking specific questions in the consultation. Consultation Questions What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for: • groups protected under the Equality Act 2010?31 • those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?
What are the safeguarding implications?	The reducing in clinically ineffective treatments would reduce the risk of harm.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Following the outcome of the national consultation if required a privacy impact assessment will be carried out.
Risk Management:	None at this stage in the consultation
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Elaine Richardson, Head of Delivery and assurance  Telephone:07855469931  e-mail: Elaine.richardson@nhs.net

1 BACKGROUND / INTRODUCTION

1.1 NHS England (NHSE) are consulting on proposals for reducing the number of clinically ineffective interventions carried out in the NHS economy at present. The link to which is https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/user_uploads/evidence-based-interventions-consultation-document-1.pdf

The consultation will run from the 4 July until the 28 September 2018.

1.2 Greater Manchester Shared Services are commissioned to provide EUR policy development support to Tameside and Glossop Strategic Commission and the GM EUR Policy Development Team on behalf of the GM EUR Steering Group, has undertaken a review of the consultation documentation and produced a comparison of the proposed NHS England commissioning criteria against the current commissioning criteria across Greater Manchester.

1.3 The review has been used to develop a response on behalf of the Clinical Commissioning Groups in Greater Manchester.

1.4 This report summarises the NHSE Proposal and sets out the proposed response.

2. NHSE PROPOSAL

2.1 NHSE has set out a hierarchy of five goals for this initiative:

1. Reduce avoidable harm;
2. Save precious professional time;
3. Help clinicians maintain their professional practice;
4. Create headroom for innovation;
5. Maximize value and avoid waste.

2.2 The proposal initially focuses on seventeen specific types of intervention split into two categories:- Category one is essentially “do not do” and Category two interventions which will be restricted to patients who meet the criteria developed to target the intervention to those who will gain the most benefit. In both categories clinicians can apply for funding on the grounds of exceptionality.

2.3 NHSE has set out to identify restrictions that are rooted in research and evidence-based guidance, for which they can establish clear, quantifiable national and local goals. It is intended that a broad consensus should be achieved to take this forward. By starting with an initial, relatively narrow, focus on a few interventions it is hoped that rapid progress can be made. NHSE also propose an array of specific actions to support the achievement of these targets.

2.4 NHSE hopes to identify established local systems that can make early progress toward these reductions in activity and can input their experience and learning into the national programme. Greater Manchester have identified themselves as potential partners.

3. NHSE PROPOSAL FOR CATEGORY ONE INTERVENTIONS

3.1 The interventions which should no longer be commissioned are:

1. Surgery for simple snoring i.e. in the absence of obstructive sleep apnoea;
2. Dilation and curettage as a diagnostic or treatment option for heavy menstrual bleeding;
3. Knee arthroscopy for patients with osteoarthritis;
4. Injections for non-specific low back pain without sciatica.

3.2 Within the consultation NHSE includes data on the current activity levels. Greater Manchester, despite having policies for 3 of these interventions and local policies for the fourth (D&C), are the 5th highest Sustainability and Transformation Partnershp in the country for spend in this area. Six of the 10 GM CCGs are in the top 50 CCGs for spend in this area and 4 of the provider trusts in GM are in the top 50 for activity with Pennine Acute Trust topping the list. Tameside and Glossop is not one of the top 50 CCGs nor is Tameside and Glossop Integrated Care Foundation Trust one of the top 50 providers.

3.3 Work is already planned in GM that will result in a significant reduction in category one interventions specifically in the revised back pain policy which will include a statement that Facet Joint Injection is no longer commissioned, in line with NG59, and the adoption of the revised knee arthroscopy policy.

4. NHSE PROPOSAL FOR CATEGORY TWO INTERVENTIONS

4.1 There are thirteen interventions for which qualifying criteria are proposed and Greater Manchester has existing policies for twelve of these as shown below:

NHSE Category 2 intervention	**GM policy status for the same intervention(s)**	**Notes**
1.Breast reduction (includes asymmetry and gynaecomastia	Policy in place for reduction, enhancement, mastopexy, asymmetry, gynaecomastia and nipple inversion	GMEUR criteria more detailed and restrictive than proposed NHSE criteria
2.Benign skin lesions	Common benign skin lesion policy in place	GMEUR do not limit the restrictions to a specific list of lesions – it has generic criteria and some criteria specific to types of lesion
3.Grommets for glue ear	Drainage of the middle ear (with or without the insertion of grommets) in place	GMEUR and NHSE criteria similar but GMEUR more detailed at present so easier to apply
4.Tonsillectomy for recurrent tonsillitis	Tonsillectomy policy in place	GMEUR policy also covers tonsillar crypts and stones
5. Haemorrhoid surgery	Surgical management including banding) of haemorrhoids & anal skin tags policy currently going through governance	GMEUR policy also restricts the type of surgery as there are excess cost when haemorrhoidectomy is done when banding could be. This has been out to clinical consultation
6.Hysterectomy for heavy menstrual bleeding	**No GMEUR policy but T&G do have a policy**	Local policies apply
7.Chalazion removal	Common benign eyelid lesion policy in place	GMEUR policy covers all benign skin lesions not just chalazion
8.Arthroscopic shoulder decompression for subacromial shoulder pain	Arthroscopic subacromial decompression for shoulder impingement policy currently going through the governance process	The proposed GMEUR policy is in line with NHSE proposals and has been out to clinical consultation
9.Carpal tunnel syndrome release	Carpal tunnel policy in place	Criteria are in line with NHSE but are more detailed at this stage
10.Dupuytren's contracture release	Dupuytren's contracture policy	Criteria are in line with NHSE but are more detailed at this stage
11.Ganglion excision	Revised GMEUR ganglion policy waiting to go through governance	Current policy in line with NHSE proposals but revised policy has stricter criteria in line with the latest royal college guidelines

12.Varicose Vein surgery	GMEUR policy in place	NHSE propose adoption of NICE CG168 criteria which is less strict than our current policy – this carries a significant financial risk
13.Trigger finger release	GMEUR Trigger finger (surgical correction of) policy in place	Criteria are in line with NHSE but are more detailed at this stage

4.2 Within the consultation NHSE includes data on the current activity levels. Greater Manchester, despite having policies for 12 of the 13 interventions with stricter criteria than those proposed by NHSE, are 24th on the list of Sustainability and Transformation Partnerships for activity in these areas. However only one GM CCG is in the top 50 list and 3 providers (the highest of which is Pennine Acute) are in the top 50 providers for activity. Tameside and Glossop is not one of the top 50 CCGs nor is Tameside and Glossop Integrated Care Foundation Trust one of the top 50 providers.

4.3 Work is already planned in GM that will support reduction in category two interventions specifically in the adoption and implementation of the following policies:

- Revised ganglion policy;
- Haemorrhoid surgery;
- Shoulder impingement policy (July GM EUR Steering Group approved the policy to go through the governance process);
- Surgical Repair of Hernias Policy (out for clinical engagement).

5. PROPOSED ACTION BY NHSE TO ALIGN INCENTIVES TO THE EVIDENCE

5.1 The interventions will not be routinely offered to NHS funded patients or offered only if specific criteria apply. However, clinicians will be able to apply for funding for category one interventions if they can demonstrate exceptionality and for prior approval for all category two interventions. The expectation is that the GP will apply for funding rather than the provider clinician.

5.2 Category one interventions will be removed from the scope of National Tariff price or a national variation will be sued so that providers are not paid for activity unless they have an individual funding request number. The proposal is this applies from April 2019.

5.3 With effect from 1 April 2019 the NHS Standard Contract will be amended to mandate compliance with the Evidence-Based Interventions policy. The proposed additions to the Contract will require both commissioners and providers to comply with the Evidence-Based Interventions policy; and enable the commissioner to withhold payment for the relevant procedure where the provider treats a patient without evidence of individual funding request approval (Category one) or other prior approval (Category two).

5.4 NHSE propose aligning the e-referral system with the new programme by excluding Category one interventions from the e-referral system except where an individual funding request has been agreed. They intend to work with CCGs and GPs on how best to implement this.

6. PROPOSED GM RESPONSE TO NHS ENGLAND'S CONSULTATION ON EVIDENCE-BASED INTERVENTIONS

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
Introduction			
1	***In what capacity are you responding?***	• ***Other (if other please specify)*** The Greater Manchester EUR Steering Group on behalf of the 10 Greater Manchester CCGs	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
2	***Have you read the document: Evidence-Based Interventions: Consultation Document?***	***Yes/No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Design Principles			
3	***Do you agree with our six design principles?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Phase 1: A focus on 17 proposed interventions			
4	***Do you agree that selecting circa 17 interventions is about the right number for this first phase?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
5	***Are there interventions you think we should add for the first phase?***	***Yes/No*** ***If you have selected 'Yes', please share your suggestions.*** Please find attached the GM EUR Policy for Cataract removal as there were (local) financial pressures related to surgery for the second eye particularly with some NHS contracted private providers – this may be happening elsewhere as well.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
6	***Are there interventions we should remove?***	***Yes/No*** ***If you have selected 'Yes', please tell us why:*** The proposed criteria for Varicose veins are not currently affordable for the GM commissioners. A recent finance report concluded: The projected costs of moving to a NICE CG168 compliant policy vary depending on the assumptions applied: • a possible saving of £98,597- assumes full compliance with NICE by providers and assumes they meet the activity split assumptions contained in CG168 and that activity remains at current levels • a cost of £403,525 - assumes full compliance with NICE by providers and that they meet the activity split assumptions contained in CG168 • a possible cost of £530,278 if activity increases by the 25% anticipated by and the procedure split remains as it is at present and there is a 25% increase in activity. **NONE of the potential costs calculated include reduced tariffs for sclerotherapy and endothermal ablation which could reduce the costs significantly if managed alongside a move to these interventions from current ratios.** The above figures do not include the cost of additional infrastructure in the community that would be needed by approx 5 of the CCGs to be able to reach full compliance.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
7	***Do you agree this should become an on-going rolling programme, subject to making sufficient progress?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
8	***What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:*** **Groups protected under the Equality Act 2010? Those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?**	Evidence based interventions target rather than ration health care, so the needs of all vulnerable groups should be part of that process. Removing ineffective treatments that can carry risk is a positive impact. There may be a perceived impact on those elderly and disabled individuals currently receiving regular facet joint and other injections for back pain as they may not currently be aware of the risks and they perceive these to be effective. However, in health terms the risks outweigh the benefits so the actual (not perceived) impact is positive.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Illustrative Activity Goals			
9	***At what level should we pitch our ambition?***	***Ambitious,*** ***Moderate,*** ***Conservative*** ***Please tell us why*** Ambitious for the category one interventions as these are of no benefit and if the zero tariff is introduced then compliance should be achieved quickly Moderate for category two as local consultation and involvement is essential for success and may take time to achieve Any goal should take account of progress to date.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
10	***Do you have any suggestions to improve our methodology?***	***Yes****/No* ***If you have selected 'Yes', please tell us your suggestions:*** Ensure any pre-existing local collaborations are fully involved and integrated into any regional /national collaboration When targets are set ensure that any monitoring arrangement for compliance are manageable and support local actions rather than adding to the local workload and therefore potentially undermining the process it is there to support.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Engaging the system: systematic, multi-channel communication and engagement with clinicians, patients and commissioners			
11	***What further suggestions do you have to enable effective communication and engagement to support with implementation?***	Take account of existing local structures and work with them rather than add another system which could cause local confusion and disengagement. Link to a key part of any local collaboration as well as with the individual organisations so that local cohesion can be maintained.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Engaging the system: Demonstrator Communities to test proposals before December 2018 and provide peer-to-peer support to other systems			
12	***Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018?***	***Yes / No*** ***If you have selected 'Yes', please provide a list:*** Greater Manchester Effective Use of Resources collaboration https://www.gmsharedservices.nhs.uk/services	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Require Individual Funding Requests for Category 1 interventions and Prior Approval for Category 2 interventions			
13	***Do you agree that with our proposals for IFR for Category 1 interventions?***	***Yes / No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		If you have selected 'No', what alternative(s) would you propose?	**Any additional comments:- None**
14	***Do you agree that with our proposals for prior approval for Category 2 interventions?***	***Yes / No*** ***If you have selected 'No', what alternative(s) would you propose?*** Cataract (particular criteria for the second eye) in place of Varicose Veins	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Introduce zero payment for Category 1 interventions without IFRs			
15	***Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?***	***Yes / No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
16	***Do you agree that this change should apply from 2019?***	***Yes / No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Amend the NHS Standard Contract for Category 1 and 2 interventions			
17	***Do you support our intention to mandate compliance with the Evidence- Based Interventions policy through the NHS Standard Contract?***	***Yes / No*** ***If you have selected 'No' please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
18	***In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:*** ***Do you support our proposed wording for the new Contract requirements?***	***Yes / No*** ***Yes / No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
	Do you have any specific suggestions for how the Contract wording could be improved?	***Please tell us more about your answers:*** Requires clarification on which evidence based intervention policy applies – is this only the one to be produced by NHS England or will local policies carry the same weight particularly if they have stricter criteria.	
Applying a rigorous approach to assess implementation			
19	***Given the mixed record of applying research-based evidence to decommission ineffective treatments, do you agree that we should introduce the range of performance management measures proposed above?***	***Yes / No*** But in a supportive way as much as possible – see responses above ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
	Do you have any suggested amendments to the proposed clinical criteria? If so, why so?	***Yes –*** Many of the criteria as set out can be open to different interpretation and some will not be easy for the lay members of the team who receive and action these requests to assess. In our experience criteria need to be very specific. **There is a lack of high level evidence linking large breasts with back pain, currently GM use this when considering exceptionality not as a qualifying criterion -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain and using the proposed NHSE criteria our activity would increase - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study supporting correctly fitted bras for larger women.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		NOTE Professional bra fitting and correct bra fitting are **NOT** the same thing and it is very difficult to prove whether or not correctly fitting bras have been worn (proof of measurement / purchase does not prove compliance) • Breast size is disproportionate to chest wall circumference Are you proposing a guide for this? Currently our panels use a chart of back and cup sizes to determine where the individual is in relation to the rest of the female population • Breast reduction planned to be 500gms or more per breast. In practice for most non-surgeons – this is a very difficult measure – cup and back sizes using standardised measurements techniques are easier • Body mass index (BMI) is <27 and stable for at least twelve months. Why is the cut off 27? evidence for increased complication puts the cut off at 30- **The impact of obesity on breast surgery complications,** Chen, C L., Plast Reconstr Surg. 2011 Nov; 128(5):395e-402e. doi: 10.1097 / PRS.0b013e3182284c05 For Benign skin lesions the GM policy did? include a specific list but used general criteria for all benign skin lesions and specific additional criteria where need in order to avoid "it's not on the list so it's not restricted" The proposal entitled "Grommets for Glue Ear in Children" covers more interventions that the title suggests which could cause confusion. In this section you state "In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes	

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age)". Is it proposed that this is a policy exclusion? i.e. no restrictions apply to this surgery This section does not cover a number of the areas where we see requests for tonsillectomy and where the evidence suggests tonsillectomy is not the treatment of choice e.g. tonsillar stones and crypts. With regard to haemorrhoids - There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated or to allow funding to be agreed at screening The biggest cost in this area in GM is with the use of haemorrhoidectomy in place of banding – the rates for the former should be really low – any policy needs to be clear on what as well as when in relation to commissioning arrangements GM cover chalazia with other benign eyelid lesions as it is not the only benign lesion that does not normally need surgical intervention in secondary care The GM ganglion policy has only recently been reviewed in line with RCS guidance and updated following clinical consultation The criteria differ significantly from NICE proposed criteria (some differences relate to policy exclusions) We would prefer to keep locally agreed criteria.	

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		The GM policy for varicose veins differs significantly from NICE guidance – the policy criteria are based on historic restrictions and were agreed after a financial paper was taken through the GM governance structure that showed the cost of moving to full NICE compliance Based on current activity and projected activity if NICE guidance was implemented across the conurbation the paper concluded that: "The overall cost in 2015/16 across GM was £2,107,081, the potential cost if Greater Manchester adopts NICE CG168 based on NICE assumptions of increased activity with no change in tariff would be £2,637,359 showing an increase in cost of £530,278 Implementing the new GMEUR Varicose Vein policy is expected, at worst, to be cost neutral. At best there may be a small saving associated with targeting treatments for those with moderate varicose veins to those at the highest risk of ulceration / bleeding" This does not include the investment in the infrastructure which would be needed in the community to implement the NICE pathway of care.	
The details below will only be used by GMSS EUR Policy Team if they need contact you regarding your responses above.			
	Name of person completing the form: **Elaine Richardson**	**Organisation:** **Tameside and Glossop Strategic Commission**	**Role within the organisation:** **Head of Delivery and Assurance**
	Email address: **Elaine.richardson@nhs.net**	**Telephone Number:** **07855469931**	

7. RECOMMENDATIONS

7.1 As set out on the front of the report.

APPENDIX 1 COMPARISON OF NHS ENGLAND PROPOSED CRITERIA AND THOSE IN CURRENT OR "UNDER REVISION" GM EUR POLICIES

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
ENT				
A	**Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))**	In two systematic reviews of a combined 72 primary research studies7, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has an up to 16% risk of severe complications (bleeding, airway compromise, death). We therefore propose it is no longer commissioned. A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion. It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to that NHS are proposing that this procedure should no longer be routinely commissioned. **Alternative Treatments** There are a number of alternatives to surgery that can improve the symptom of snoring. These include: • Weight loss • Stopping smoking • Reducing alcohol intake • Medical treatment of nasal congestion (rhinitis) • Mouth splints (to move jaw forward when sleeping)	**GM068 Invasive Treatments for Snoring** Invasive Treatments for Snoring	Surgical treatment of simple snoring (where snoring is not complicated by episodes of breathing cessation) is regarded as a procedure of low clinical priority and therefore not routinely commissioned.
Gynaecology				
B	**Dilatation and curettage (D&C)**	NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.[8] Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), should be used to	No GM EUR Policy - Local CCG policies apply.	

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) should be used to treat heavy periods. D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) should be used to investigate heavy periods. Medication and intrauterine systems (IUS) should be used to treat heavy periods. For further information, please see: **https://www.nice.org.uk/guidance/ng88** **https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy**		
Orthopaedics				
C	**Knee arthroscopy for patients with osteoarthritis**	NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis. More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and managing pain.[9] Arthroscopic knee washout should not be used as a treatment for osteoarthritis because it is clinically ineffective. More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. In younger people with osteoarthritis, other procedures such as osteotomy may be appropriate. For further information, please see: **https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117** **https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance**	**GM034 Knee arthroscopy** Currently undergoing review draft new policy below: GM Knee Arthroscopy Policy v2.2 DRAFT .pdf	Knee arthroscopy is **only** commissioned if the following criteria are met: • Intermittent (true) locking[1] that has not responded to at least 3 months of non-surgical treatment. **AND one of the following:** • There is a loose body (or bodies) that is causing the locking and which has been confirmed by a magnetic resonance (MR) scan or on X-ray if a bony loose body is involved. **OR** • Where a detailed understanding of the degree of compartment damage within

[1] **Intermittent (True) locking:** A loose body in the knee joint gets stuck or caught and stops the knee from moving at all. The knee remains fixed for a variable period of time in the position where it 'locked' despite attempts to manipulate the knee.

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		https**://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not http://www.escape-pain.org/**		the knee is required **OR** • There is a significant meniscal tear (e.g. bucket handle tear, flap, cleavage or radial with refractory pain and) which is thought to be the cause of intermittent locking / giving way **OR** • The individual is between the ages of 35 and 55 with a history of trauma to the knee and the arthroscopy will delay the need for knee replacement **NOTE: Knee arthroscopy, lavage and debridement is not commissioned for a degenerative knee unless the above mandatory criteria are also present.**
D	**Injections for nonspecific low back pain without sciatica**	NICE recommends that spinal injections should not be offered for nonspecific low back pain. Alternative options like pain management and physiotherapy have been shown to work. Sciatica is tingling, pain or weakness in the leg due to irritation of the sciatic nerve. Spinal injections of local anaesthetic and steroid should not be offered for patients with nonspecific low back pain without sciatica, as they are unproven clinically. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Radiofrequency denervation (destroying the nerve that supplies the painful facet joints in the spine) can be considered according to NICE guidance. For further information, please see:	**GM046 Low Back Pain** Back Pain (Treatment for Low Back Pain with or without sciatica) **GM070 Facet Joint Injections** Facet Joint Injections for Neck and Back Pain **GM004 Radiofrequency**	All 3 policies have been withdrawn and are currently under review to ensure compliance with NICE NG59.

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		https://www.nice.org.uk/guidance/ng59	**Denervation** Radiofrequency Denervation for Back Pain	

E	**Breast reduction**	The evidence highlights that breast reduction is only successful in specific circumstances and the procedure can lead to complications - for example not being able to breast feed permanently. 11 We are therefore proposing that breast reduction is only undertaken under the criteria outlined in Appendix 2.:_ From Appendix 2 We would like to seek views on the criteria as part of this consultation. Wearing a professionally fitted bra (**NOTE** Professional bra fitting and correct bra fitting are **NOT** the same thing) – very difficult to implement as proof of purchase is not proof it fits or has been worn , losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts **NOTE the lack of evidence linking lage breasts with back pain -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study (see below supporting correctly fitted bras for larger women). We propose that the NHS will only provide breast reduction for women if all the following criteria are met: • The woman has received a full package of supportive care from their GP and a physiotherapy assessment has been	**GM006 - Aesthetic Breast Surgery** Breast Surgery (Aesthetic) **NOTE the lack of evidence linking large breasts with back pain -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study (see below supporting correctly fitted bras for	**This also covers breast augmentation, breast asymmetry, breast lift, inverted nipples. Adult and adolescent gynaecomastia** **Breast Reduction** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Breast reduction surgery is **not** routinely commissioned. **If applying for funding on the grounds of clinical exceptionality the following standard set of information will need to be provided in addition to the individual clinical exceptional circumstances.** ***Please NOTE that these are not qualifying criteria, they provide a standard set of information which is used by panels as an aid when determining exceptionality:*** • In order to ensure consistency in decision making and a full understanding of the clinical picture by all staff reviewing the case for **all** applications relating to the female breast, measurements **must** be submitted

		provided. • 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). • Breast size is disproportionate to chest wall circumference (Are you proposing a guide for this? Currently our panels use a chart of back and cup sizes to determine where the individual is in relation to the rest of the female population • Breast reduction planned to be 500gms or more per breast. (In practice for most non-surgeons – this is a very difficult measure – cup and back sizes using standardised measurements techniques are easier) • Body mass index (BMI) is <27 and stable for at least twelve months. (evidence for increased complication puts the cut off at 30) **The impact of obesity on breast surgery complications,** Chen, C L., Plast Reconstr Surg. 2011 Nov; 128(5):395e-402e. doi: 10.1097 / PRS.0b013e3182284c05 Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery Ideally no further pregnancies are planned. **Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation**. Surgery can be approved for a difference of 150 - 200gms size difference as measured by a specialist. See comment above re difficulty measuring or assessing this for non-breast surgeons. The BMI needs to be <27 and stable for at least twelve months. Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes. This proposal does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be	larger women). (**NOTE** Professional bra fitting and correct bra fitting are **NOT** the same thing)	using either method in Appendix 2 of this policy, please give actual measurements as well as the band and cup size. **Applications using other methods will not be accepted**. • Confirmation that a correctly fitted bra has been worn for a period of at least 6 months and has not relieved the symptoms. • Evidence of a history of intertrigo, if applicable, its frequency and medication used. • Where the patient has reported back and neck pain, evidence that a course of physiotherapy has been completed without improvement of symptoms. • The patient's height and weight records for the previous 2 years (or, if this is not available, a statement from the clinician that their weight has been stable for at least 2 years). This must include the patient's current height and weight (BMI must be less than 30). • Patients **must** be advised that if they go on to have further children they may develop further aesthetic problems with the breasts and it is unlikely that further aesthetic breast surgery would be funded on the NHS. • Non-identifiable photographs, preferably medical illustrations if available, will be requested, to support the decision making process, but will not form the sole basis of the decision. It is not mandatory for photographs to be provided by a patient. • The patient **must** have completed puberty **Breast Lifts (Mastopexy)** All surgery involving incision into healthy tissue in this case a healthy breast whatever

		adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process. **Gynaecomastia:** Surgery for gynaecomastia is not funded under the NHS. Surgery can be performed for gynaecomastia secondary to treatment for prostate cancer.		its size and shape is considered to be aesthetic. Mastopexy surgery is **not** routinely commissioned, unless part of an approved breast reduction procedure. **Breast Asymmetry** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. • Surgery is only commissioned where there is a difference in breast size of 3 cups (i.e. there should be at least 2 cup sizes between the sizes given for each breast). ***For example:*** *the difference between a B cup on one side and a DD on the other is 3 cup sizes with 2 cup sizes in between: B to (C to D) to DD.* The application should include current band and cup measurements for both breasts. In order to ensure consistency in decision making and a full understanding of the clinical picture by all staff reviewing the case for **ALL** applications relating to the female breast, measurements **must** be submitted using **Method 1** in Appendix 2 of this policy, please give actual measurements as well as the band and cup size. **Applications using other methods will not be accepted**. • The patient **must** have completed puberty • The application should also include the patient's height and weight records for the previous 2 years (or, if this is not available, a statement from the clinician that their weight has been stable for at least 2 years). This must include the patient's current

				height and weight (BMI must be less than 30). **NOTE:** • Due to the risks and long term implications relating to breast implants, **surgery to reduce the larger breast only will be approved.** • Requests made by clinicians to enhance the smaller breast, will be considered under clinical exceptionality. This includes, but is not limited to, cases where reduction to the size of the larger breast would leave the women with a bust size disproportionate to her frame. • The outcome of reduction surgery can be affected by the individual's weight and how stable that weight is, which is why this information is requested. **Gynaecomastia (Adult)** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Gynaecomastia surgery is **not** routinely commissioned. **Adolescent Gynaecomastia** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Adolescent gynaecomastia surgery is **not** routinely commissioned. **NOTE for all breast surgery exceptionality requests there is a standard set of information required alongside any other evidence of exceptionality**

F	**Removal of benign skin lesions**	Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined in Appendix 2. Risks from the procedure can include bleeding, pain, infection, and scarring. We would like to seek views on the criteria proposed in Appendix 2.[12] Appendix 2: **This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:** • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • dermatofibroma • lipomas • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata **The GM policy does not have a specific list but uses general criteria for all benign skin lesions and specific additional criteria where needed (to avoid "it's not on the list so it's not restricted")** **The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:** • The lesion is unavoidably and significantly	**GM013 - Common Benign Skin Lesions** Skin Lesions (Common Benign)	**Benign skin lesions** Removal of benign skin lesions will only be considered if **ONE** of the following applies: • Impairment of function or significant facial disfigurement, e.g. large lipoma. • Rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular). • There is significant pain as a direct result of the lesion. • There is a confirmed history of recurrent infection / inflammation. • There is reason to believe that a commonly benign or non-aggressive lesion may be changing to a malignancy, or there is sufficient doubt over the diagnosis to warrant removal. The following additional criteria are also applicable to the lesions listed below and referral may be made if the patient meets the criteria for that specific lesion **AND / OR** the mandatory criteria above. **Lipoma (fatty lump)** • The lump is over 5cm in diameter (due to the increased risk of missed diagnosis of a liposarcoma). • Where there are any concerns, the soft tissue guidelines should be followed.

		traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue • If left untreated, more invasive intervention would be required for removal • Facial lesions > 1cm that cause significant disfigurement • Facial warts in all ages causing significant psychological impact • Facial spider naevi in children causing significant psychological impact • Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.		**Warts** • The diagnosis is uncertain. **OR** • There are multiple recalcitrant warts and the person is immunocompromised. **OR** • The person has areas of skin that are extensively affected, for example, mosaic warts. **Verrucas** • The person has diabetes. **Actinic/Solar Keratosis** • If there is any reason to suspect that it is one of the small percentage at high risk of undergoing malignant change and transforming into a squamous cell carcinoma. The referral should include details of the reasons the referrer has for this suspicion.
ENT				
G	**Grommets for Glue Ear in Children** - this title is more restricted than the proposed criteria	Evidence suggests that grommets only offer a short-term hearing improvement in children with glue ear who have no other serious medical problems or disabilities. They should be offered in cases that have a history of persistent (at least 3 months) bilateral, hearing loss as defined by the NICE guidance. Hearing aids can also be offered as an alternative to surgery. [13]	**GM015** - **Surgical drainage of the middle ear (with or without the insertion of grommets)** Drainage of the middle ear, Surgical (with or without the insertion of grommets)	This policy applies to children under the age of 12 years (in line with NICE CG60). Adults with symptoms suggestive of otitis media with effusion (OME) should be referred for investigation. An IFR form with

		Appendix 2 We are proposing the NHS only commissions this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met: All children must have had specialist audiology and ENT assessment. Persistent bilateral otitis media with effusion over a period of 3 months. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral 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. The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist 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). Is it proposed that this is a policy exclusion?		details of clinical exceptionality is required for children over the age of 12 years. **Otitis media with effusion (OME) assessment** Referral for assessment for surgery for children with OME can be made if: • The child has Down's Syndrome or has a cleft palate. • The child has had a developmentally appropriate hearing test confirming hearing loss and there are functional issues (including but not limited to speech and language development). This should be evidenced by the hearing test result and/ or a corroborating statement from the child's school / nursery etc. • Significant hearing loss persists on two documented occasions. • The tympanic membrane is structurally abnormal. • An alternative diagnosis is suspected. **Persistent bilateral OME with a hearing level in the better ear of 25–30 dBHL or worse** Surgical drainage of the middle ear is commissioned for children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and

				4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention. **Persistent bilateral OME with a hearing loss less than 25–30 dBHL** Commissioned for children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. **NOTE:** The decision as to whether or not grommets are also needed is a clinical one based on the individual case and is at the discretion of the clinician, provided the child meets the criteria for surgical drainage. **Concurrent Adenoidectomy** Adenoidectomy for the management of otits media is not routinely commissioned but can be performed at the same time as OME surgery if it is indicated for a comorbidity. The request should include details of the indication for adenoidectomy as well as those for drainage of the middle ear. **Acute Otitis Media (AOM)** Referral for assessment for surgery for children with

				persistent UORU recurrent AOM can be made if all other standard treatments have been tried and failed (see NICE CKS AOM summary in the evidence review for details) with clear information provided on why this case is clinically exceptional.
H	**Tonsillectomy for recurrent tonsillitis**	Recurrent sore throats are a very common condition that present a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the SIGN criteria are met. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.[14] Appendix 2: We are proposing that the NHS only commissions this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance: Sore throats are due to acute tonsillitis AND The episodes are disabling and prevent normal functioning AND Seven or more, well documented, clinically significant, adequately treated sore throats in the preceding year OR Five or more such episodes in each of the preceding two years OR Three or more such episodes in each of the preceding three years.	**GM028 Tonsillectomy** Tonsillectomy	**Commissioned** See High Value Care Pathway section 1.1 Pathway for children (<16 years) with obstructive sleep disordered breathing: ENT UK Tonsillectomy revised commissioning guide 2016 Tonsillectomy is commissioned for children and adults who meet the following criteria: • Sore throats are due to acute tonsillitis and recorded as such in medical notes. **AND** • The episodes of sore throat are disabling and prevent normal functioning. **AND** • Where there is a history of: Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year **OR** Five or more such episodes in each of the preceding two years **OR**

		Further information on the SIGN guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future. This does not cover a number of the areas where we see requests for tonsillectomy and where the evidence suggests tonsillectomy is not the treatment of choice.		Three or more such episodes in each of the preceding three years **OR** A second episode of Quinsy, irrespective of the timescale. **Tonsillectomy for snoring and sleep apnoea in children** See High Value Care Pathway section 1.2 Pathway for children (<16 years) with obstructive sleep disordered breathing: ENT UK Tonsillectomy revised commissioning guide 2016 • Do not refer children with simple snoring without symptoms or signs of apnoea as they are unlikely to benefit from adeno-tonsillectomy. o Consider allergy testing and appropriate treatment. • In older children >6 years with mild/moderate symptoms of obstructive sleep disordered breathing consider a trial of nasal saline irrigation and/or intranasal steroids for 6-8 weeks. • Refer for a specialist opinion if there are ongoing concerns about obstructive sleep disordered breathing. If the request is for surgery to treat apnoea and is from secondary care a statement that the following been

				undertaken should be included: • A reassessment of the patient's clinical history and examination and if available (to the requesting clinician) a recording of the child's sleep. • Evidence that a discussion of management options has taken place with the patient / family using shared decision making strategies and tools where appropriate, including surgery where there is a clear diagnosis of obstructive sleep apnoea. • Evidence that there has been a follow-up period of children with moderate signs and symptoms prior to a decision of surgery with (if indicated) the results of overnight pulse oximetry, ideally at home or in selected cases an overnight polysomnogram to determine further management (where the diagnosis is less certain). **NOTE: Children with suspected severe apnoea need urgent specialist assessment.** **Not commissioned** Tonsillectomy is not commissioned for tonsillar crypts / stones: conservative management is the treatment of choice.
General Surgery				

I	**Haemorrhoid surgery**	Numerous interventions exist for the management of haemorrhoids (piles). The evidence recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.15 Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less severe haemorrhoids Appendix 2 Often haemorrhiods (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection. Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically: □ Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or □ Irreducible and large external haemorrhoids There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated and or so funding can be agreed at screening The biggest cost is with the use of haemorrhoidectomy in place of banding – the rates for the former should be really low – any policy needs to be clear on what as well as when in relation to commissioning arrangements	**Proposed GM042 GM policy** **Surgical Management of haemorrhoids and anal skin tags** Currently going through governance process  Haemorrhoids and Anal Skin Tags.pdf	**Policy Inclusion Criteria** Haemorrhoidectomy will not be carried out unless there is evidence to demonstrate that recurrent and persistent bleeding has failed to respond to conservative treatment **OR** haemorrhoids cannot be reduced. Haemorrhoidectomy is commissioned in line with the following: • Rrecurrent or persistent bleeding, which has not responded to primary care management. • Fourth degree haemorrhoids or third-degree haemorrhoids that are too large for non-operative measures (haemorrhoidectomy may be needed). • Perianal haematoma (a blue or dark coloured swelling at the anal verge) if symptoms are for less than 24 hours duration for clot evaluation. • Combined internal and external haemorrhoids with severe symptoms (surgery may be required). • Thrombosed haemorrhoids when bleeding is problematic,

				or there is chronic irritation or leakage. • Extremely painful, acutely thrombosed external haemorrhoids presenting within 72 hours of onset (reduction or excision may be needed). • Internal haemorrhoids that have prolapsed and become swollen, incarcerated, and thrombosed (haemorrhoidectomy may be needed). **Note:** Symptomatic haemorrhoids found as part of colonoscopy investigation can be banded if patient fully consented for the procedure, and this is included within the original costs, i.e. makes no change to the tariff charged). Surgical management (including banding) of anal skin tags is **not** commissioned. Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. **Policy Exclusions** Any perianal lesion or episodes of perianal bleeding that are

				suspected of being due to malignancy are excluded from this policy and should be referred via the normal 2-week pathway.
J	**Hysterectomy for heavy menstrual bleeding**	NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.16 Heavy periods can be reduced by using medicines or intrauterine systmes (IUS) or losing weight (if necessary). Appendix: Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices. Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.	No GM EUR policy - Local CCG policies apply.	
Ophthalmology				
K	**Chalazia removal**	The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery. We propose chalazia be removed only according to the criteria listed in Appendix 2.17 Incision and curettage of chalazia should only be undertaken if at least **one** of the following criteria have been met: □ Has been present for more than 6 months and has	**GM044 Removal of Common Benign Eyelid Lesions** Eyelid Lesions (Removal of Common Benign)	**Referral to secondary care where the benign lesion may not be the primary condition** Referrals for the treatment of common benign eyelid lesions can be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis

		been managed conservatively with heat, lid cleaning and massage for 4 weeks □ Alternative treatment (e.g. injection with triamcinolone) has been considered (Need a meds management view on this one) □ Where it interferes significantly with vision. □ Where it interferes with the protection of the eye by the eyelid through affecting lid closure or lid anatomy □ Where it is a source of infection that has required medical attention twice or more within a six month time frame. □ Where it is a source of infection causing an abscess requiring drainage □ If malignancy (cancer) is suspected, lesion will be removed, in common with all suspicious lesions Some of the above would be GM policy exclusions and some apply to benign eyelid lesions in general. The cost of this activity isn't restricted to the treatment of Chalazion alone		and the lesion may not be benign in nature. Examples of reasons for referral include (but are not exclusive) to: • Significant pre-septal cellulitis / orbital cellulitis • Atypical presentation, re-occurrence in same site, may require cancer exclusion • Protrusion of the eye • Rapidly growing • Visual field affected • Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye • New and unexpected visual problems (e.g. double vision) • Reduced light reflexes or abnormal swinging light test • Symptomatically unwell • CNS symptoms or signs **Referral to secondary care where the benign lesion is the primary condition** Where the eyelid lesion is symptomatic referrals can be made for the following criteria: • Persistent (more than 6 months and not responded to conservative treatment) • There is significant pain as a direct result of the lesion • There is a confirmed history of recurrent infection / inflammation • Significant redness of the eye in the absence of an obvious cause

Orthopaedics				
L	**Arthroscopic shoulder decompression for subacromial shoulder pain**	Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases. Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery. Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf In order to facilitate non-operative treatment in primary and intermediate care, BESS and GIRFT have produced patient exercise rehab videos and booklets for GPs and patients to use. http://www.bess.org.uk/index.php/public-area/shpi-videos18 We propose that arthroscopic subacromial decompression for pure subacromial shoulder impingement is 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	**Proposed GM032 GM policy** **Arthroscopic sub-acromial decompression for shoulder impingement**  GM Shoulder Impingement Policy v0	**Prior to referral** Patients must be provided with information to enable them to understand their condition and the following summary should be included in the consent for the procedure and signed by the patient. The presence of this signed consent may be the subject of future audits.: *'Current evidence informs us that there is uncertainty as to whether arthroscopic sub-acromial decompression is any better than physiotherapy. This means that after undergoing the procedure the same number of people may fail to improve as would fail with just physiotherapy. Reduced function and worse pain is experienced for some time after the procedure and rehabilitative physiotherapy is required to improve function to the level experienced before the procedure. This may mean that you are unable*

		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.		*to work or undertake routine chores for up to 3 months. Risk of serious complication is very low. Very rarely an infection of the joint, septic arthritis, can occur.*[2] **Exclude degenerative cuff tears:** Prior to referral all steps should be taken to rule out degenerative partial and full cuff tears that are common in the 50+ age group which do not need referral. **Non-invasive management:** addition prior to Orthopaedic surgical referrals (for impingement) for consideration for arthroscopic sub-acromial decompression the following must apply: • A positive impingement test should be demonstrated **AND** • All methods of conservative management should be tried first: (analgesia, rest, and appropriate physiotherapy) **Initial treatment with steroid injection:** **ALL** of the following apply, then a

				steroid injection into the joint should be tried with conservative management continuing post injection *(the injection **MUST** be into the sub-acromial space, and done by someone competent to deliver the injection into the right space (i.e. the bursa) and in an appropriate clinical setting):* • The patient has been compliant with conservative management which was given for at least 6 weeks **AND** • Patient has been symptomatic for at least 3 months from the start of conservative treatment **AND** • Symptoms interfere with daily living or employment (for example waking several times a night, pain when dressing) **NOTE:** Steroid injections should be managed in line with any GMMMG recommendations and should be carried out by a practitioner trained in the technique in an appropriate setting. **Referral for consideration of surgical management**

				Consider referral for arthroscopic sub-acromial decompression if: • A degenerative partial, or full, cuff tear has been excluded by ultrasound scan if necessary **AND** • Steroid injections have been tried and have failed to relieve symptoms **OR** the patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with post injection conservative management **AND** • The referral is at least 8 weeks after the last steroid injection **AND** • The patient has confirmed that they wish to have surgery **AND** • Findings on appropriate shoulder x-ray views are consistent with shoulder impingement (with ultrasound scan if rotator cuff tear needs to be excluded) **NOTE:** Open surgery for sub-

				acromial decompression is NOT commissioned unless part of a wider surgical procedure.
M	**Carpal tunnel syndrome release**	Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time, splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. We are proposing that surgical treatment of carpal tunnel is only offered under the criteria included at Appendix 2 and would like to seek views on the proposed criteria as part of this consultation. 19 Appendix 2: Surgical treatment of carpal tunnel should be provided if the following criteria are met: □ Patient has acute, severe symptoms that persist for more than three months after conservative therapy with either local corticosteroid injection (medication injected into the wrist) and/or nocturnal splinting (stopping the wrist from moving during the night with a support); **OR** □ Mild to moderate symptoms persist for at least four months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least eight weeks); **OR**	**GM035 Surgical Interventions for Carpal Tunnel Syndrome** Carpal Tunnel Syndrome (Surgical Interventions for)	**Commissioned** **NOTE: Please refer to any relevant GMMMG guidance prior to the following:** **Try corticosteroid injections if:** • there was no improvement with 3 months of conservative treatment **OR** • the symptoms are not severe or constant **OR** • there is no severe sensory disturbance and/or thenar motor weakness **OR** • there is no progressive motor or sensory deficit If the injection(s) fail to relieve

		□ There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction (moving the thumb away from the hand); **AND** □ Severe symptoms significantly interfering with daily activities and sleep which have been assessed. There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated and or so funding can be agreed at screening. This can lead to the policy being bypassed as criteria are interpreted differently.		symptoms then refer for surgical intervention. **NOTE:** • Injections should be carried out by an appropriately trained clinician. If this is not available in primary care, then the patient should be referred to secondary care for the injections. • Refer for electromyography and nerve conduction studies if the diagnosis is uncertain **OR** if indicated prior to surgery. **Patients should be referred for surgical intervention without trying corticosteroid injections first if:** • electromyography and nerve conduction studies show nerve damage **OR** • the symptoms are severe and constant **OR** • there is severe sensory disturbance and/or thenar motor weakness **OR** • there is progressive motor or sensory deficit **Not commissioned** Surgery for carpal tunnel syndrome associated with

				pregnancy is not commissioned.
N	**Dupuytren's contracture release**	NICE has reviewed the evidence for surgical treatment of Dupuytren's contracture. It found that after 3 to 5 years, the problem had returned in about half of the patients treated. We propose that surgery is only offered according to the criteria outlined in Appendix 2. 20 Appendix 2 Surgery should be avoided in cases where there is no contracture, and in patients with a mild contracture that is not progressing and does not impair function. Less invasive techniques percutaneous needle fasciotomy (PNF, where the thickening in the palm is cut by using a needle inserted through the skin) or collagenase injection (injecting medication into the thickened tissue in the palm) can be considered in suitable cases. The criteria for surgical treatment of Dupuytren's contracture should be: □ Conservative and non-operative treatment tried; **AND** □ Patient has loss of extension in one or more joints exceeding 25 degrees; **OR** □ Patient has at least 10 degrees loss of extension in two or more joints. For further information, please see: □ **https://www.nice.org.uk/guidance/ipg43**	**GM049 Dupuytren's Contracture** Dupuytren's Contracture	Management of Dupuytren's Contracture depends on the stage of the disease. Dupuytren's can be classified as mild, moderate and severe to guide treatment options. These classifications are used for this policy. **Mild** • No functional problems **AND either:** • No contracture **OR** • TFD (total flexion deformity) between 0 and 45 degrees (TFD is the total of the degrees of flexion across all joints in a single finger.) **Treatment at this stage:** Reassurance and observation. **Moderate** Functional problems with activities of daily living as a direct result of the deformity **AND** there is evidence of moderate disease with up to 2 affected joints: • Metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° **OR**

				• First web contracture **Treatment at this stage:** Collagenase **OR** needle fasciotomy, if appropriately trained, **OR** in rapidly progressing cases, referral for limited fasciectomy. **Severe** • TFD greater than 90 degrees **Treatment at this stage**: Referral for surgery for limited fasciectomy **OR** dermofasciectomy, as appropriate. Single joint contractures classified as moderate **OR** severe may be treated with collagenase, needle fasciotomy **OR** limited fasciectomy, at the discretion of the treating physician. **Collagenese (Xiapex)** Commissioned in line with NICE TA459: Collagenase clostridium histolyticum for treating Dupuytren's contracture. Collagenase clostridium histolyticum (CCH) is recommended as an option for treating Dupuytren's contracture with a palpable cord in adults, only if the following apply: • 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 2 affected joints. **AND ALL OF THE FOLLOWING:** • Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting. **Recurrent Disease** Recurrent disease may be treated in line with the above classification as for new disease. Any treatment outside of this will require a request via the IFR route
O	**Ganglion excision**	Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can cause complications, and recurrence is common following surgery. The complications may be	**GM025 Ganglion Cyst Removal** **Reference:**	Ganglion cyst surgery is not routinely commissioned. Surgery is only commissioned for ganglion of the flexor tendon

		similar to or worse than the original problem. We are proposing that Ganglion excision is only offered under the criteria outlined in Appendix 2. 21 Ganglion excision should only be provided in the following cases: □ The ganglion is painful seed ganglia and of diagnostic uncertainty; **OR** □ In patients presenting a significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts; **OR** □ The ganglia are mucoid cysts arising at the distal interphalangeal joint and disturbing nail growth or discharging; **OR** □ The ganglion is causing significant functional impairment and/or pain unrelieved by aspiration or injection. If there is diagnostic uncertainty after diagnostic tests have been performed (e.g. MRI) then referral to a specialist soft tissue cancer service should be considered. Alternative options include pain relief or needle aspiration of the ganglion.	 GM Ganglion Cyst Removal Policy v3.1 DI This policy has only recently been reviewed in line with RCS guidance and following clinical consultation The criteria differ significantly from NICE proposed criteria BUT some difference elate to policy exclusions	sheaths where grip is affected. NOTE needle puncture of the "sheath" should be considered first (where suitable facilities are available) as less than half recur after this Where indicted and where suitable facilities are available aspiration can be done in primary care for all ganglion as an aid reassurance (for all grades). **Mild** • an asymptomatic lump **Treatment:** Reassurance and observation. **Moderate** • symptomatic lump with a long duration of symptoms • occult ganglion **Severe** • severe pain • restriction of activities of daily living • concern over the diagnosis **Treatment:** As most ganglion will resolve spontaneously and as a high proportion will recur after surgery the routine treatment for

				all should be reassurance and observation, with aspiration in primary care for reassurance. Refer for ultrasound / MRI if there are concerns about the diagnosis.
P	**Trigger finger release**	Trigger finger often resolves following a period of conservative management (splinting, analgesia). Steroid injection can be considered. We are proposing that surgery is only offered in specific cases where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs. We would like to seek views on the proposed criteria in Appendix 2 as part of this consultation.[22] Appendix: Surgery should be only performed in specific cases where alternative measures have not been successful. Alternative treatments include rest, single dose steroid injection, splinting, and non-steroidal anti-inflammatory drugs. Surgery should only be offered in the following situations □ No response to conservative management (splinting, analgesia) AND □ At least one cortisone injection AND □ Persistent or recurrent triggering, or for a locked finger.	**GM038 Surgical Correction of Trigger Finger** Trigger Finger (Surgical Correction of)	All patients with trigger finger / thumb should have been managed as follows before referral for surgical intervention: • They have been given and followed advice on avoiding activities that cause pain, wherever possible. • They have used a small splint to hold the finger or thumb straight at night, preferably fitted by a hand therapist when available. The splint should hold the finger straight at night. • If indicated, they have been given a steroid injection in an appropriate clinical setting which would be expected to relieve the pain and triggering in up to 70% of cases (but the success rate is lower in people with diabetes). The risks of injection are small (it very occasionally causes some thinning or colour change in the skin at the site of injection). Improvement may occur within a few days of injection but may take several weeks. If clinically appropriate, the patient may be offered a second injection at the

				discretion of the treating clinician. • Patients whose trigger finger has recurred and in whom steroid injections previously failed should be offered the injection but, if they are reluctant to try an injection again, then they may be referred for surgery without having been injected for the recurrence.
Vascular Surgery				
Q	**Varicose vein surgery**	NICE has published detailed guidance on what treatment should be considered for varicose veins and when. Surgery for varicose veins is not recommended before alternative, less invasive options are considered. Surgery is a traditional treatment that involves removal of the vein by ligation (tying off the vein) and 'stripping' out the vein and does not always get rid of varicose veins; they often come back again. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy should be tried before considering surgery. Compression hosiery is not recommended if an interventional treatment is possible. 23 1.1 Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery. 1.2 Refer people to a vascular service if they have any of the following;-	**GM003 Varicose Veins** Varicose Veins The GM policy differs significantly from NICE guidance – the policy criteria are based on historic restrictions and were agreed after a financial paper was taken through the GM governance structure that showed the cost of moving to full NICE compliance Based on current activity and projected activity if NICE was implemented the paper concluded the: “The overall cost in 2015/16 across GM was £2,107,081, the potential cost if Greater Manchester adopts NICE CG168 based on NICE assumptions of increased activity with no change in	All patients should be given advice on lifestyle changes, exercise and skin care. Secondary care referral and management is commissioned for the following: **Urgent referral for bleeding** • They are bleeding from a varicosity. • They have bled from a varicosity and are at risk of bleeding again. **Severe varicose veins** Referral to a vascular service for patients with severe varicose veins – these are varicose veins that are associated with any one of the following: • They have an ulcer which is progressive and/or painful. • They have recurrence of an ulcer • They have an ulcer which has failed to respond to 12 weeks or more of active treatment or is

		□ Symptomatic * primary or recurrent varicose veins. □ Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. □ Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. □ A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). □ A healed venous leg ulcer. *Symptomatic: "Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching)." For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment 1.3 Refer people with bleeding varicose veins to a vascular service immediately 1.4 Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable. For further information, please see: 1.https://www.nice.org.uk/guidance/qs67 (NICE QUALITY STANDARD) 2.https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article	tariff would be £2,637,359 showing an increase in cost of £530,278 Implementing the new GMEUR Varicose Vein policy is expected, at worst, to be cost neutral. At best there may be a small saving associated with targeting treatments for those with moderate varicose veins to those at the highest risk of ulceration / bleeding" This does not include the investment in the infrastructure which would be needed to implement the NICE pathway of care.	deteriorating despite treatment • Progressive skin changes that have resulted in actual atrophie blanche, which is indicative of venous disease, that may benefit from surgery. **Moderate varicose veins** Patients with: • Extensive tortuous varicose veins of the whole lower limb (indicative of long saphenous insufficiency) who would be considered at high risk of bleeding due to coagulation disorders, anticoagulant and other therapies affecting clotting time and extensive superficial veins of the lower leg particularly over bony prominences at risk of bleeding from **minor** external trauma. • Single phlebitis which affects 5cm or greater length in the long saphenous vein. **NOTE:** Applications for exceptionality can be made for other cases of thrombophlebitis but these must include a balanced assessment of risk including the risk of DVT from the proposed intervention.