NHS
Somerset
Clinical Commissioning Group

HERNIA REPAIR (ADULTS)
CRITERIA BASED ACCESS (CBA) POLICY

Version:	2021.v3
Recommendation by:	Somerset CCG Clinical Commissioning Policy Forum (CCPF)
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Target audience:	**SCCG**: • NHS Providers • GP Practices • Contracts Team **Medical Directors:** • Somerset Foundation Trust • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT
Application Form	EBI Generic application form if appropriate to apply

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VERSION CONTROL

Document Status:	Current policy
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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1516.v2	July 2017	Change CSU template to SCCG template
1516.v2a	November 18	Update SCCG template, remove SFI wording
1819.v2b	June 2020	Update template, rebranding IFR to EBI, 3 year review no clinical amendments

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	February 2016
Quality Impact Assessment QIA. Date:	March 2018
Sponsoring Director:	Sandra Cory
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1 GENERAL PRINCIPLES (CBA)

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Evidence Based Interventions Service (EBI) by submission of an EBI application form

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary care without them meeting the criteria or funding approval not secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015)

1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY CRITERIA BASED ACCESS

2.1 Hernias in Female Patients

Suspected groin hernias in female patients do not require funding authorisation for a referral to Secondary Care due to the increased risk of incarceration/strangulation

2.2 **Femoral Hernias**

Suspected groin hernias in female patients do not require funding authorisation for a referral to Secondary Care due to the increased risk of incarceration/strangulation

2.3 The Commissioner **does not commission** surgery for the following:

- The use of a **Biologic Mesh**
    - Any additional costs from the Complex Hernia Procedures PBR Tariff FZ87 – where use of a biological mesh is the sole reason for using this HRG code
- Small, asymptomatic hernias
- Minimally symptomatic hernias
- Large, wide necked hernias unless there is demonstrable evidence it is causing significant symptoms
- Groin pain, including 'athletic pubalgia' sometimes known as 'sports hernia' or 'Gilmore's groin'
- Impalpable hernias/abdominal wall weakness

2.4 **Initial management of patients with hernias:**

- Patients with BMI >35: the decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient, but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered

- Patients who smoke should be warned of clinical advice that hernia recurrence rates are 3 times higher in smokers than non-smokers. All patients who smoke should be encouraged to stop and offered information on local cessation support services

2.5 **REFERRAL TO SECONDARY CARE AND SUBSEQUENT TREATMENT MAY BE PROVIDED WHERE PATIENTS MEET THE CRITERIA BELOW:**

An annual audit may be requested to confirm patients have been treated in accordance with the criteria

2.6 **Inguinal**

a) For asymptomatic or minimally symptomatic hernias, the commissioner advocates a watchful waiting approach including providing reassurance, pain management etc. under informed consent

b) The hernia is difficult or impossible to reduce [i.e. history of incarceration or real difficulty reducing the hernia confirmed by ultrasound]

2.7 **Inguino-scrotal hernia**

a) The hernia increases in size month on month

b) Laparoscopic surgery is recommended as one of the treatment options for the repair of inguinal hernia
(NICE TA83 https://www.nice.org.uk/guidance/ta83)

c) To enable patients to choose between open and laparoscopic surgery (either by the transabdominal preperitoneal [TAPP] or by the totally extraperitoneal [TEP] procedure), they should be fully informed of all of the risks (for example, immediate serious complications, postoperative pain/numbness and long-term recurrence rates) and benefits associated with each of the three procedures. In particular, the following points should be considered in discussions between the patient and the surgeon:

d) Individual's suitability for general anaesthesia

e) Nature of the presenting hernia (that is, primary repair, recurrent hernia or bilateral hernia)

f) Suitability of the particular hernia for a laparoscopic or an open approach

g) Experience of the surgeon in the three techniques

h) Laparoscopic surgery for inguinal hernia repair by TAPP or TEP should only be performed by appropriately trained surgeons who regularly carry out the procedure

i) Appropriate conservative management has been tried first e.g. weight reduction where appropriate

2.8 **Umbilical, Epigastric or Spigelian**
Surgical treatment will only be approved when one of the following criteria is met:

a) Increase in size month on month (and surgery is clinically indicated) **OR**

b) To avoid incarceration or strangulation of bowel and/or omentum

2.9 **Incisional**
Surgical treatment will only be approved when the following criteria are met:

Appropriate conservative management has been tried first e.g. weight reduction where appropriate

2.10 **Impalpable hernia and groin pain**

a) Surgery is not commissioned in patients with groin pain, but no visible external swelling

b) Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair

c) Management of persistent groin pain that has not resolved after a period of watchful waiting should be based on individual clinical assessment. Where groin pain is severe and persistent with diagnostic uncertainty, options include referral for musculoskeletal assessment or imaging

d) Ultrasound should not be routinely requested in the early management of groin pain

2.11 **The National Commissioning Guidance recommends:**

a) A routine outpatient follow up is not required after inguinal hernia repair

b) A hernia repair should be a day case procedure (BPT target 90%)

3 BACKGROUND

3.1 A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall

3.2 In many cases, hernias cause no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin. The lump can often be pushed back in, or will disappear when you lie down. Coughing or straining may make the lump appear

3.3 Hernias can occur throughout the body, but they most often develop in the area of your body between your chest and hips. Some of the more common types of hernia are described below

- Inguinal hernias
- Femoral hernias
- Umbilical hernias
- Hiatus hernia

3.4 **Other types of hernia**

- **Incisional hernias** – these occur when tissue pokes through a surgical wound in your abdomen that has not fully healed
- **Epigastric hernias** – these occur when fatty tissue pokes through your abdomen, between your navel and the lower part of your breastbone (sternum
- **Spigelian hernias** – these occur when part of your bowel pokes through your abdomen at the side of your abdominal muscle, below your navel
- **Diaphragmatic hernias** – these occur when organs in your abdomen move into your chest through an opening in the diaphragm. This can affect babies if their diaphragm does not develop properly in

the womb, but can also affect adults

- **Muscle hernias** – these occur when part of a muscle pokes through your abdomen. They can also occur in leg muscles as the result of a sports injury

3.5 An asymptomatic inguinal hernia has been defined as an inguinal hernia without pain or discomfort for the patient, and a minimally symptomatic hernia as an inguinal hernia with complaints that do not interfere with normal daily activities

3.6 There is increasing evidence that not all asymptomatic or minimally symptomatic hernias will progress to complication or a state that will require surgical intervention, and many clinicians now agree that watchful waiting is a treatment option. In a few cases the risk of surgery may outweigh the benefit

4 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

4.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

4.2 Completion of a **Generic EBI Application Form** by a patient's GP or Consultant is required

4.3 Applications cannot be considered from patients personally

4.4 Only electronically completed EBI applications will be accepted to the EBI Service

4.5 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBI service. This will reassure the service that the patient has a reasonable expectation of the outcome of the application and its context

4.6 EBI applications are reviewed and considered against clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS England information using the link below page 9-13;
https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-indivdual-funding-requests.pdf

4.7 Social, Emotional and Environmental factors *i.e. income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application

4.8 Where appropriate photographic supporting evidence can be forwarded with

the application form

4.9 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question

- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

5 ACCESS TO POLICY

5.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

5.2 **Or write to us**: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somccg.pals@nhs.net

6 REFERENCES

The following sources have been considered when drafting this policy:

6.1 NICE TA83 https://www.nice.org.uk/guidance/ta83

6.2 NHS Choices

6.3 National Commissioning Guidance https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/hernia

6.4 Simons MP, Aufenacker T. European Hernia Society guidelines on the treatment on inguinal hernia in adult patients. Hernia 2009; 13:343-403

6.5 Fitzgibbons RJ, Giobbe-Hurder A. Watchful waiting vs. Repair of Inguinal Hernia in Minimally Symptomatic Men. JAMA 2006; 295:285292

6.6 O'Dwyer PJ, Norrie J. Observation or Operation for Patients with an Asymptomatic Inguinal hernia. Ann Surg 2006; 244:167-173