Procedures of Low Clinical Priority (Cheshire Commissioning Policy)

NHS Eastern Cheshire, NHS South Cheshire, NHS West Cheshire and NHS Vale Royal CCGs

2017/18

(First Publication Date NHS Eastern Cheshire and West Cheshire 28 April 2017
NHS South Cheshire and NHS Vale Royal CCGs 14 August 2017)

Updated August 2018
# Table of Contents

1. Introduction .................................................................................................................. 10
2. Core Clinical Eligibility .............................................................................................. 10
3. Referral & Approval Process ....................................................................................... 11
4. Exceptionality ............................................................................................................. 12
5. Psychological Distress ............................................................................................... 12
6. Personal Data (including photographs) ..................................................................... 13
7. Medicines Management ............................................................................................. 13
8. Evidence ..................................................................................................................... 14

1. Complementary Therapies ........................................................................................ 14
   Complementary Therapies ........................................................................................... 14
2. Dermatology ............................................................................................................. 15
   Skin Resurfacing Techniques ..................................................................................... 15
   Surgical or Laser Therapy Treatments for Minor Benign Skin Lesions e.g. sebaceous cyst .......................................................... 15
   Surgical Treatment for Removal of Lipoma in Secondary Care ................................ 15
   Treatments for Skin Pigment Disorders .................................................................... 16
   Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers .................................................. 16
   Secondary Care treatment for Acne Vulgaris (Mild to Moderate) ............................ 17
   PMLE (Polymorphic Light Eruption) Treatment - Desensitising Light Therapy using UVB (ultra-violet shortwave) or PUVA (Psoralen combined with UVA) .............. 17
3. Diabetes ...................................................................................................................... 18
   Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus .................................................. 18
   Monogenic Diabetes Testing ...................................................................................... 19
   Maturity Onset Diabetes of the Young (MODY) ......................................................... 19
4. ENT ............................................................................................................................. 19
   Adenoidectomy ........................................................................................................... 19
   Pinnaplasty – for Correction of Prominent Ears ......................................................... 20
   Insertion of Grommets for Glue Ear ........................................................................ 20
   Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children ........................................................... 22
Surgical Remodelling of External Ear Lobe ............................................................... 22
Use of Sinus X-ray .................................................................................................. 22
Rhinoplasty - Surgery to Reshape the Nose ........................................................... 22
Surgery of Laser Treatment of Rhinophyma ............................................................ 23
Septorhinoplasty ..................................................................................................... 23
Ear Wax removal including microsuction (excluding primary care) ....................... 24
5. Equipment .......................................................................................................... 24
Use of Lycra Suits .................................................................................................. 24
6. Fertility ............................................................................................................. 25
Infertility Treatment for Subfertility ....................................................................... 25
7. General Surgery ................................................................................................. 26
Haemorrhoidectomy - Rectal Surgery: ................................................................. 26
Removal of Haemorrhoidal Skin Tags .................................................................... 26
Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias .............. 26
Surgical correction of Diastasis of the Recti ......................................................... 26
Surgery for Asymptomatic Gallstones ................................................................... 26
Lithotripsy for Gallstones ...................................................................................... 27
Rectopexy and STARR (Stapled Transanal Resection of the Rectum) ................... 27
8. Gynaecology ...................................................................................................... 27
Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding ................ 27
Hysterectomy with or without Oophrectomy ......................................................... 27
D&C (dilatation and curettage) ............................................................................... 28
Hysteroscopy ......................................................................................................... 28
Fibroid Embolisation/uterine artery embolisation ................................................... 28
Surgical correction of vaginal/ uterovaginal prolapse ............................................ 28
Secondary Care follow up of mirena coil insertion .............................................. 29
9. Mental Health .................................................................................................... 29
Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) ....................... 29
Treatment of Gender Dysphoria .......................................................................... 30
Non-NHS Drug and Alcohol Rehabilitation ......................................................... 30
10. Neurology
- Bobath Therapy
- Trophic Electrical Stimulation for Facial/Bells Palsy
- Functional Electrical Stimulation (FES)

11. Ophthalmology
- Upper Lid Blepharoplasty - Surgery on the Upper Eyelid
- Lower Lid Blepharoplasty - Surgery on the Lower Eyelid
- Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)
- Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)
- Cataract Surgery
- Coloured (Iriens) Filters for Treatment of Dyslexia
- Intra Ocular Telescope for Advanced Age-Related Macular Degeneration
- Surgical Removal of Chalazion or Meibomian Cysts
- Surgical treatment for Proptosis/ Dysthyroid eye disease
- Photodynamic Therapy for ARMD
- Multifocal (non-accommodative) intraocular lenses

12. Oral Surgery
- Surgical Replacement of the Temporo-Mandibular Joint
- Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement

13. Paediatrics
- Cranial Banding for Positional Plagiocephaly

14. Plastic & Cosmetic Surgery
- Reduction Mammoplasty
- Augmentation Mammoplasty - Breast Enlargement
- Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation
- Mastopexy - Breast Lift
- Surgical Correction of Nipple Inversion
- Male Breast Reduction Surgery for Gynaecomastia
Hair Removal Treatments including Depilation ................................................................. 40
Laser Treatment or Electrolysis – for Hirsutism .................................................................. 40
Surgical Treatment for Pigeon Chest .................................................................................. 41
Surgical Revision of Scars ................................................................................................. 41
Laser Tattoo Removal ........................................................................................................ 41
Apronectomy or Abdominoplasty ....................................................................................... 41
Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty) ............................................................................................................ 43
Treatments to Correct Hair Loss for Alopecia .................................................................... 44
Hair Transplantation .......................................................................................................... 45
Treatments to Correct Male Pattern Baldness ..................................................................... 45
Labiaplasty, Vaginoplasty and Hymenorrhaphy ................................................................. 45
Liposuction .......................................................................................................................... 46
Rhytidectomy - Face or Brow Lift ....................................................................................... 46
All procedures undertaken on cosmetic grounds ............................................................. 47

15. Respiratory ....................................................................................................................... 47

Treatments for Snoring ...................................................................................................... 47
Soft Palate Implants and Radiofrequency Ablation of the Soft Palate ................................ 47
Sodium Tetradecyl Sulfate (STS) Injection or ‘snoreplasty’ ................................................ 47
Uvulopalatoplasty and Uvulopalatopharyngoplasty ............................................................. 47
Investigations and treatment for Sleep Apnoea ................................................................. 48
Sleep studies/ Hypersomnia ............................................................................................... 48

16. Trauma & Orthopaedics ................................................................................................. 49

Low back pain and sciatica in over 16’s ........................................................................... 49
Diagnostic, Interventions and Treatments for acute and chronic low back pain. Excluding spinal pathology, radiculopathy and children ..................................................... 49
Radiofrequency Facet Joint Denervation ......................................................................... 51
Intra Discal Electro Thermal Annuloplasty (IDET) ............................................................ 51
Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) TAMARS (technology assisted micromobilisation and reflex stimulation) ................................................................. 52
Fusion .................................................................................................................................. 52
Epidural Injection ................................................................................................................ 52
Spinal Decompression ................................................................................................................................................................. 53
Endoscopic Laser Foraminoplasty ....................................................................................................................................................... 53
Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain ............................................................................................... 53
Endoscopic Lumbar Decompression ..................................................................................................................................................... 53
Percutaneous Disc Decompression using Coblation for Lower Back Pain .............................................................................................. 53
Non-Rigid Stabilisation Techniques ...................................................................................................................................................... 53
Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine ......................................................................... 53
Percutaneous Intradiscal Laser Ablation in the Lumbar Spine .......................................................................................................................................... 53
Transaxial Interbody Lumbosacral Fusion ................................................................................................................................................... 53
Therapeutic Endoscopic Division of Epidural Adhesions .................................................................................................................................. 54
Automated Percutaneous Mechanical Lumbar Discectomy ........................................................................................................................... 54
Prosthetic Intervertebral Disc Replacement in the Lumbar Spine ........................................................................................................... 54
Bone Morphogenetic Proteins ....................................................................................................................................................................... 54
Dibotermin Alfa ........................................................................................................................................................................................ 54
Eptotermin Alpha ......................................................................................................................................................................................... 54
Surgery for Trigger Finger ............................................................................................................................................................................. 54
Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain .............................................................................................................. 55
Secondary Care Administered Steroid Joint Injections .................................................................................................................................. 56
Dupuytren’s Disease ..................................................................................................................................................................................... 56
Palmar Fasciectomy/Needle Faciotomy ......................................................................................................................................................... 56
Dupuytren’s Disease ..................................................................................................................................................................................... 56
Surgical treatment ............................................................................................................................................................................................. 56
Hip and Knee Replacement Surgery ......................................................................................................................................................... 57
&............................................................................................................................................................................................................... 57
Hip Resurfacing ............................................................................................................................................................................................ 57
Diagnostic Arthroscopy for Arthritis of the Knee ........................................................................................................................................ 58
Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee ....................................................................................................... 58
Patient Specific Unicompartmental Knee Replacement .......................................................................................................................... 58
Patient Specific Total Knee Replacement .............................................................................................................................................. 58
Surgical Treatment for Carpal Tunnel Syndrome ........................................................................................................................................ 59
Nerve Conduction Studies for Carpal Tunnel Syndrome

Surgical Removal of...

Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)

Surgical Removal of Ganglions

Hip Arthroscopy for Femoro-Acetabular Impingement

Surgical Removal of Bunions/Surgery for Lesser Toe Deformity

Surgical Treatment of Morton's Neuroma

Surgical Treatment of Plantar Fasciitis

Treatment of Tendinopathies

Extracorporeal Shock Wave Therapy

Autologous Blood or Platelet Injection

Injections for Tendonitis (Jumpers Knee)

Shoulder Arthroscopy

17. Urology

Circumcision

Penile Implant: A Surgical Procedure to Implant a Device into the Penis

Erectile Dysfunction – secondary care

Male sterilisation under general anaesthetic

Reversal of Male Sterilisation

ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome

Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome

Surgery for Prostatism

Surgical treatment for Hydroceles – adults and children

Surgical removal of benign epididymal cysts

18. Vascular

Surgery for Extreme Sweating

Hyperhydrosis – all areas

Surgical Resection Endoscopic Thoracic Sympathectomy

Chelation Therapy for Vascular Occlusions

Varicose Veins Interventional Treatments
1. Introduction
The Cheshire and Wirral CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available in Cheshire and Wirral. This document is intended to be a statement of such arrangements made by the Cheshire and Wirral CCGs and act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which Cheshire and Wirral CCGs will commission the service, either via existing contracts or on an individual basis. It gives guidance to referrers on the policies of the CCGs in relation to the commissioning of procedures of low clinical priority, thresholds for certain treatment and those procedures requiring individual approval.

In making these arrangements, the Cheshire and Wirral CCGs have had regard to relevant law and guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012 and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012; the Joint Strategic Needs Assessment; and relevant guidance issued by NHS England.

The Cheshire and Wirral CCGs have a duty to secure continuous improvement in the quality of services and patient outcomes, but are also under a duty to exercise their functions effectively, efficiently and economically. Therefore, health benefits must be maximised from the resources available. As new services become available, demand increases and procedures that give maximum health gain must be prioritised. This means that certain procedures will not be commissioned by CCGs unless exceptional clinical grounds can be demonstrated. The success of the scheme will depend upon commitment by GPs and other clinicians to restrict referrals falling outside this protocol.

The NHS Standard Contract requires that the provider must manage referrals in accordance with the terms of any Prior Approval Scheme. If the provider does not comply with the terms of any Prior Approval Scheme in providing a service, the commissioners will not be liable to pay for that service.

CCGs will not pay for activity unless it meets the criteria set out in the document or individual approval has been given and the Referral and Approval Process as set out has been followed. This prior approval scheme will be incorporated into all NHS standard NHS contracts agreed by CCGs. Compliance with this policy will be monitored via regular benchmarking reports and case note audits.

To support this approach a set of Core Clinical Eligibility Criteria have been developed and are set out below; patients may be referred in accordance with the referral process if they meet these criteria. In some limited circumstances, a ‘Procedure of Lower Clinical Priority’ (PLCP) may be the most clinically appropriate intervention for a patient. In these circumstances, agreed eligibility criteria have been established and these are explained. If the later sections of the document, if the criteria are met the procedure will be commissioned by the CCG.

2. Core Clinical Eligibility
Patients may be referred in accordance with the referral process where they meet any of the following Core Clinical Eligibility criteria:

All NICE Technology Appraisals will be implemented.

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.

Reconstructive surgery post cancer or trauma including burns.
Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on 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.

Any patient who needs urgent treatment will always be treated.

No treatment is completely ruled out if an individual patient’s circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patient’s responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.

Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

3. Referral & Approval Process

Interventions specified in this document are not commissioned unless clinical criteria are met, except in exceptional circumstances. Where clinical criteria are met treatment identified will form part of the normal contract activity.

If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a Procedure of Lower Clinical Priority, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. If in doubt over the local process, the referring clinician should contact the General Practitioner. Failure to comply with the local process may delay a decision being made. The referral letter should include specific information regarding the patient’s potential eligibility.

Diagnostic procedures to be performed with the sole purpose of determining whether or not a Procedure of Lower Clinical Priority is feasible should not be carried out unless the eligibility criteria are met or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the CCG as an exceptional case.

The referral process to secondary care will be determined by the responsible CCGs. Referrals will either:

Have received prior approval by the CCG.

OR

Clearly state how the patient meets the criteria.

OR

Be for a clinical opinion to obtain further information to assess the patient’s eligibility.

GPs should not refer unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. In cases where there may be an element of doubt the GP should discuss the case with the IFR Team in the first instance.
If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information and the CCG notified. Where a GP requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given to the GP and the patient returned to the GP’s care, in order for the GP to make a decision on future treatment.

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not, and may request additional information before seeing the patient. Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient’s notes should clearly reflect exactly how the criteria were fulfilled, to allow for case note audit to support contract management. Should the patient not meet the eligibility criteria this should be recorded in the patient’s notes and the consultant should return the referral back to the GP with a copy to the CCG, explaining why the patient is not eligible for treatment.

Should a patient not fulfil the clinical criteria but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Team for assessment contact details for the IFR team can be found in Appendix 1.

Where the treatment has changed in the middle of a care pathway and a decision to treat has been made based on the old criteria the treatment can be completed i.e. if the patient has been listed for surgery. Where a clinical decision as to the nature of treatment has not yet been made then the new criteria should be applied with immediate effect.

4. Exceptionality
In dealing with exceptional case requests for an intervention that is considered to be a poor use of NHS resources, the Cheshire & Wirral CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

The patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

The Cheshire & Wirral CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS namely, that people with equal need should be treated equally. Therefore non-clinical factors will not be considered except where this policy explicitly provides otherwise.

In essence, exceptionality is a question of equity. The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

5. Psychological Distress
Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly provides otherwise. Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as a route into aesthetic surgery.

Unless specifically stated otherwise in the policy, any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with
expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient’s psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

6. Personal Data (including photographs)
In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

Clearly label the envelope to a named individual i.e. first name & surname, and job title.

Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Information in Payment: Costs incurred for photographic evidence will be the responsibility of the referrer. Photographic evidence is often required in cases which are being considered on exceptionality. They are reviewed by clinical member/s of the IFR team only.

7. Medicines Management
Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

• Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG.
• Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication.
• Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1.
• Any drug used out with NICE Guidance (where guidance is in existence).
• Any proposed new drug/new use of an existing drug (whether covered by NICE or PbR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG.
• Any medicines that are classed by the CCG as being of limited clinical value.
• Any medicines that will be supplied via a homecare company agreement.

The Clinical Commissioning Group does not expect to provide funding for patients to continue 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.
NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.

**Conditions & Interventions:** The conditions & interventions have been broken down into speciality groups.

GPs should only refer if the patient meets the criteria set out or individual approval has been given by the CCG as set out in the CCG’s process as explained above. Requests for purely cosmetic surgery will not be considered except where this policy explicitly provides otherwise. Patients meeting the core clinical eligibility criteria set out above can be referred, all other referrals should be made in accordance with the specified criteria and referral process. The CCG may request photographic evidence to support a request for treatment.

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

Where CCGs have variations in their local clinical policies/pathways or clinical thresholds then this will be highlighted in the comments section indicating there is a local CCG addendum.

### 8. Evidence

At the time of publication the evidence presented was the most current available. Where reference is made to publications over five years old, this still represents the most up to date view.

<table>
<thead>
<tr>
<th>Treatment/Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
</tr>
</thead>
</table>
## 2. Dermatology

### 2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)

Only be commissioned in the following circumstances:

**Severe scarring following:**
- Acne once the active disease is controlled.
- Chicken pox.
- Trauma (including post-surgical).

Procedures will only be performed on the head and neck area.


Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.


Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. [www.evidence.nhs.uk](http://www.evidence.nhs.uk)

NHS England (2013)

Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

### 2.2 UPDA TED Surgical or Laser Therapy Treatments for Minor Benign Skin Lesions e.g. sebaceous cyst

Will be commissioned in any of the following circumstances:

- Symptoms causing significant functional impairment/significant ongoing pain (Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities)
- Significant facial disfigurement.
- Suspicion of cancer
- Sebaceous cyst where there has been more than one episode of infection

Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.


Uncomplicated benign skin lesions should NOT be referred.
Send suspected malignancy on appropriate pathway.

Consider if benefit outweighs risk associated with surgery.

### 2.3 Surgical Treatment for Removal of Lipoma in Secondary Care.

Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position.

Lipomas that are under 5cms should be observed only unless the above applies.

Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which...

| 2.4 | Treatments for Skin Pigment Disorders | NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross.*


Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. |
| 2.5 | Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers | Will be commissioned in any of the following circumstances:

- Severe pain substantially interfering with functional abilities.
- Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.
- Extensive warts (particularly in the immune-suppressed patient).
- Facial warts. |

| have also shown rapid growth and are painful should be referred to an appropriate skin cancer clinic. |

Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only.

Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.

*Access available for Wirral patients via Dermatology Department. |

Most viral warts will clear spontaneously or following application of topical treatments.

65% are likely to disappear spontaneously within 2 years. |


Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.


patient.co.uk/doctor/viral-warts-excluding-verrucae

http://www.patient.co.uk/doctor/verrucae |
• Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.

numerous OTC preparations available.
Community treatments such as cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.

| 2.6 NEW | Secondary Care treatment for Acne Vulgaris | Will be commissioned in any of the following circumstances:
- Patient has severe acne that is unresponsive to oral antibacterials
- Patient has moderate to severe acne that is partially unresponsive to treatment that is starting to scar
- Patients with acne who have failed two full courses of oral antibiotic treatment combined with appropriate topical treatment for a minimum of 6 months
- Patients with severe nodulo-cystic, conglobate acne
- Patients at risk of post-inflammatory hyperpigmentation
- Patients with associated and severe psychological symptoms regardless of severity of acne

Patients that do not meet this criteria should be managed in Primary Care or Intermediate Tier Dermatology service. |

https://cks.nice.org.uk/acne-vulgaris
http://www.nhs.uk/conditions/acne/pages/treatmentoptions.aspx

| 2.7 NEW | PMLE (Polymorphic Light Eruption) Treatment - Desensitising Light Therapy using UVB (ultra-violet shortwave) | Not routinely commissioned unless ALL of the following criteria are met:
- Diagnosis by Dermatology Consultant
- Severe with symptoms causing significant functional impairment (Symptoms preventing the patient

Clinical discussion with the patient should include educating patients not to use sunbeds as an

http://www.nhs.uk/conditions/polymorphic-light-eruption/Pages/Introduction.aspx
or PUVA (Psoralen combined with UVA)

- fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities
  - Symptoms remain severe despite preventative treatments
  - Light therapy deemed likely to make significant improvement to patients symptoms

3. Diabetes

3.1 Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus

Not routinely commissioned and only considered if ALL of the following criteria are met;

- Type 1 diabetes.
- AND Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151.
- AND HbA1c which is equal to or greater than 69 (8.5%) mmol/OR experiencing severe hypoglycaemic attacks which require intervention by a carer.
- AND Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value.
- AND Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum).
- AND Motivated to comply with the requirements.

The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months.

Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012.


Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805.


For further references please refer to Public Health Continuous Glucose Monitors Paper.
### 3.2 NEW

**Monogenic Diabetes Testing**

**Maturity Onset Diabetes of the Young (MODY)**

Only commissioned in the following circumstances:
- Patient has been assessed using the probability calculator with documentation of the outcome: [http://diabetesgenes.org/content/mody-probability-calculator](http://diabetesgenes.org/content/mody-probability-calculator)
- Assessment/discussion with diabetes team to whether patient would benefit from testing and test recommended
- Outcome of the test will change clinical management of the patient

[http://www.diabetesgenes.org/content/guidelines-genetic-testing-mody](http://www.diabetesgenes.org/content/guidelines-genetic-testing-mody)

[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363133/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363133/)

[http://www.bmj.com/content/343/bmj.d6044](http://www.bmj.com/content/343/bmj.d6044)

### 4. ENT

**4.1 UPDATED**

**Adenoidectomy**

Commissioned only in either of the following clinical situations.

- In Children
  For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy.
  In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 4.3

- Or

  Recurrent glue ear following removal of grommets

  Adenoidectomy is not routinely commissioned as an isolated procedure


**Tonsillectomy and Adenoidectomy in Children with Sleep Related Breathing Disorders – The Royal College of Anaesthetists - July 2010.**

Adenoidectomy for recurrent or chronic nasal symptoms in children
The Cochrane Library 2010.

Adenoidectomy for otitis media in children
The Cochrane Library 2010.

Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract)
Centre for Reviews and Dissemination 2013.

**NICE “Do not do” recommendation:**
“Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.”
4.2 UPDATA TED

Pinnaplasty – for Correction of Prominent Ears

May be commissioned in the following circumstances:

Surgical “correction” of prominent ear(s) only when all of the following criteria are met:

1. Referral only for children aged up to 18 years at the time of referral.

AND

2. With very significant ear deformity or asymmetry.

AND

3. Patients present with significant detrimental impact on child's ability to lead a normal life

Patients not meeting these criteria should not be routinely referred for surgery.

Incisionless otoplasty is not commissioned.

http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0004/98869/FullReporthta18050.pdf
Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ. Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis. Health Technology Assessment 2014;18(5)

Pinnaplasty
Department of Health (2007).

Local PCT consensus - review conducted 2007.


IPG 422: Incisionless otoplasty
NICE 2012.

http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty
Royal College of Surgeons (2013).

4.3 UPDATA TED

Insertion of Grommets for Glue Ear (otitis media with effusion)

CHILDERN
The CCG will commission treatment with grommets/myringotomy for children with otitis media with effusion (OME) where:

There is a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year.

OR

There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon).

AND

http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome
Royal College of Surgeons (2013).

NICE Pathway – Surgical management of Otitis Media with effusion in children (2012).

CG60 Surgical management of children with otitis media with effusion (OME)
(February 2008).

The advice in the NICE guideline covers:
• The surgical management of OME in children younger than 12
• OME persists after three months.

AND

• The child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse confirmed over 3 months.

OR

Persistent bilateral OME with hearing loss less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child’s developmental, social or educational status.

Children with Downs Syndrome are normally fitted with Hearing Aids.

Management of children with cleft palate is under specialist supervision.

Do not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 5.1 Adenoidectomy.

ADULTS

Grommets in adults with OME will be funded only in the following circumstances:

Persistent bilateral OME with hearing loss Less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant symptoms preventing the patient fulfilling vital work or educational responsibilities or preventing the patient carrying out vital domestic or carer activities.

OR

Evidence of retracted ear drum

OR

• Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.

years.

• Guidance for managing OME in children with Down’s syndrome and in children with all types of cleft palate.

It does not specifically look at the management of OME in:

• Children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease).
• Children with multiple complex needs.

Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children - Cochrane Ear, Nose and Throat Disorders Group 2010.


<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Commissioning Criteria</th>
<th>Additional Information</th>
</tr>
</thead>
</table>
| 4.4     | Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children | Tonsillectomy will only be commissioned where:  
- Seven or more well documented clinically significant adequately treated episodes of tonsillitis in the preceding year;  
- OR  
- Five or more such episodes in each of the previous two years;  
- OR  
- Three or more such episodes in each of the preceding three years.  
Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis - Cochrane Ear, Nose and Throat Disorders Group (2008).  
Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009.  
[http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy) - Royal College of Surgeons (2013) |
<p>| 4.5     | Surgical Remodelling of External Ear Lobe | This is not routinely commissioned. | Modernisation Agency’s Action on Plastic Surgery 2005. |
| 4.6     | Use of Sinus X-ray | X-rays of sinuses are not routinely commissioned. | Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. |
| 4.7     | Rhinoplasty - Surgery to Reshape the Nose | This procedure is NOT available under the NHS on cosmetic grounds. | Patients with isolated airway problems (in the |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Procedure</th>
<th>Commissioning Criteria</th>
<th>Further Reading</th>
</tr>
</thead>
</table>
| 4.10 NEW | Ear Wax removal including microsuction (excluding primary care) | Not routinely commissioned unless the following exceptions apply:  
- Perforated ear drum OR  
- Otitis Externa OR  
- Hearing loss and all other methods of wax removal have been tried and failed OR  
- Enable inspection of ear drum due to clinical concern of other pathologies and other methods of wax removal have failed OR  
- Clinical risk of other methods of removal | http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907972/ | Ear wax removal should be managed in primary care and does not require onward referral. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 5.1 Use of Lycra Suits | Lycra Suits are not normally commissioned for postural management of cerebral palsy.  
Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. | What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy?  
Health Improvement Scotland, May 2013.  
For further references please refer to Public Health Lycra Suits Paper. | Any application for exceptional funding should include a comprehensive assessment of the child’s postural management needs with clear outcome goals and time frames.  
Public Health Recommendation:  
Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.  
Lycra suit orthoses for cerebral palsy should be assigned low priority. |
| 6.1 UPDA TED | Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation | See Infertility Treatment for Subfertility Policy for Cheshire CCGs. | CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013.
| 7.1 | Haemorrhoidectomy - Rectal Surgery: Removal of Haemorrhoidal Skin Tags | Surgery commissioned for symptomatic:  
- Grade III and IV haemorrhoids.  
- Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:-  
  - Diet modification to relieve constipation.  
  - Topical applications.  
  - Stool softeners and laxatives.  
  - Rubber band ligation.  
  - Sclerosant injections.  
  - Infrared coagulation.  
  - Surgical treatment options include:-  
  - Stapled excision (haemorrhoidectomy).  
  - Stapled haemorrhoidopexy.  
  - Haemorrhoidal artery ligation.  

Removal of skin tags is not routinely commissioned. | Haemorrhoidal artery ligation  
NICE 2010.  
TAG128: Stapled haemorrhoidopexy for the treatment of haemorrhoids  
NICE 2007.  
Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008.  
Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US.  
Management of haemorrhoids  
Haemorrhoids  
NICE Clinical Knowledge Summaries 2012  
http://cks.nice.org.uk/#azTab  
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding  
Royal College of Surgeons (2013). | There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure.  
Short term efficacy and cost effectiveness is similar. |

| 7.2 | Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias  
Surgical correction of Diastasis of the Recti | Surgery: not commissioned if no symptoms, easily reducible (i.e. can be ‘pushed back in’) and not at significant risk of complications.  
Surgical repair is not routinely commissioned. | A systematic review on the outcomes of correction of diastasis of the recti  
Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al. | Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect. |

| 7.3 | Surgery for Asymptomatic Gallstones | This procedure is not routinely commissioned. | http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones  
Royal College of Surgeons (2013). | This procedure is considered a Low clinical priority for asymptomatic gallstones. |
| 7.4 | Lithotripsy for Gallstones | Lithotripsy not routinely commissioned. | Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for unrelated reasons. | Lithotripsy rarely performed as rate recurrence high. |
| 7.5 | Rectopexy and STARR (Stapled Transanal Resection of the Rectum) | Only be commissioned if patient meets the threshold below:  
- case has been discussed by MDT with agreement that this is best option for patient  
- conservative management has been tried and failed - This includes a selection of the following appropriate for the individual: dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback.  
- patient has faecal incontinence or obstructed defecation syndrome  
- symptoms cause significant functional impairment defined by the BNSSG Health Community as: - Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities. | [Link to Rectopexy and STARR policy](https://www.bristolccg.nhs.uk/media/medialibrary/2016/09/rectopexy_and_STARR_policy_.pdf) | [Link to Patient Information on Rectal Prolapse](http://patient.info/doctor/rectal-prolapse) |

### 8. Gynaecology

| 8.1 | UPDA TED | Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding  
Hysterectomy with or without Oophrectomy | Hysterectomy not commissioned unless all of the following requirements have been met:  
- An unsuccessful trial (defined as no improvement) with a levonorgestrel intrauterine system (e.g. Mirena) for 6 months or more unless medically contra-indicated or the woman has made an informed choice not to use this treatment. | CG44 Heavy menstrual bleeding: full guideline NICE 2007.  
QS47 Heavy Menstrual Bleeding NICE 2013. |
The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance.

- Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives
- A suitable course of progestagen
- Endometrial ablation has been tried (unless patient has fibroids >3cm)

| 8.2 | D&C (dilatation and curettage) | Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure. |
| 8.3 NEW | Hysteroscopy | Hysteroscopy is only commissioned as a second line option once all appropriate investigations have been undertaken including physical pelvic examination and endometrial pipelle biopsy |
| 8.4 NEW | Fibroid Embolisation/uterine artery embolisation | This procedure is only commissioned in line with current NICE guidance [https://www.nice.org.uk/guidance/IPG367/chapter/1-guidance](https://www.nice.org.uk/guidance/IPG367/chapter/1-guidance) |
| 8.5 NEW | Surgical correction of vaginal/ uterovaginal prolapse | This will only be commissioned if:  
  - symptomatic prolapse (causing significant pressure and discomfort to affect activities of daily living) or  
  - Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence (significantly affecting urinary, bowel function or sexual function)  
  - Key outcomes of intervention should be restoration of bladder, bowel and sexual function and long-term success  
  - AND  
  - Evidence that for mild-to-moderate prolapse conservative management has been trialed and failed including; lifestyle modification, pelvic floor exercises, electrical stimulation, biofeedback, vaginal pessary, local oestrogen creams and oral treatments unless contraindicated. For [http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx](http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx) |
severe prolapse consider non-surgical treatments first, after assessing likely impact (positive and negative) on the key outcomes. AND

- If prolapse is severe or is mild-to-moderate but symptoms cause significant functional impairment (Symptoms significantly affecting the patient fulfilling activities of daily living vital work or educational responsibilities – including symptoms significantly affecting the patient carrying out vital domestic or carer activities)

| 8.6 NEW | Secondary Care follow up of mirena coil insertion | Secondary care checking mirena coil insertion is not routinely commissioned. |

9. **Mental Health**

9.1 **Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)**

Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned.

If inpatient treatment is recommended an IFR referral will be required.


Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.

NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on
<table>
<thead>
<tr>
<th>Section</th>
<th>Topic</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>Treatment of Gender Dysphoria</td>
<td>Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at Charing Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non-core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.</td>
<td>NHS England interim protocol (2013). Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities. Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. Where the provision of “non-core surgery” is appropriate the GIC should apply for treatment funding through the CCG. Liverpool, Sefton and Knowsley have a local support service in place at LCH.</td>
</tr>
</tbody>
</table>


### 10.3 Functional Electrical Stimulation (FES)

Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury.

It is not routinely commissioned for lower motor neurone lesions.

It is under review by NICE for dysphagia and muscle recovery chronic disease.

Patients must have receptive cognitive abilities.

**Exclusion Criteria:**
- Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin.
- Chronic oedema at site of stimulation.
- Diagnosis of deep vein thrombosis.
- Receptive dysphasia (unable to understand instructions).
- Complete peripheral nerve damage.
- Pacemaker in situ.
- Pregnancy or intention to become pregnant.
- Active cancer.
- Uncontrolled epilepsy.
- Metal in region of stimulation e.g.: pin and plate.
- Ataxic and polio patients are generally poor responders although there are exceptions.

**References:**

### 11. Ophthalmology

#### 11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid

Only commissioned in the following circumstances:

- Eyelid function interferes with visual field.

**References:**
- Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base. London Health Observatory 2010.

**Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.**

**Hooded lids causing significant functional impaired vision confirmed by an appropriate**
specialist can warrant surgical treatment.
Impairment to visual field to be documented.

Excessive skin in the lower lid may cause “eye bags” but does not affect function of the eyelid or vision and therefore does not need correction.

### 11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.

- Only commissioned in any of the following circumstances:
  1. Correction of ectropion or entropion which threatens the health of the affected eye.
  2. Removal of lesions of eyelid skin or lid margin.
  3. Rehabilitative surgery for patients with thyroid eye disease.

**Eyelid Surgery**
- The British Association of Aesthetic Plastic Surgeons 2011.
- Local PCT consensus – review conducted 2007.
- Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.

### 11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)

- Only commissioned for:
  - Larger lesions which satisfy all of the following:
    1. Not responded to treatment for underlying familial lipoprotein lipase deficiency.
    3. Causing significant disfigurement.
  - Topical treatments may be available in a primary care or community setting.

**Local PCT consensus – review conducted 2007.**
- DermNet NZ information resources updated Jan 2013.
- http://www.patient.co.uk/doctor/xanthelasma

The following treatments should be considered for patients with xanthelasma:
- Topical trichloroacetic acid (TCA) or cryotherapy.

Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.

Lesions are harmless.

### 11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness

- Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned.
<table>
<thead>
<tr>
<th>Section</th>
<th>Reference</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.6</td>
<td>Coloured (irlens) Filters for Treatment of Dyslexia</td>
<td>There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence. Coloured filters for reading disability: A systematic review WMHTAC 2008</td>
</tr>
<tr>
<td>11.7</td>
<td>Intra Ocular Telescope for Advanced Age-Related Macular Degeneration</td>
<td>This is not routinely commissioned as there is limited published evidence of effectiveness. Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012).</td>
</tr>
<tr>
<td>11.8</td>
<td>Surgical Removal of Chalazion or Meibomian Cysts</td>
<td>Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND • Causes blurring or interference with vision. OR Guidance for the management of referrals for Meibomian Cysts NHS Cornwall &amp; Isles of Scilly Devon, Plymouth and Torbay (January 2013). <a href="http://www.kernowccg.nhs.uk/media/136633/chalazion_meibomian_cyst_guidance_16.01.2013.pdf">http://www.kernowccg.nhs.uk/media/136633/chalazion_meibomian_cyst_guidance_16.01.2013.pdf</a> NHS Cornwall &amp; Isles of Scilly, Devon, Plymouth and Torbay Individual CCG addendums apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk.</td>
</tr>
</tbody>
</table>
| 11.9 NEW | Surgical treatment for Proptosis/ Dysthyroid eye disease | Only commissioned if:  
• condition caused by thyroid disease  
• artificial tears have been tried for at least 6 months and failed |
|   |   | http://patient.info/doctor/thyroid-eye-disease-pro |
| 11.10 NEW | Photodynamic Therapy for ARMD | Photodynamic Therapy for ARMD is not routinely commissioned. |
| 11.11 NEW | Multifocal (non-accommodative) intraocular lenses | Multifocal (non-accommodative) intraocular lenses are not routinely commissioned. |

**12. Oral Surgery**

**12.1 Surgical Replacement of the Temporo-Mandibular Joint**

Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement

Only commissioned in the following circumstances:

• Any or a combination of the following symptoms are present:
  o Restricted mouth opening <35mm).
  o Dietary score of< 5/10 (liquid scores 0, full diet scores 10).
  o Occlusal collapse (anterior open bite or retrusion).
  o Excessive condylar resorption and loss of height of vertical ramus.
  o Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms).
  o Other significant quality of life issues.

AND

• Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve

Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.

*TMJ Replacement Guidance.pdf*

Total prosthetic replacement of the Temporomandibular joint (IPG329)  
NICE 2009

http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes
### 13. **Paediatrics**


### 14. **Plastic & Cosmetic Surgery**


| 14.2 UPDA TED | Augmentation Mammoplasty - Breast Enlargement | This procedure is not routinely commissioned. The following exceptions apply:  
In all cases:  
• The BMI is <25 and stable for at least twelve months.  
AND  
• Congenital absence i.e. no obvious breast tissue.  
In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.  
Patients requiring reconstructive surgery post cancer treatment are excluded from this policy.  
All non-surgical options must have been explored e.g. padded bra. | Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800  
Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.  
NHS England (2013). | Patients should be made aware that:  
1 in 5 implants need replacing within 10 years regardless of make.  
Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.  
Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. |
<table>
<thead>
<tr>
<th>14.3</th>
<th>Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention.</td>
<td></td>
</tr>
<tr>
<td>If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.</td>
<td></td>
</tr>
<tr>
<td>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
<td></td>
</tr>
<tr>
<td>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</td>
<td></td>
</tr>
<tr>
<td>Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</td>
<td></td>
</tr>
<tr>
<td>Poly Implant Prothése (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).</td>
<td></td>
</tr>
<tr>
<td>Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
<td></td>
</tr>
<tr>
<td>Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.</td>
<td></td>
</tr>
<tr>
<td>1 in 5 implants need replacing within 10 years regardless of make.</td>
<td></td>
</tr>
<tr>
<td>Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.</td>
<td></td>
</tr>
<tr>
<td>Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.</td>
<td></td>
</tr>
<tr>
<td>14.4</td>
<td>Mastopexy - Breast Lift</td>
</tr>
<tr>
<td>Not routinely commissioned.</td>
<td></td>
</tr>
<tr>
<td>May be considered as part of other breast surgery to achieve an appropriate cosmetic outcome.</td>
<td></td>
</tr>
<tr>
<td>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</td>
<td></td>
</tr>
<tr>
<td>14.5</td>
<td>Surgical Correction of Nipple Inversion</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
</tr>
<tr>
<td>14.6</td>
<td>Male Breast Reduction Surgery for Gynaecomastia</td>
</tr>
<tr>
<td></td>
<td>The following exception will apply:</td>
</tr>
<tr>
<td></td>
<td>• gynaecomastia caused by cancer treatment</td>
</tr>
<tr>
<td></td>
<td>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</td>
</tr>
<tr>
<td></td>
<td>Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
</tr>
<tr>
<td></td>
<td>Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule.</td>
</tr>
<tr>
<td></td>
<td>This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months.</td>
</tr>
</tbody>
</table>
| 14.7 UPDA TED | Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism | Not routinely commissioned. Except in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances not routinely commissioned. Will be considered via Individual Funding Request if all of the following clinical circumstances are met:  
- Abnormally located hair-bearing skin following reconstructive surgery located on face and neck.  
- There is an existing endocrine medical condition and severe facial hirsutism.  
1. Ferryman Gallwey *(A method of evaluating and quantifying hirsutism in women)* Score 3 or more per area to be treated.  
2. Medical treatments have been tried for at least one year and failed.  
3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight.  
All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist).  
Photographs will also be required to allow the CCG’s to visibly assess the severity equitably.  
cks.nice.org.uk/hirsutism#scenario - NICE: Clinical Knowledge Summaries 2010.  
Laser and photoepilation for unwanted hair growth – Cochrane Library 2009.  
Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service | The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre. |
## 14.8 Surgical Treatment for Pigeon Chest

This procedure is not routinely commissioned by the NHS on cosmetic grounds.

**Reference:**

nice.org.uk/guidance/IPG310

**NICE (2009).**

## 14.9 Surgical Revision of Scars

Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.

**Reference:**


## 14.10 Laser Tattoo Removal

Only commissioned in any of the following circumstances:
- Tattoo is result of trauma inflicted against the patient’s will.
- The patient was a child and not responsible for his/her actions at the time of tattooing.
- Inflicted under duress.
- During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function).

**Reference:**

Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.


## 14.11 UPDAP TED

Apronecctomy or Abdominoplasty (Tummy Tuck)

Not routinely commissioned other than if required prior to life saving surgery or if all of the following criteria are met:
- Patient is aged 18 years or above
- The flap hangs at or below the level of the

**Reference:**

Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.


Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced.
symphysis pubis.

Patients BMI is <25 and stable for at least 24 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).

Or

Patient has lost 50% of their original body weight and maintained weight loss for 24 months.

Bariatric surgery (if performed) was performed at least 3 years previously.

AND any of the following:

Causes significant problems with activities of daily life (e.g. ambulatory restrictions).

Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.

Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made).

IFR information **must** contain the following information:-

- Date of bariatric surgery (where relevant).
- Pre-operative or original weight and BMI with dates.
- Series of weight and BMI readings demonstrating weight loss and stability achieved.
- Date stable weight and BMI achieved.


Poor level of evidence of positive outcomes.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14.12 Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)</td>
<td>Current weight/BMI.  Patient compliance with continuing nutritional supervision and management (if applicable).  Details of functional problems.  Details of associated medical problems.</td>
</tr>
<tr>
<td></td>
<td>Not routinely commissioned.  If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered.  Patients BMI is &lt;25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).  Bariatric surgery (if performed) was performed at least 3 years previously.  AND any of the following:  Causes significant problems with activities of daily life (e.g. ambulatory restrictions).  Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.  IFR information must contain the following information;  • Date of bariatric surgery (where relevant).  • Pre-operative or original weight and BMI with dates.  • Series of weight and BMI readings demonstrating weight loss and stability achieved.  • Date stable weight and BMI achieved.</td>
</tr>
<tr>
<td></td>
<td>The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is less likely to be indicated except for appearance. Therefore it will not be available on the NHS.</td>
</tr>
</tbody>
</table>
| 14.13 | Treatments to Correct Hair Loss for Alopecia | Only commissioned in either of the following circumstances:
- Result of previous surgery.
- Result of trauma, including burns.

Hair Intralace System is not commissioned.
Dermatography is not commissioned.
NHS wigs will be available according to NHS policy. | British Association of Dermatologists’ guidelines for the management of alopecia areata 2012
Interventions for alopecia areata – Cochrane Library 2008.


Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment.

No evidence of effective treatments for alopecia – Cochrane Pearls 2008.


Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding).

<p>| 14.15 | Treatments to Correct Male Pattern Baldness | This is not routinely commissioned. | Modernisation Agency’s Action on Plastic Surgery 2005. |
| 14.17 Liposuction | Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophies or non-exciscable clinically significant lipomata. An individual funding request will be required. Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. | Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6). <a href="http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20final%20Position%20Statement.pdf">http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20final%20Position%20Statement.pdf</a> |
| 14.18 UPDA TED Rhytidectomy - Face or Brow Lift | This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: Congenital facial abnormalities causing significant functional impairment or impairment of normal emotional development i.e. symptoms preventing patient fulfilling routine work/ educational responsibilities or domestic/carer responsibilities. Facial palsy. | Modernisation Agency’s Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Changes to the face and brow result due to normal ageing; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function. |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.19</td>
<td>NEW</td>
<td><strong>All procedures undertaken on cosmetic grounds</strong>&lt;br&gt;This is not routinely commissioned. The following exclusions apply:&lt;br&gt;• Procedure related to cancer treatment&lt;br&gt;• Burns/accident victim&lt;br&gt;• Severe birth defects&lt;br&gt;<a href="http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/is-cosmetic-surgery-available-on-the-NHS.aspx">http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/is-cosmetic-surgery-available-on-the-NHS.aspx</a></td>
</tr>
</tbody>
</table>

### 15. Respiratory

**15.1 Treatments for Snoring**<br>Soft Palate Implants and Radiofrequency Ablation of the Soft Palate<br>Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty'<br>Uvulopalatoplasty and Uvulopalatopharyngoplasty<br>Not routinely Commissioned.<br>Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007).<br>Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005).<br>Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003).<br>Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005).<br>Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs – Health Technology Assessment (2009).<br>Effects and side-effects of surgery for snoring and obstructive sleep apnoea NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on
### 15.2 Treatment for Sleep Apnoea

Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as ‘Snoreplasty’ is not well recognised in the UK as an effective method of treating snoring.

The British Snoring & Sleep Apnoea Association do not recommend or support this method of treatment. UPPP may compromise the patient’s subsequent ability to use nasal CPAP.

### 15.3 Sleep Studies/Hypersomnia

Sleep studies are only commissioned if any of the following are suspected:  
- Excessive daytime sleepiness affecting work/social activities/driving and Epworth score of ≥11 or patients with a score <11 if deemed high risk/clinically exceptional e.g. neurological condition OR
- Weight management advice/referral has been given if BMI above 30

Sleep studies are only commissioned if any of the following apply:
- Suspected sleep apnoea (see above)
<table>
<thead>
<tr>
<th>16. Trauma &amp; Orthopaedics</th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 16.1 UPDATED | Low back pain and sciatica in over 16's Diagnostic, Interventions and Treatments for acute and chronic low back pain. Excluding spinal pathology, radiculopathy and children. | Diagnostic imaging should not be routinely offered unless:  
- in a specialist setting where the results are likely to change clinical management  
OR  
- Diagnostic imaging is required prior to referral for surgical intervention  
Management should be in line with NICE Guidance and should consist of advice and information to enable self-management. Patients should be encouraged to continue with normal activities. Structured exercise programmes (including group exercise), psychological therapies and manual therapy should be considered. Manual therapy should only be offered as part of a treatment package, including exercise with or without psychological therapy.  
The following treatments **should not** be offered for low back pain and sciatica:  
- Spinal Injections – injections of therapeutic substances into the back  
- Orthotics such as belts/corsets, foot orthotics, rocker sole shoes  
- Lumbar support  
- Traction | [https://www.nice.org.uk/guidance/NG59](https://www.nice.org.uk/guidance/NG59) | Amendments made based on version developed by Lancashire & Midlands CSU in collaboration with the Walton Centre |
<table>
<thead>
<tr>
<th>Pharmacological Intervention for sciatica (neuropathic pain in adults)</th>
</tr>
</thead>
</table>
| - Acupuncture  
- Ultrasound  
- Percutaneous electrical nerve simulation (PENS)  
- Transcutaneous electrical nerve stimulation (TENS)  
- Interferential therapy  
- Laser therapy  
- Therapeutic ultrasound  |

Consider oral non-steroidal anti-inflammatory drugs (NSAIDS) at lowest effective dose for shortest possible time. If NSAIDS are contraindicated/ not tolerated or ineffective, consider weak opioids.

**Do not** offer:
- Paracetamol alone  
- Opioids for acute low back pain (unless NSAIDs are contraindicated)  
- Opioids for chronic low back pain  
- Selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine, reuptake inhibitors or  
- tricyclic antidepressants  
- Anticonvulsants  

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia). If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.  
- Consider tramadol only if acute rescue therapy is needed (see NICE Guidance CG173 for long term use).
• Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:
• cannabis sativa extract
• capsaicin patch
• lacosamide
• lamotrigine
• levetiracetam
• morphine
• oxcarbazepine
• topiramate
• tramadol (this is referring to long-term use)
• venlafaxine

16.2 Updated August 2017

Radiofrequency Facet Joint Denervation

Treatments for low back pain will only be commissioned in line with NICE guidance NG59 'Low back pain and sciatica in over 16s: assessment and management' (November 2016).

The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when:
• comprehensive conservative treatment approach has not worked for them
  AND
• the main source of pain is thought to come from structures supplied by the medial branch nerve
  AND
• The clinical presentation is consistent with symptoms arising from the facet joint:
  o Increased pain unilaterally or bilaterally on lumbar paraspinal

https://www.nice.org.uk/guidance/NG59

IPG 319: Percutaneous intradiscal electrothermal therapy for low back pain

Clinical Guidance and Policy Statement being reviewed/updated during Quarter 1 2017-18
palpation
  - Increased back pain on 1 or more of the following:
    - Extension (more than flexion); rotation; extension/side flexion; extension/rotation
  - No radicular symptoms
  - No sacroiliac joint pain elicited using a provocation test

  **AND**
  - They have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral
  - Low back pain is chronic in nature
  - The patient has significant short term pain relief to a diagnostic medial branch block.

Do not offer imaging for people with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation.

Providers who offer radiofrequency denervation will be expected to submit patient outcome data to the UK National Spinal RF Registry

http://cl1.n3-dendrite.com/csp/spinalrf/FrontPages/index.html

---

<table>
<thead>
<tr>
<th>16.3 UPDA TED</th>
<th>Fusion</th>
<th>This procedure is NOT routinely commissioned however there are clinical exceptions to this. Please see appendix 4.</th>
<th><a href="http://www.ukssb.com/assets/PDFs/2017/May/National-Low-Back-and-Radicular-Pain-Pathway-May-2017_final.pdf">http://www.ukssb.com/assets/PDFs/2017/May/National-Low-Back-and-Radicular-Pain-Pathway-May-2017_final.pdf</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amendments made based on supplementary information to support NICE Guidance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.4 UPDA</td>
<td>Epidural Injection</td>
<td>Do not use epidural for neurogenic claudication in people who have central spinal canal stenosis</td>
<td><a href="http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_v">http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_v</a> is7%2030.01.13.pdf</td>
</tr>
<tr>
<td>TED</td>
<td>Consider a single epidural injection or single trans foraminal nerve root injection of local anaesthetic and steroid as appropriate in people with acute and severe sciatica. 'Non Specific Back Pain – Not routinely commissioned'.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.5 NEW</td>
<td>Spinal Decompression</td>
<td>Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.</td>
<td></td>
</tr>
<tr>
<td>16.7</td>
<td>Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain</td>
<td>This procedure is NOT routinely commissioned. IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.</td>
<td></td>
</tr>
<tr>
<td>16.8</td>
<td>Endoscopic Lumbar Decompression</td>
<td>This procedure is NOT routinely commissioned. IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009</td>
<td></td>
</tr>
<tr>
<td>16.9</td>
<td>Percutaneous Disc Decompression using Coblation for Lower Back Pain</td>
<td>This procedure is NOT routinely commissioned. IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006</td>
<td></td>
</tr>
<tr>
<td>16.10</td>
<td>Non-Rigid Stabilisation Techniques</td>
<td>This procedure is NOT routinely commissioned. IPG 366: Non-rigid stabilisation techniques NICE 2010</td>
<td></td>
</tr>
<tr>
<td>16.11</td>
<td>Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine</td>
<td>This procedure is NOT routinely commissioned however there are clinical exceptions to this. Please see appendix 4. <a href="http://www.ukssb.com/assets/PDFs/2017/May/National-Low-Back-and-Radicular-Pain-Pathway-May-2017_final.pdf">http://www.ukssb.com/assets/PDFs/2017/May/National-Low-Back-and-Radicular-Pain-Pathway-May-2017_final.pdf</a> Amendments made based on supplementary information to support NICE Guidance</td>
<td></td>
</tr>
<tr>
<td>16.12</td>
<td>Percutaneous Intradiscal Laser Ablation in the Lumbar Spine</td>
<td>This procedure is NOT routinely commissioned. IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.</td>
<td></td>
</tr>
<tr>
<td>16.13</td>
<td>Transaxial Interbody Lumbosacral Fusion</td>
<td>This procedure is NOT routinely commissioned. IPG 387: Transaxial interbody lumbosacral fusion NICE 2011.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procedure Description</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>16.14</td>
<td>Therapeutic Endoscopic Division of Epidural Adhesions</td>
<td>This procedure is NOT routinely commissioned. IPG 333: Therapeutic endoscopic division of epidural adhesions. NICE 2010.</td>
<td></td>
</tr>
<tr>
<td>16.15</td>
<td>Automated Percutaneous Mechanical Lumbar Discectomy</td>
<td>This procedure is NOT routinely commissioned. IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.</td>
<td></td>
</tr>
</tbody>
</table>
https://www.nice.org.uk/savingsAndProductivityAndLocalPractice
Resource?ci=http%3a%2f%2fsearch.nice.org.uk%2fusingguidanc
e%2fdonotdorecommendations%2fdefault.jsp%3faction%3ddetails
%26dndid%3d961 |
| 16.20 | Secondary Care Administered Steroid Joint Injections | Provision of joint injections in line with commissioning policy for pain should ONLY be undertaken in primary care setting unless:  
- Ultrasound guidance is needed or as part of another procedure being undertaken in theatre (which may include use of image intensifier x-ray guidance)  
- Alternative guidance has been provided elsewhere in the policy e.g. Section 16.1, 16.2, 16.4 and 16.19. | Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012. |
| 16.21 | Dupuytren’s Disease Palmar Fasciectomy/Needle Fasciotomy Radiotherapy Collagenase Injections for Dupuytren’s Disease | Not routinely commissioned. | IPG043 Needle fasciotomy for Dupuyren’s contracture - guidance  
Dupuytrens disease  
NICE Clinical Knowledge Summaries (2010).  
British society hand surgeons  
New guidelines awaited.  
NHS North West London commissioning policy – Dupuytren’s Disease  
April 2013.  
Common Hand Conditions  
| 16.22 | Dupuytren’s Disease Surgical treatment | Not routinely commissioned. Only commissioned in the following circumstances:  
- Metacarpophalangeal joint and/or proximal IP joint contracture of 30 +  
- Young person with early onset disease without family history, clinical assessment demonstrates they will benefit from surgery  
AND  
- Severely impacting daily living and functional limitation | IPG368: Radiation therapy for early Dupuytren's disease  
NICE 2010. |
<p>| 16.23 | Dupuytrens | Not routinely commissioned. |  |</p>
<table>
<thead>
<tr>
<th>NEW</th>
<th>Contracture – conservative treatment</th>
<th>Note, the term conservative refers to interventions such as injections. Primary care management such as stretching exercises are not included</th>
</tr>
</thead>
</table>
| **16.24** Hip and Knee Replacement Surgery & Hip Resurfacing | Referral is based on local referral pathways. **Funding for total or partial knee replacement surgery is available if the following criteria are met**
1. Patients with BMI <40. **AND**
2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. **AND**
3. Has radiological features of severe disease. **OR**
4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.

**Referral criteria for Total Hip Replacements (THR) should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria;**
1. Patient complains of severe joint pain. **AND**
2. Functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. **OR**
3. Patient complains of mild to moderate joint pain.

| [Clinical thresholds knee replacement](http://www.nice.org.uk/guidance/ta304) York & Humber Health Intelligence (2011). |
| Relevant NICE Guidance (TA44) as referred to above | Local Addendums apply in relation to referral criteria/pathways in individual CCGs |
pam AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).

| 16.25 | Diagnostic Arthroscopy for Arthritis of the Knee | Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate. However it is not routinely commissioned for any of the following indications:  
- Investigation of knee pain.  
- Treatment of Osteo-Arthritis including Arthroscopic washout.  
- If there is diagnostic uncertainty despite a competent examination or if there are “red flag” symptoms then a Magnetic resonance imaging (MRI) scan may be indicated.  
If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered. | CG59 Osteoarthritis. Section 3.1  
NICE 2008  
Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis  
NICE 2007.  
Knee replacement: A guide to good practice  
Commissioning Guide: Painful osteoarthritis of the knee  
Royal College of Surgeons (2013).  
http://guidance.nice.org.uk/CG177  
CG177Osteoarthritis (NICE 2014) |
| 16.26 | Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee | Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies). |  |
| 16.27 | Patient Specific Unicompartmental Knee Replacement | This is not commissioned. |  
IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance  
NICE, 2009 |
| 16.28 | Patient Specific Total | This is not commissioned. |  
EMERGING TECHNOLOGY Total Knee Replacement Using |
<table>
<thead>
<tr>
<th>UPDATA TED</th>
<th>Patient-specific Templates</th>
<th>Mild cases often resolve spontaneously after 6 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.29</td>
<td>IPG 345: Mini-incision surgery for total knee replacement</td>
<td>Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases.</td>
</tr>
<tr>
<td></td>
<td>NICE 2010</td>
<td>Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients have not responded to 6 months of conservative treatments, including:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Night-time use of wrist splints.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Analgesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Corticosteroid injection in appropriate patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conservative treatments contraindicated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe cases:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following treatments are not commissioned for carpal tunnel syndrome:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diuretics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NSAIDS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vitamin B6.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Activity modification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Heat treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Botulinum toxin.</td>
</tr>
<tr>
<td></td>
<td>16.30</td>
<td>Nerve Conduction Studies for Carpal Tunnel Syndrome</td>
</tr>
</tbody>
</table>
| 16.31 | Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) | Only commissioned for mucoid cysts under the following circumstance:  
Failure of conservative treatments including watchful waiting.  
AND any of the following:  
• Nail growth disturbed.  
• Discharging, ulcerated or infected.  
• Size interferes with normal hand function. | Digital Mucous Cyst  
Overview of condition – Medscape. |
| 16.33 | Hip Arthroscopy for Femoro–Acetabular Impingement | CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria:  
A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.  
An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.  
The patient has had severe FAI symptoms (restriction of movement, pain and ‘clicking’) or significantly compromised functioning for at least 6 months.  
The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy. | IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011.  
NHS Hull Clinical Commissioning Group 2012.  
Commissioning Guide: Painful osteoarthritis of the hip  
Royal College of Surgeons (2013).  
IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance  
NICE, 2011 | Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term.  
With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes. |
| 16.34 | Surgical Removal of Bunions | Requests for the removal of bunions will only be | Buenos |
### Bunions/Surgery for Lesser Toe Deformity

Considered where:

- Conservative methods of management* have failed.
- AND
- The patient suffers significant functional impairment** as a result of the bunions.
- AND
- Radiographic evidence of joint damage (at point of referral).
- AND
- Severe deformity

*Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate.

**Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.

Treatment will not be commissioned for cosmetic appearance only.

---

### Surgical Treatment of Morton’s Neuroma

Surgical treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway:

- The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal

---

### Additional Resources

- NICE Clinical Knowledge Summaries (2012)
  - IPG 332: Surgical correction of hallux valgus using minimal access techniques
  - NICE (2010)
  - Commissioning Guide: Painful deformed great toe in adults
  - Royal College of Surgeons (2013)

- 16.35 Surgical Treatment of Morton’s Neuroma

- Surgical treatment provides pain relief to a client with Morton’s Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012.


- Morton's neuroma

- NICE Clinical Knowledge Summaries (2010).
| 16.36 | **Surgical Treatment of Plantar Fasciitis** | Surgical Treatment is not routinely commissioned unless the following pathway has been followed:
1. Patient has documented evidence that they are not responding to conservative treatments
2. Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following.
3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss.
4. Been referred to a podiatrist or physiotherapist.
Plantar fasciitis
NICE Clinical Knowledge Summaries (2009).
Plantar fasciitis
BMJ 2012;345:e6603. |
| 16.37 | **Treatment of Tendinopathies**
**Extracorporeal Shock Wave Therapy**
**Autologous Blood or Platelet Injection** | These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow. | IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis
NICE 2009.
IPG 312: Extracorporeal shockwave therapy for refractory Achilles tendinopathy
NICE 2009.
IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow
NICE 2009.
IPG 437: Autologous blood injection for plantar fasciitis
NICE 2013.
IPG 438: Autologous blood injection for tendinopathy
NICE 2013. |
| 16.38 | **NEW**
**Injections for Tendonitis (Jumpers Knee)** | This is not routinely commissioned. | http://www.nhs.uk/Conditions/Tendonitis/Pages/Treatment.aspx |
| NEW | Only commissioned if:  
| • Frozen shoulder has been persistent for at least 12 months AND the following have all been tried and failed:  
| • Activity modification  
| • Physiotherapy and exercise programme  
| • Oral analgesia  
| • Intra-articular joint injections  
| • Manipulation | shoulder-arthroscopy-for-degenerative-shoulder-disorders/ |
| 16.40 NEW | Hip Injections  
| Not routinely commissioned. Only commissioned if the following is met:  
| • Diagnostic aid (single injection)  
| • Introduce contrast medium to the joint as part of hip arthrogram  
| • Inflammatory arthropathy  
| • Bursitis |  

Commissioned for therapeutic intervention in early disease if:  
| • Significant pain causing functional impairment AND  
| • Conservative management (including pharmaceutical) not improving symptoms  

Hip injections are not commissioned for long term management. |
| 17. Urology |  
| 17.1 UPDA TED | Circumcision  
| Indicated for the following condition;  
| • Balanitis xerotica obliterans.  
| • Traumatic foreskin injury/scarring where it cannot be salvaged.  
| • 3 or more episodes of balanitis/balanoposthitis.  
| • Pathological phimosis.  
| • Irreducible paraphimosis.  
Balanitis NICE Clinical Knowledge Summaries 2009. |
<table>
<thead>
<tr>
<th>17.2</th>
<th>Penile Implant: A Surgical Procedure to Implant a Device into the Penis</th>
<th>Now commissioned by NHS England (see link for latest guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.3</td>
<td>Erectile Dysfunction – secondary care</td>
<td>Not routinely commissioned. Only commissioned for certain medical conditions e.g.</td>
</tr>
</tbody>
</table>
| | |  - post cancer  
| | |  - discussion about injectable prostaglandins (if other treatments unsuccessful).  
<p>| | |  - As part of assessment of ED when combined with Peyronies Disease |
| 17.4 | Male sterilisation under Local Anaesthetic | This is currently routinely commissioned via community providers ONLY (list of providers available from the Local CCG) unless attempted in community services but failed procedure due to patient discomfort or technical difficulty preventing completion. Direct referral will then be made by Community Provider to secondary care. |
| | Male sterilisation under General Anaesthetic | This is not routinely commissioned and would require IFR. Criteria would include significant scrotal/hemiscrotal pathology that would prevent safe management under local anaesthetic. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.5</td>
<td>Reversal of Male Sterilisation</td>
<td>The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.</td>
</tr>
<tr>
<td>17.6</td>
<td>ESWT (extracorporeal shockwave therapy) for Prostatodynia or Pelvic Floor Syndrome</td>
<td>This is not commissioned as there is limited clinical evidence of effectiveness.</td>
</tr>
<tr>
<td>17.7</td>
<td>Hyperthermia Treatment for Prostatodynia or Pelvic Floor Syndrome</td>
<td>This is not commissioned as there is limited evidence of effectiveness.</td>
</tr>
</tbody>
</table>
| 17.8    | Surgery for Prostatism | Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances:  
- International prostate symptom score >7; dysuria;  
- Post voided residual volume >150ml;  
- Recurrent proven Urinary Tract Infections (UTI);  
- Deranged renal function;  
- Prostate-specific antigen (PSA) > age adjusted normal values. |
| 17.9 NEW | Surgical treatment for Hydroceles – adults and children | This is not routinely commissioned. The following exclusions apply:  
In the case of communicating hydrocele:  
- patient is aged over 18 months of age  
In the case of non-communicating hydrocele, the patient is experiencing:  
- discomfort and/or disfigurement resulting in functional impairment preventing individual fulfilling work/study/carer or domestic duties (adult) |

Contraception – sterilization – NICE Clinical Knowledge Summaries 2012  
http://cks.nice.org.uk/contraception-sterilization#scenario  
Guidelines on chronic pelvic pain  
European Association of Urology (2012).  
CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men  
NICE 2010.  
LUTS in men, age-related (prostatism)  
NICE Clinical Knowledge Summaries (2010).  
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts  
Royal College of Surgeons (2013).  

No references to treatment thresholds found.
OR
- discomfort and/or disfigurement resulting in inability to participate in normal social and educational activity (adolescent)

| 17.10 NEW | Surgical removal of benign epididymal cysts | Not routinely commissioned. Exclusion apply only if **ALL** the following criteria are met:
- it is large enough to cause change in shape and size of scrotum
- cyst is putting pressure on other structures in the testes
- cyst is causing prolonged or significant pain | http://patient.info/health/epididymal-cyst

Hyperhidrosis Patient.co.uk.

| 18.2 Chelation Therapy for Vascular Occlusions | This is not commissioned. | Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006.
Effect of Disodium EDTA Chelation Regimenon Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250. | A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.

| 18.3 UPDATA TED | Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery. | Referral for consideration of surgical treatment only for symptomatic varicose veins
Refer to vascular surgeons if:
Symptomatic primary or symptomatic recurrent varicose veins defined as:
- lower limb skin changes, such as | CG168: Varicose Veins in the legs NICE 2013.
Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base -
pigmentation or eczema, thought to be caused by chronic venous insufficiency.
- superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
- venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks)
- healed venous leg ulcer.
- liposclerosis
- varicose eczema
- history of phlebitis

AND

evidence that conservative management has been tried for 6 months or more and failed

<table>
<thead>
<tr>
<th>19. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1 Botulinum Toxin A &amp; B</td>
</tr>
<tr>
<td>Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.</td>
</tr>
<tr>
<td>The use of botulinum toxin type A is commissioned in the following indications:</td>
</tr>
<tr>
<td>• Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections.</td>
</tr>
<tr>
<td>• Blepharospasm and hemifacial spasm.</td>
</tr>
<tr>
<td>• Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8).</td>
</tr>
<tr>
<td>• Focal dystonia, where other measures are inappropriate or ineffective.</td>
</tr>
<tr>
<td>• Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other</td>
</tr>
</tbody>
</table>

London Health Observatory 2010.
A systematic review and meta-analysis of treatments for varicose veins – Centre for Reviews and Dissemination 2011
Ultrasound-guided foam sclerotherapy for varicose veins – NICE IPG 440 2013
A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein – Centre for Review and Dissemination 2013
CG 168: Varicose veins
NICE 2013
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins
Royal College of Surgeons (2013)

NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260
Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171

**Diagnosis and management of hyperhidrosis** British Medical Journal.
measures are inappropriate or ineffective.
- Idiopathic cervical dystonia (spasmodic torticollis).
- Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260).
  
  http://guidance.nice.org.uk/TA260
- Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women)
  
  http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men)
  
  http://guidance.nice.org.uk/CG97
- Sialorrhoea (excessive salivary drooling), when all other treatments have failed.

Botulinum toxin type A is not routinely commissioned in the following indications:
- Canthal lines (crow’s feet) and glabellar (frown) lines.
- Hyperhidrosis.
- Any other indication that is not listed above

The use of Botulinum Type B is not routinely commissioned.

Where the use of botulinum toxin is used to treat an indication outside of the manufacturer’s marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications.

For patients with conditions which are not
routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Wirral Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Wirral. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG’s defined processes.

If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.

| 19.2 | NEW | Correction of privately funded treatment | Correction of privately funded treatment is not routinely commissioned unless in an emergency. |
9. Appendix 1 Cataract Referral Guide

Referral Criteria Exceptions -
The threshold for referring a patient for cataract surgery is 6/12 in the worst eye.

The following is an extract from the local policy on Low Priority Treatments Version 12, September 2012, based on OPCS 4.6 and ICD 10, and gives useful information relating to the cataract surgery threshold and agreed exceptions.

Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability patients may experience as a result of cataracts. The criteria set out below attempt to explicitly take that into account.

The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test), and it is anticipated that the threshold set out below will not render the majority of people unable to drive. This policy also recognises the increasing body of evidence that second eye surgery does benefit patients. The policy statement below applies to both first and second eyes, with a best corrected visual acuity of 6/12 or worse in the affected eye used as the threshold for cataract surgery.

Unless one or more of the following criteria are met, a best corrected visual acuity of better than 6/12 in the affected eye will not normally be funded:

- Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) OR
- Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in daylight or bright conditions OR
- Patients who need to drive at night who experience significant glare due to cataracts which affects driving OR
- Difficulty with reading due to lens opacities OR
- Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field OR
- Significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye OR
- Patients with glaucoma who require cataract surgery to control intraocular pressure OR
- Patient with diabetes who require clear views of their retina to look for retinopathy OR
- Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs).

The provider must only accept referrals meeting the terms of Cataract Referral criteria. The provider must receive a referral for each eye operated on, i.e. if the original referral states left eye, the provider cannot operate on both the left and right eye. A further assessment will be performed by the Community Optometrist, and if appropriate, a second eye referral made. This can be made as part of a Post-Operative Assessment process where an approved scheme is in place.
10. Appendix 2 IEFR Process

Diagram:

- Identification of need
- Identification of Commissioner CCG v NHS England
- Decision made
- NHS England commissioned services
- NHS England IFR proforma completed
- NHS England decision process followed
- Decision communicated
- CCG commissioned services
- Local IFR proforma completed
- Local decision process followed
11. Appendix 3 IFER Panel Contact Details

Telephone: 01244 650 305
Email:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cheshire CCG</td>
<td><a href="mailto:Westcheshireccg.IFR@nhs.net">Westcheshireccg.IFR@nhs.net</a></td>
</tr>
<tr>
<td>Eastern Cheshire CCG</td>
<td><a href="mailto:Eastern.Cheshireccg.IFR@nhs.net">Eastern.Cheshireccg.IFR@nhs.net</a></td>
</tr>
<tr>
<td>South Cheshire CCG</td>
<td><a href="mailto:southcheshireccg.ifr@nhs.net">southcheshireccg.ifr@nhs.net</a></td>
</tr>
<tr>
<td>Vale Royal CCG</td>
<td><a href="mailto:valeroyalccg.ifr@nhs.net">valeroyalccg.ifr@nhs.net</a></td>
</tr>
</tbody>
</table>