NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Carpal Tunnel interventions and surgery

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
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1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication https://www.aomrc.org.uk/ebi/clinicians/carpal-tunnel-syndrome-release/.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Summary of intervention

3.1 Open or endoscopic surgical procedure to release median nerve from carpal tunnel.

4. Policy statement

4.1 Interventions for correction of carpal tunnel are not routinely commissioned for mild cases with intermittent symptoms which cause little or no interference with sleep or daily activities.

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

4.2.1 Corticosteroid injection(s) into the wrist (good evidence for short term, 8-12 weeks' effectiveness)

OR

4.2.2 Night splints (not as effective as steroid injections)

4.3 Surgical treatment of carpal tunnel is routinely commissioned if either of the following criteria are met:

4.3.1 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 8 weeks

OR

4.3.2 There is either: (1) a permanent (ever-present) reduction in sensation in the median nerve distribution or (2) muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

5. Exclusions

5.1 None

6. Rationale

6.1 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.

6.2 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.

6.3 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%.

7. Underpinning evidence

7.1 Atroshi I, Flondell M, Hofer M, Ranstam J. Methylprednisolone injections for the carpal tunnel syndrome: a randomized, placebo-controlled trial. Annals of internal medicine. 2013;159(5):309-17.

7.2 Chesterton LS, Blagojevic-Bucknall M, Burton C et al. The clinical and cost- effectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (instincts trial): An open-label, parallel group, randomised controlled Lancet. 2018, 392: 1423-33.

7.3 Gerritsen AA, de Vet HC, Scholten RJ, Bertelsmann FW, de Krom MC, Bouter LM. Splinting vs surgery in the treatment of carpal tunnel syndrome: A randomized controlled JAMA. 2002, 288: 1245-51.

7.4 Korthals-de Bos IB, Gerritsen AA, van Tulder MW et al. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: Results of an economic evaluation alongside a randomized controlled trial. BMC Musculoskelet 2006, 7: 86.

7.5 Louie D , Earp B & Philip Blazar P Long-term outcomes of carpal tunnel release: a critical review of the literature HAND (2012) 7:242–246

7.6 Marshall S, Tardif G, Ashworth N. Local corticosteroid injection for carpal tunnel Cochrane Database Syst Rev. 2007(2):CD001554.

7.7 Page MJ, Massy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel Cochrane Database Syst Rev. 2012(7):CD010003.

7.8 Shi Q, MacDermid JC. Is surgical intervention more effective than non- surgical treatment for carpal tunnel syndrome? A systematic review. J Orthop Surg 2011;6:17.

7.9 Stark H, Amirfeyz R. Cochrane corner: local corticosteroid injection for carpal tunnel J Hand Surg Eur Vol. 2013;38(8):911-4.

7.10 Ryan D, Shaw, A Graham S, Mason W. Variation in CCG policies for the treatment of carpal tunnel syndrome Royal College of Surgeons, The Bulletin Volume: 99 Issue: 1, January 2017, pp. 28-31.

7.11 Verdugo RJ, Salinas RA, Castillo JL, Cea Surgical versus non-surgical treatment for carpal tunnel syndrome. Cochrane Database Syst Rev. 2008(4):CD001552.

8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

9. Coding

SQL code

```
WHEN left(der.Spell_Dominant_Procedure,4) IN ('A651','A659')
AND der.Spell_Primary_Diagnosis like '%G560%'
AND APCS.Admission_Method not like ('2%')
THEN 'M_carpal'
```

Global cancer exclusion

```
APC
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (apcs.der_diagnosis_all not like '%C[0-9][0-9]%'
AND apcs.der_diagnosis_all not like '%D0%'
AND apcs.der_diagnosis_all not like '%D3[789]%'
AND apcs.der_diagnosis_all not like '%D4[012345678]%'
OR apcs.der_diagnosis_all IS NULL)
```

10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.