NHS
Midlands and Lancashire
Commissioning Support Unit

# Criteria Based Clinical Treatments

**Provided by:**

NHS Halton CCG
NHS Liverpool CCG
NHS Southport and Formby CCG
NHS South Sefton CCG
NHS St Helens CCG
NHS Warrington CCG

**Version control**

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# Contents

# INTRODUCTION

**Purpose and Scope**

CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed. This document is intended to be a statement of such arrangements made by the CCGs and will act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which CCGs will commission the service.

This policy describes the eligibility criteria under which the CCGs listed below will commission treatments or interventions classified as 'Criteria Based Clinical Treatments' (CBCT). The term Criteria Based Clinical Treatments, refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP).

In making these arrangements, the CCGs have given regard to relevant legislation and NHS guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012, Equality legislation – duties discharged under the Public Sector Equality Duty 2011, the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, the Joint Strategic Needs Assessment, relevant guidance issued by NHS England and the NHS Constitution.

**Context**

CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of their population.

It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. Therefore, it will not be possible for CCGs to commission all the healthcare needs of the population they serve. As a result, CCGs need to prioritise their commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.

The CCGs intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.

Using the CBCT policies as presented in this document, the CCGs can prioritise their resources using evidence based information that determines what is clinically effective and therefore cost effective and likely to provide the greatest proven health gain for the whole of the CCG's population.

The main objective for having CBCT policies is to ensure that:

- Patients receive appropriate health treatments in the right place and at the right time;
- Treatments with no or a very limited clinical evidence base are not routinely undertaken; and
- Treatments with minimal health gain are restricted.

# INTRODUCTION

This also means that certain procedures will not be commissioned by CCGs unless patients meet all the criteria set out in relation to a procedure or treatment; or exceptional clinical circumstances can be demonstrated.

CCGs recognise there may be exceptional clinical circumstances where it may be clinically effective to fund any of the procedures listed in this policy for individual patients. Either where:

- The clinical threshold criteria as specified by this policy is not met; or
- The procedure is not routinely commissioned;

In accordance with each CCG's Individual Funding Request (IFR) process, the patient's circumstances as clinically evidenced in an application made by the patient's clinician will be considered on a case-by-case basis. This position is supported by each CCG's Ethical Framework which can be found on the respective CCG website.

**Background**

The following CCGs have worked collaboratively to develop this harmonised core set of commissioning criteria:

- Halton CCG;
- Knowsley CCG;
- Liverpool CCG;
- St Helens CCG;
- South Sefton CCG;
- Southport and Formby CCG;
- Warrington CCG;

This policy aims to improve consistency by bringing together one common set of criteria for treatments and procedures across the Merseyside and Warrington CCG footprints. This will help to reduce variation of access to NHS services in different areas (which is sometimes called 'postcode lottery' in the media) and allow fair and equitable treatment for all local patients.

**Principles**

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

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment;
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment;
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor;
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment;
- CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community;
- CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance;

# INTRODUCTION

- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered;
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

**Core eligibility criteria**

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

These core clinical eligibility criteria are as follows:

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

**Policy Categories**

Each procedure/treatment is categorised as either 'not routinely funded' or 'restricted' and these are defined as follows:

- Not routinely funded (NRF) – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

- Restricted – This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality;

# INTRODUCTION

**Diagnostic Procedures**

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

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

**Psychological factors**

Psychological distress alone will not be accepted as a reason to fund surgery. 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.

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. Any application citing psychological distress will need to be considered as an IFR .

**Lifestyle and surgery**

Lifestyle factors can have an impact on the functional results of some elective surgery. In particular, smoking is well known to affect the outcomes of some foot and ankle procedures. In addition, many studies have shown that the rates of postoperative complications and length of stay are higher in patients who are overweight or who smoke. Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to secondary care, should be able to access CCG and Local Authority Public Health commissioned smoking cessation and weight reduction management services prior to surgery.

Patient engagement with these "preventive services" may influence the immediate outcome of surgery. While failure to quit smoking or lose weight will not be a contraindication for surgery, GPs and Surgeons should ensure patients are fully informed of the risks associated with the procedure in the context of their lifestyle.

# INTRODUCTION

**CBCT Referral/Treatment Listing Processes**

**Primary Care**

Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, 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. NB. This may be via a referral management or prior approval team.

If in doubt over the local process, the referring clinician should contact the relevant CCG, IFR Team or Referral Management Team for guidance. Failure to comply with the local process may delay a decision being made.

Any referral letter should include specific information regarding the patient's potential eligibility. 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.

In cases where there may be an element of doubt the General Practitioner/Optometrist/Dentist should discuss the case with the IFR Team in the first instance.

**Secondary Care**

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. The consultant may also request additional information before seeing the patient.

If a secondary care consultant considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the consultant should follow the listing process for treatment. NB. For some CCGs this will involve following a process of prior approval. If in doubt over the CCG requirements, the consultant should contact the relevant CCG or the IFR Team for guidance. Failure to comply with the CCGs' processes may delay a patient's treatment and/or release of funding resources.

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 including prior approval authorisation where relevant. This will 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 General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

**IFR Applications/Clinical Exceptionality**

Exceptionality is where a patient does not meet all of the criteria outlined for a specific procedure or treatment or, the procedure or treatment is not routinely commissioned.

# INTRODUCTION

In this scenario, 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 Panel for consideration. The person who fills in the IFR can be a consultant or a GP.

In dealing with clinically exceptional requests for an intervention that is considered to be a poor use of NHS resources, the Merseyside 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 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.

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.

Individual Funding Requests should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form; can be found on the CCGs websites.

IFR contact information follows, however please refer to the CCG IFR policy for more information:

Individual Funding Request Case Manager
Midlands and Lancashire Commissioning Support Unit (MLCSU)
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ
Telephone: 01244 650 305

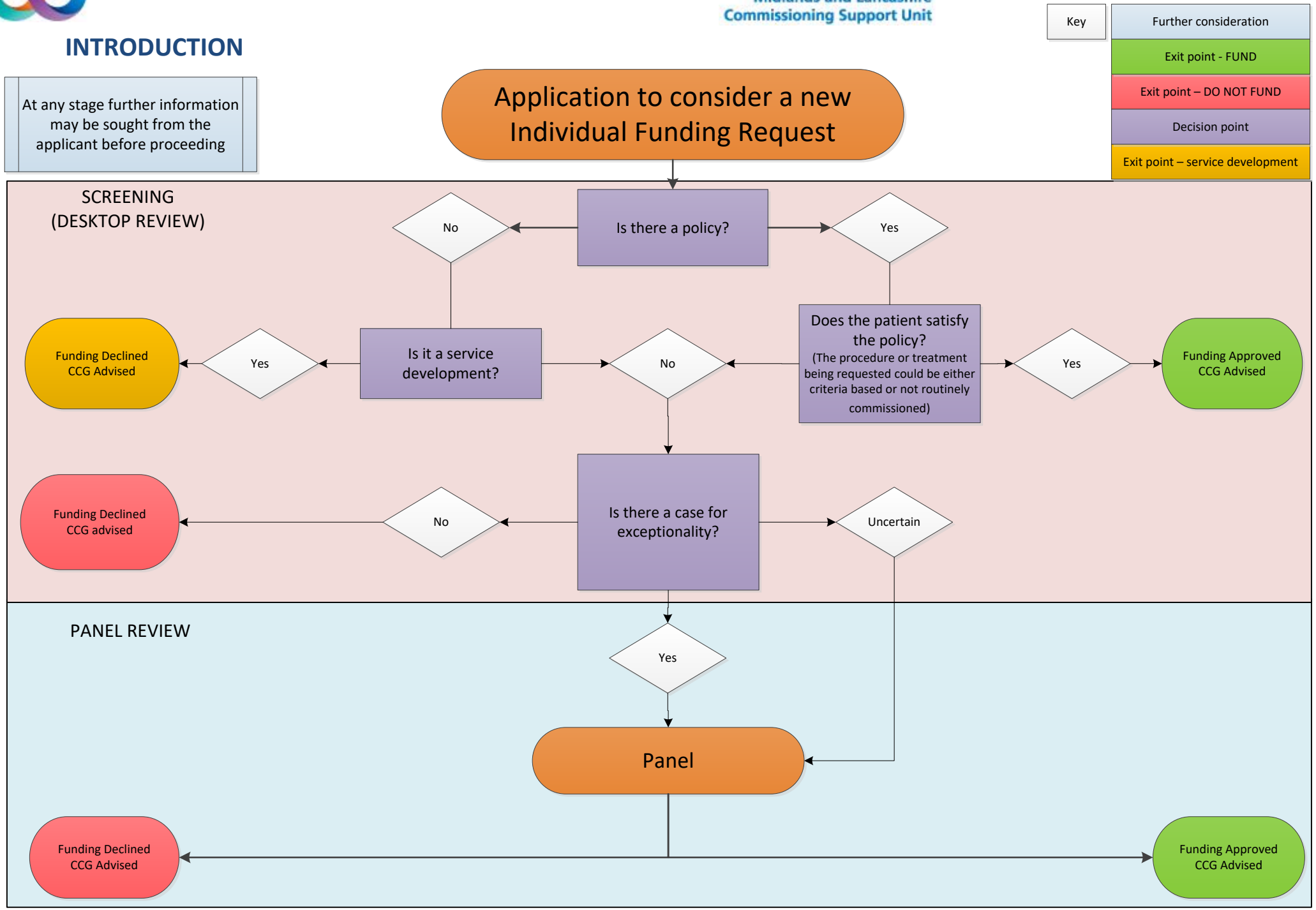
Email addresses for Individual Funding Request teams at CCGs:

| CCG | Email Address |
|---|---|
| Halton CCG | IFR.manager@nhs.net |
| Knowsley CCG | |
| Liverpool CCG | |
| South Sefton CCG | |
| Southport & Formby CCG | |
| St Helens CCG | |
| Warrington CCG | Warringtonccg.IFR@nhs.net |

Midlands and Lancashire Commissioning Support Unit

## INTRODUCTION

At any stage further information may be sought from the applicant before proceeding



# INTRODUCTION

**Medicines**

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;

**Clinical Trials**

The CCGs do 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.

**Photographic evidence**

Photographic evidence may be required in cases which are being considered for clinical exceptionality in line with the IFR processes. However, photographic evidence will not be accepted for consideration unless it is impossible to make the case in any other way.

The decision to submit photographic evidence remains with the patient and responsible clinician and must meet the CCGs criteria for submission as outlined by the CCGs IFR Policy.

If photographs are accepted for consideration in accordance with the CCGs criteria, they will be examined by clinical members of the IFR team. In the course of the work for the case the applicant should be aware that other members of the IFR Panel, IFR Process Reviews Panel or IFR team who prepare the papers may need to handle or see the photographs.

**Personal data**

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.

# INTRODUCTION

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.

Costs incurred will be the responsibility of the referrer, this includes photographic evidence.

**Copies of this policy**

Electronic copies of this policy can be found on the websites of the respective CCGs. Alternatively; you may contact the CCG and ask for a copy of the Criteria Based Clinical Treatments 2017-18 policy document.

**Monitoring and review**

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

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

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

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

**Evidence**

At the time of publication the evidence presented per procedure/treatment was the most current available. Where reference is made to older publications these still represents the most up to date view.

## GLOSSARY

| Term | Meaning |
|---|---|
| **Analgesics** | Painkillers. |
| **Asymptomatic** | Without symptoms. |
| **Augmentation** | Increasing in size, for example breast augmentation. |
| **Benign** | Does not invade surrounding tissue or spread to other parts of the body; it is not a cancer. |
| **Binocular vision** | Vision in both eyes. |
| **Body Mass Index (BMI)** | Body Mass Index - a measure that adults can use to see if they are a healthy weight for their height. |
| **CCG** | Clinical Commissioning Group. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. |
| **Chronic** | Persistent |
| **Co-morbidities** | Other risk factors alongside the primary problem. |
| **Congenital** | Present from birth |
| **Conservative treatment** | The management and care of a patient by less invasive means; these are usually non-surgical |
| **DOH** | Department of Health |
| **Eligibility/Threshold** | Whether someone qualifies. In this case, the minimum criteria to access a procedure. |
| **Exceptional clinical circumstances** | A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient. |
| **Functional health problem/difficulty/impairment** | Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living. |
| **GP** | General Practitioner. |
| **Histology** | The structure of cells or tissue under a microscope. |
| **Individual Funding Request (IFR)** | A request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment. |
| **Irreducible** | Unable to be reduced. |
| **Malignant/malignancy** | Harmful. |
| **Monocular vision** | Vision in one eye only. |
| **Multi-disciplinary** | Involving several professional specialisms for example in a Multi-disciplinary team (MDT). |
| **NICE guidance** | The guidance published by the National Institute for Health and Care Excellence. |
| **Not routinely funded (a procedure)** | This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **NSAIDS** | Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation. |
| **Paediatric(ian)** | Medical care concerning infants, children and adolescents usually under 18. |

## GLOSSARY

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|---|---|
| **Pathology/pathological** | The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing. |
| **PCT** | Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups). |
| **PLCP** | Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances. |
| **Precipitates** | Brings about/triggers. |
| **Primary care** | a patient's first point of interaction with NHS services e.g. a GP surgery. |
| **Rationale** | Explanation of the reason why. |
| **Restricted (a procedure)** | This means CCG will fund the treatment if the patient meets the stated clinical threshold for care. |
| **Secondary care** | Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services. |
| **Stakeholders** | Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc. |
| **Symptomatic** | Something causing or exhibiting symptoms. |

## A2. Dermatology

### A2.2 Surgical Treatments for Minor Skin Lesions

The removal of benign skin lesions are not routinely commissioned for cosmetic reasons.

| Intervention | Surgical Treatments for Minor Skin Lesions |
|---|---|
| **Policy Statement** | **Restricted**<br><br>Please note the removal of benign skin lesions are not routinely commissioned for cosmetic reasons. |
| **Minimum eligibility criteria** | The CCG will only fund this treatment if the patient meets **ONE** of the following:<br>• Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway)<br>OR<br>• Symptomatic e.g. ongoing pain or functional impairment.<br>OR<br>• Risk of infection.<br>OR<br>• Significant facial disfigurement.<br>OR<br>• All vascular lesions on the face except benign, acquired vascular lesions such as thread veins.<br><br>For any of the above scenarios, referral for treatment should be made to a community provider |
| **Rationale** | This is because all removal of Benign (non-cancerous) or Congenital Skin Lesions that does not meet the criteria above is deemed to be cosmetic. |
| **Evidence for inclusion and threshold** | NHS Modernisation Agency - Information for commissioners of Plastic Surgery - referrals and guidelines in Plastic Surgery (Action on Plastic Surgery) (2005)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 |

## A2.3 Policy for Surgical removal of Lipoma

Lipoma are fat deposits underneath the skin. They are usually removed on cosmetic grounds, although patients with multiple subcutaneous lipoma may need a biopsy to exclude neurofibromatosis.

Removal of Lipoma in secondary care is restricted. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.

| **Intervention** | **Surgical removal of Lipoma** |
|---|---|
| **Policy Statement** | **Restricted** |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• Lipoma is on the face or neck<br>***AND*** one of the following:<br>• suspected malignancy<br>**OR**<br>• significant functional impairment caused by the lipoma<br>**OR**<br>• to provide histological evidence in conditions where there are multiple subcutaneous lesions<br>This excludes lipomas unless they are on the face (including pinna) or the neck and they become infected or be symptomatic. Lipomas on other areas of the body should be referred back to primary care as agreed locally<br>This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because all removal of Lipoma that does not meet the criteria below is deemed to be cosmetic and does not meet the principles laid out in this policy. |
| **Evidence for inclusion and threshold** | NHS Modernisation Agency - Information for commissioners of Plastic Surgery - referrals and guidelines in Plastic Surgery (Action on Plastic Surgery) (2005)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br>NHS Choices – Lipoma<br>Weblink:<br>http://www.nhs.uk/Conditions/lipoma/Pages/Introduction.aspx |

## A4. ENT

### A4.1 Policy for Adenoidectomy

An adenoidectomy is an operation to remove the adenoids – small lumps of tissue at the back of the nose, behind the palate.

Adenoids are part of the immune system, which helps fight infection and protects the body from bacteria and viruses. Adenoids are only present in children. They start to grow from birth and are biggest when your child is approximately three to five years old.

But by age seven to eight they start to shrink and by the late teens, are barely visible. By adulthood, the adenoids will have disappeared completely.

The adenoids disappear because – although they may be helpful in young children – they are not an essential part of an adult's immune system.

A good summary of adenoids and adenoidectomy is provided by NHS Choices.
Weblink:
http://www.nhs.uk/conditions/Adenoids-and-adenoidectomy/Pages/Introduction.aspx

| Intervention | Adenoidectomy |
|---|---|
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Adenoidectomy will only be funded if Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis (see weblink below), with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.<br><br>Or<br><br>Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.<br><br>This means (for patients who do not require tonsillectomy and/or grommets) the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons Commissioning Guide for Rhinosinusitis (2013): The Royal College of Surgeons of England and ENT UK (2013). Commissioning guide: Rhinosinusitis, Available from: https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/rhinosinusitis-commissioning-guide/<br>This guide has been prepared for commissioners by the Royal College of Surgeons following a review of the latest research evidence.<br><br>Robb PJ et al (2009), Tonsillectomy and adenoidectomy in children with sleep-related breathing disorders: consensus statement of a UK multidisciplinary working |

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|---|---|
| | party, Annals of the Royal College of Surgeons of England, 91, 371-373. Available from: http://europepmc.org/articles/PMC2758429;jsessionid=MVfPN7W1Ky1PN4EiKikL.52<br><br>https://www.nice.org.uk/guidance/cg60<br>*Adenoidectomy is not recommended*<br><br>"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."<br><br>Scottish Intercollegiate Guidelines Network, NHS Quality Improvement Scotland. *Management of sore throat and indications for tonsillectomy 117.* April 2010. http://www.sign.ac.uk/pdf/qrg117.pdf |

## A4.2 Policy for Pinnaplasty

Ear correction surgery is cosmetic surgery to alter the size or shape of the ears, or pin them back if they stick out.
Pinning back the ears is known as an otoplasty, or pinnaplasty. It's usually carried out on children and young teenagers, although adults may wish to have it done, too.

An otoplasty isn't suitable for children younger than five as their ears will still be growing and developing.

Most people are happy with the results of an otoplasty, and generally it's a safe procedure. But it can be expensive and there are still risks to consider.
Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| **Intervention** | **Pinnaplasty** |
|---|---|
| **Policy Statement** | Not routinely commissioned |
| **Minimum eligibility criteria** | Pinnaplasty is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons and British Association of Plastic, Reconstructive and Aesthetic Surgeons – Pinnaplasty Commissioning Guide (2013)<br>Weblink:<br><br>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty/at_download/file |

## A4.4 Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children

**Tonsillitis is inflammation of the tonsils. It's usually caused by a viral infection or a bacterial infection.**
This is a common type of infection in children, although it can sometimes affect adults.
The symptoms of tonsillitis include:
• sore throat that can feel worse when swallowing
• high temperature (fever) over 38C (100.4F)
• coughing
• headache

A good summary about treating Tonsillitis is provided by NHS Choices:
Weblink: http://www.nhs.uk/Conditions/Tonsillitis/Pages/Treatment.aspx

| **Intervention** | Policy for Tonsillectomy for recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children |
|---|---|
| **Policy Statement** | **Restricted**<br><br>**Note:** Tonsillectomy should **not** be carried out for tonsil stones and/or halitosis as there is no clinical evidence to suggest that this is an effective treatment for these conditions. |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets one or more of the following criteria:<br>• 7 or more documented clinically significant, adequately treated episodes of tonsillitis in the preceding year;<br>**OR**<br>• 5 or more documented episodes in each of the preceding two years<br>**OR**<br>• 3 or more documented episodes in each of the preceding three years.<br>**AND**<br>• If symptoms are disabling and prevent normal functioning<br><br>Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following:<br>Aural temperature of at least 38.3°C<br>Tender anterior cervical lymph nodes<br>Tonsillar exudates<br>Tonsillar enlargement giving rise to symptoms of upper airways obstruction<br><br>**Note:** it is the referring clinician's responsibility to ensure all evidence pertaining to the minimum eligibility criteria above are |

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| | provided as part of the referral.<br><br>**Note:** Walk in Centre or Out of Hours documented episodes that are communicated in writing to GP Practices are included in the episode count.<br><br>There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance below (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome.<br>Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.<br><br>**Note:** When in doubt, implement a six month period of clinical watchful waiting. (Watchful waiting involves carefully monitoring your symptoms to see whether they improve or get worse.)<br><br>This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because of the Royal College of Surgeons recommendations for High Value Care Pathway for Tonsillectomy published in 2013 (see weblink below). |
| **Evidence for inclusion and threshold** | Royal College of Surgeons - Commissioning guide: Tonsillectomy (2013).<br>Weblink:<br>https://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy<br>SIGN - Management of sore throat and indications for tonsillectomy (2010).<br>Weblink:<br>http://www.sign.ac.uk/pdf/sign117.pdf<br>NHS Choices - Tonsillitis<br>http://www.nhs.uk/conditions/Tonsillitis/Pages/Introduction.aspx<br>NHS Choices – Quinsy; Tonsillitis<br>Weblink:<br>http://www.nhs.uk/conditions/Quinsy/Pages/Introduction.aspx<br>http://www.nhs.uk/conditions/tonsillitis/Pages/Introduction.aspx |

## A4.7 Policy for Rhinoplasty

Rhinoplasty, commonly known as a 'nose job', is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty.

| Intervention | Rhinoplasty |
|---|---|
| **Policy Statement** | **Restricted**<br><br>a) Rhinoplasty is not routinely commissioned for cosmetic reasons.<br><br>b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. a sepoplasty. |
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• Documented medical breathing problems caused by obstruction of the nasal airway **OR**<br>• Correction of complex congenital conditions e.g. Cleft lip and palate<br><br>This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Rhinoplasty Guide<br>Weblink:<br>https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/ |

## A7. General Surgery

### A7.1 Policy for Hemorrhoidectomy. Rectal surgery and removal of haemorrhoidal and anal skin tags

Symptoms range from temporary and mild, to persistent and painful. In many cases, piles are small and symptoms settle down without treatment. Surgical Haemorrhoidectomy can be used for third or fourth degree haemorrhoids.

A Haemorrhoidectomy is an operation to cut away the haemorrhoid(s) is an option to treat grade 3 or 4 piles, or for piles not successfully treated by banding or other methods. It is usually carried out under general anaesthetic, which means you will be asleep during the procedure and won't feel any pain while it is carried out.

Internal haemorrhoids are classified by their degree of prolapse, which helps determine management:

- Grade One: No prolapse
- Grade Two: Prolapse that goes back in on its own
- Grade Three: Prolapse that must be pushed back in by the patient
- Grade Four: Prolapse that cannot be pushed back in by the patient (often very painful)

A conventional haemorrhoidectomy involves gently opening the anus so the haemorrhoids can be cut out. You will need to take a week or so off work to recover.

You will probably experience significant pain after the operation, but you will be given painkillers. You may still have pain a few weeks after the procedure, which can also be controlled with painkillers. Seek medical advice if you have pain that continues for longer.

After having a haemorrhoidectomy, there is around a 1 in 20 chance of the haemorrhoids returning, which is lower than with non-surgical treatments. Adopting or continuing a high-fibre diet after surgery is recommended to reduce this risk.

| **Intervention** | **Treatments for hemorrhoids. Rectal surgery and removal of haemorrhoidal and anal skin tags** |
|---|---|
| **Policy Statement** | **Restricted**<br>This policy is to be used where conservative treatment of haemorrhoids has previously failed.<br>Treatment of bleeding haemorrhoids depends on the degree of prolapse and severity of symptoms.<br>In general, the treatment options vary by haemorrhoid severity or grade. |

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| **Minimum eligibility criteria** | a) **Haemorrhoidectomy for grades 1 or 2** is not routinely commissioned.<br>b) **Haemorrhoidectomy for grades 3 or 4** will be funded if the patient meets one or more of the following criteria:<br>• Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding<br>**OR**<br>• Irreducible and large external haemorrhoids<br>**Removal of skin tags is not routinely commissioned.**<br>This means **(for patients who DO NOT meet the specified criteria)** that the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | **Haemorrhoidectomy for grades 1 or 2** is not routinely commissioned because Haemorrhoids can often be treated by simple measures such as eating more fibre or drinking more fluid or using standard topical measures. If these measures are unsuccessful, then haemorrhoids can usually be treated in a clinic setting providing local treatments including Rubber Band Ligation or Injecting the Haemorrhoids.<br>**Haemorrhoidectomy for grades 3 or 4** will only be funded in the circumstances mentioned above is because Excisional Haemorrhoidectomy is more effective than rubber band ligation in the long term and is the treatment of choice for **recurrent** grade 2 and grade 3/4 haemorrhoids. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons - Commissioning guide: Rectal Bleeding (2013)<br>Weblink: https://www.rcseng.ac.uk/-/media/files/.../rectal-bleeding--commissioning-guide.pdf<br><br>Royal College of Surgeons – haemorrhoidectomy pre-operation guide.<br>Weblink: http://www.rcseng.ac.uk/members/resources/pre-op-leaflets/Colorectal/Haemorrhoidectomy.pdf/view<br><br>NHS Choices - Piles (haemorrhoids)<br>Weblink:<br>http://www.nhs.uk/conditions/Haemorrhoids/Pages/What-is-it-page.aspx |

## A7.2 Policy for Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti

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

A hernia usually develops between your chest and hips. In many cases, it causes no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin.

The lump can often be pushed back in or disappears when you lie down. Coughing or straining may make the lump appear.

A good summary about treating hernias is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/hernia/Pages/Introduction.aspx

A good summary about Disatasis Recti is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/your-body-after-childbirth.aspx?tabname=pregnancy#separated

| Intervention | Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti |
|---|---|
| **Minimum eligibility criteria** | **Not routinely commissioned**<br><br>This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because these procedures highly specialised and techniques for treatment are not well developed making treatment complicated. |
| **Evidence for inclusion and threshold** | A systematic review on the outcomes of correction of diastasis of the recti<br>Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al. |

## A7.3 Surgery for Asymptomatic Gallstones

Gallstones are small stones, usually made of cholesterol, that form in the gallbladder. In most cases they don't cause any symptoms and don't need to be treated.

However, if a gallstone becomes trapped in an opening (duct) inside the gallbladder, it can trigger a sudden, intense abdominal pain that usually lasts between one and five hours. This type of abdominal pain is known as biliary colic.

Some people with gallstones can also develop complications, such as inflammation of the gallbladder (cholecystitis), which can cause:

- persistent pain
- jaundice
- a fever

When gallstones cause symptoms or complications, it's known as gallstone disease or cholelithiasis.

A Good summary of Gallstones is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/gallstones/Pages/Introduction.aspx

| Intervention | Surgery for Asymptomatic Gallstones |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Rationale** | This is because the majority of people with gallbladder stones remain asymptomatic and require no treatment. |
| **Evidence for inclusion and threshold** | https://www.rcseng.ac.uk/-/media/files/rcs/.../gallstones--commissioning-guide.pdf<br>Royal College of Surgeons (2016). |

## A8. Gynaecology

### A8.1 Policy for Hysterectomy for Heavy Menstrual Bleeding

Heavy periods, also called menorrhagia, are when a woman loses an excessive amount of blood during consecutive periods. Menorrhagia can occur by itself or in combination with other symptoms, such as menstrual pain (dysmenorrhoea). Heavy bleeding does not necessarily mean there is anything seriously wrong, but it can affect a woman physically, emotionally and socially, and can cause disruption to everyday life.

Hysterectomy is one of the most frequently performed surgery on women, and can be performed vaginally as well as abdominally. Common indications include menorrhagia, fibroids, endometriosis, uterine prolapse and cancer of uterus and cervix.

Hysterectomy is one of a number of NICE recommended treatments of heavy menstrual bleeding (menorrhagia), but is associated with more complications compared to treatment with progestogens.

Therefore Hysterectomy is not routinely commissioned as a first-line treatment solely for HMB.
The NICE recommended treatments, including hysterectomy, are detailed below and Women should be given the following information on potentially unwanted outcomes.

A good summary of Hysterectomy is provided by NHS Choices:
Weblink:
http://www.nhs.uk/Conditions/hysterectomy/Pages/Introduction.aspx

| Intervention | Hysterectomy for Heavy Menstrual Bleeding |
|---|---|
| Policy Statement | **Restricted** |
| Minimum eligibility criteria | Hysterectomy is not commissioned unless all of the following criteria have been met:<br>• The following treatments have failed, are not appropriate or are medically contra-indicated:<br>○ An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena)<br>○ Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives.<br>○ Norethisterone 15 mg daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens<br>○ Up to 4 courses of ulipristal acetate 5mg for women with heavy menstrual bleeding and fibroids of 3cm or more in diameter.<br>○ Endometrial ablation has been tried (unless patient |

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| | has fibroids >3cm)<br><br>The procedure should not be offered where a patient wishes to cease menstruation. |
| Rationale | This is because NICE Clinical Guideline 44 recommends that:<br><br>Hysterectomy should not be used as a first-line treatment solely for HMB. Hysterectomy should be considered only when:<br>• other treatment options have failed, are contraindicated or are declined by the woman<br>• there is a wish for amenorrhoea<br>• the woman (who has been fully informed) requests it<br>• the woman no longer wishes to retain her uterus and fertility<br><br>Women offered hysterectomy should have a full discussion of the implication of the surgery before a decision is made. The discussion should include: sexual feelings, fertility impact, bladder function, need for further treatment, treatment complications, the woman's expectations, alternative surgery and psychological impact.<br><br>Women offered hysterectomy should be informed about the increased risk of serious complications (such as intraoperative haemorrhage or damage to other abdominal organs) associated with hysterectomy when uterine fibroids are present.<br><br>Women should be informed about the risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy.<br><br>Individual assessment is essential when deciding the route of hysterectomy. The following factors need to be taken into account:<br>• presence of other gynaecological conditions or disease<br>• uterine size<br>• presence and size of uterine fibroids<br>• mobility and descent of the uterus<br>• size and shape of the vagina<br>• history of previous surgery<br><br>Taking into account the need for individual assessment, the route of hysterectomy should be considered in the following order: first line vaginal; second line abdominal.<br><br>Under circumstances such as morbid obesity or the need for oophorectomy during vaginal hysterectomy, the laparoscopic |

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| | approach should be considered, and appropriate expertise sought.<br><br>When abdominal hysterectomy is decided upon then both the total method (removal of the uterus and the cervix) and subtotal method (removal of the uterus and preservation of the cervix) should be discussed with the woman. |
| **Evidence for inclusion and threshold** | NICE - Clinical guideline: Heavy menstrual bleeding CG44 (2007).<br>Weblink:<br>http://www.nice.org.uk/guidance/CG44<br>NHS Choices - Heavy periods (menorrhagia)<br>Weblink:<br>http://www.nhs.uk/conditions/Periods-heavy/Pages/Introduction.aspx<br><br>Please note that the NICE website indicates that this clinical guideline is undergoing a full review, with expected date for the updated guidance to be published in November 2017:https://www.nice.org.uk/guidance/indevelopment/gid-ng10012. This policy will need to be reviewed again once the updated CG is published |

## A8.2 Policy for Dilatation and Curettage

Dilation and Curettage for Menorrhagia has been the traditional technique for obtaining samples of endometrium for pathological examination. However, 'blind' dilatation and curettage (D&C) has been shown to miss significant amounts of pathology.

D&C used to be commonly used to examine the womb and remove abnormal growths, but nowadays hysteroscopies are carried out instead.

A good summary of Hysteroscopy is provided by NHS Choices:
Weblink:
http://www.nhs.uk/conditions/hysteroscopy/Pages/Introduction.aspx

| Intervention | Dilatation and Curettage |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned |
| **Rationale** | This is because NICE Clinical Guideline 44 recommends that:<br>Ultrasound is the first-line diagnostic tool for identifying structural abnormalities.<br>Dilatation and curettage should not be used as a diagnostic tool.<br>Dilatation and curettage should not be used as a therapeutic treatment**.** |
| **Evidence for inclusion and threshold** | NICE - Clinical guideline: Heavy menstrual bleeding CG44 ( Last updated 2016).<br>Weblink:<br>http://www.nice.org.uk/guidance/CG44<br><br>National Collaborating Centre for Womens Health (2007) Heavy Menstrual Bleeding. Evidence Tables.<br>https://www.nice.org.uk/guidance/cg44/evidence/evidence-tables-pdf195071294<br><br>NHS Choices - Hysteroscopy<br>Weblink:<br>http://www.nhs.uk/conditions/hysteroscopy/Pages/Introduction.aspx |

## A9. Mental Health

### A9.4 Policy for Private Mental Health Care

Private Mental Health Care is not routinely commissioned because most mental health conditions can be managed in the community with input from Community Mental Health teams.

NHS England Specialist Commissioning provides NHS specialist services for various conditions including PTSD, eating disorders and severe OCD.

There is also a specialist NHS Mental Health service provided for affective disorders.

| Intervention | Policy for Private Mental Health Care |
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| **Policy Statement** | Not Routinely Commissioned |

## A11. Ophthalmology

### A11.5 Policy for Cataract Surgery

A cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).

The Royal College of Ophthalmologists' National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to:

- 6/6 Snellen (3% of cataract surgery patients)
- 6/9 Snellen (5% of cataract surgery patients)
- 6/12 Snellen (36% of cataract surgery patients)

So eyes with visual acuities of 6/9 or better, accounted for only about 10% of cataract surgery.

| **Intervention** | **Cataract Surgery** |
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| Policy Statement | The presence of a cataract in itself does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risks and benefits of surgery. This assessment will usually be undertaken by an accredited community optometrist prior to referral.<br>Where both eyes are affected by cataract, the first eye referred for cataract surgery is usually expected to be the eye where cataract has caused the greatest reduction in visual acuity.<br>This policy does not extend to cataract removal incidental to the management of other eye conditions. |
| Minimum eligibility criteria | Referral of patients to ophthalmologists for cataract surgery should be based on the following indications:<br>1. The patient has sufficient cataract to account for visual symptoms.<br>It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired.<br><br>A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any |

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| | of the following factors, although this is not an exhaustive list:<br>a. the patient is at significant risk of falls<br>b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving<br>c. the impact of symptoms is compromising the patient's independence<br>d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities<br>e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces.<br>f. the patient is experiencing disabling glare.<br>**AND**<br>2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/<br>3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery<br>**Guidance for second eye surgery in patients with bilateral cataracts**<br><br>**The second eye criteria is**<br>As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon |
| **Guidance/evidence**<br><br>Atlas of Variation *Tacking Unwarranted Variation in Healthcare across the NHS* Public Health England, NHS Right Care and NHS England September 2015<br><br>*Evidence Review Cataract Surgery* –ChaMPs May 2014<br><br>Royal College of Ophthalmologists *Commissioning Guide for Cataract Surgery* February 2015<br><br>NHS Choices<br><br>NHS Patient Decision Aids – Cataract | |

## A14. Plastic Surgery

### A14.1 Reduction Mammoplasty - Female Breast Reduction

**Breast Reduction Surgery**
Breast reduction surgery can help women who are unhappy with the shape, weight or droop of their breasts by making them smaller and more lifted.

But if it's done to improve appearance rather than for health reasons, it's not normally available on the NHS. Instead, you'll need to pay for the procedure privately.

Weblink:
http://www.nhs.uk/Conditions/Breast-reduction/Pages/Introduction.aspx

| Intervention | Reduction Mammoplasty - Female Breast Reduction |
|---|---|
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets ALL of the following criteria<br>• Musculo-skeletal symptoms are not due to other causes.<br>AND<br>• There is at least a two year history of attending the GP with the problem.<br>AND<br>• Other approaches such as analgesia and physiotherapy have been tried.<br>AND<br>• The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache).<br>AND<br>• The wearing of a professionally fitted brassiere has not helped.<br>AND<br>• Patients BMI is <25 and stable for at least twelve months.<br>AND<br>• The patients breast is a cup size H or larger.<br>AND<br>• There is a proposed reduction of at least a three cup sizes.<br>AND<br>• Aged over 18 years old.<br>AND<br>• It is envisaged there are no future planned pregnancies.<br>Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist – see the Breast Augmentation policy. |

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| **Evidence for inclusion and threshold** | An investigation into the relationship between breast size, bra size and mechanical back pain<br>British School of Osteopathy (2010).<br>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.<br><br>Royal College of Surgeons – Breast Reduction Guide<br>Weblink:<br>https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/breast-reduction-guide/<br><br>NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).<br>Weblink:<br>https://www.nice.org.uk/guidance/cg80<br><br>NICE Quality Standard 12 – Breast Cancer (2016)<br>Weblink:<br>https://www.nice.org.uk/guidance/qs12<br><br>British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0<br><br>Breast Cancer Care – Breast Reconstruction<br>Weblink:<br>https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction<br><br>Commissioning Criteria – Plastic Surgery.<br>Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br>Health Commission Wales (2008).<br><br>Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. *British Journal of Plastic Surgery*, *56*(3), 230–236.<br><br>Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. *Chiropractic & Osteopathy*, *16*(1), 1–7. |

## A14.2 Augmentation Mammoplasty - Breast Enlargement

**Breast Enlargement**
Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Reduction Mammoplasty - Female Breast Reduction |
|---|---|
| **Minimum eligibility criteria** | Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria:<br>• There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist.<br>AND<br>• The patient's BMI is under 25 and has been stable for at least 12 months<br>AND<br>• Aged over 18 years old. |
| **Evidence for inclusion and threshold** | NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).<br>Weblink:<br>https://www.nice.org.uk/guidance/cg80<br><br>NICE Quality Standard 12 – Breast Cancer (2016)<br>Weblink:<br>https://www.nice.org.uk/guidance/qs12<br><br>British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0<br><br>Breast Cancer Care – Breast Reconstruction<br>Weblink:<br>https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction<br><br>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<br><br>Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. |

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| | Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45.<br><br>Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64.<br><br>North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf<br><br>Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050.<br><br>*Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* |

## A14.3 Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation

**COSMETIC SURGERY**

Cosmetic surgery is often carried out to change a person's appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner.

1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment
3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment
5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community
6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance
7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.

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

| Intervention | Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation |
|---|---|
| **Minimum eligibility criteria** | Removal and/or replacement of silicone implants is not routinely commissioned.<br><br>The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:<br><br>Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only, but will **not** replace them. |
| **Evidence for inclusion and threshold** | Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group<br>Department of Health (June 2012). |

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| | NHS Choices: PIP breast implants<br>http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx<br><br>NHS Choices: Breast Enlargement<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.4 Mastopexy - Breast Lift

Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.
Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx

| Intervention | Mastopexy - Breast Lift |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | NICE Quality Standard 12 – Breast Cancer (2016)<br>Weblink:<br>https://www.nice.org.uk/guidance/qs12<br><br>British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0<br><br>Breast Cancer Care – Breast Reconstruction<br>Weblink:<br>https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction<br><br>NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).<br>Weblink:<br>https://www.nice.org.uk/guidance/cg80<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.5 Surgical Correction of Nipple Inversion

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx

| Intervention | Surgical Correction of Nipple Inversion |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.6 Male Breast Reduction Surgery for Gynaecomastia

**Gynaecomastia**

Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of >2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological.

Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter. Surgery
Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Male Breast Reduction Surgery for Gynaecomastia |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf<br><br>NHS Choices: Breast Reduction (male) http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-reduction-male.aspx<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.7 Policy for Policy for Hair Removal Treatments

Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.

Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or Middle-Eastern descent.

A range of treatment options are available:

- Patients can self-fund options such as shaving, waxing, depilatories (hair removal creams) and bleaching creams. They can also self-fund the physical treatments listed below.
- Co-cyprindiol tablets (anti-androgen) may be prescribed. It should be noted however that eflornithine cream has Black status on the Pan Mersey formulary and is not recommended for prescribing.

| Intervention | Policy for Policy for Hair Removal Treatments |
|---|---|
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR**<br>• Is undergoing treatment for pilonidal sinuses to reduce recurrence<br><br>This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - hirsuitism patient information leaflet<br>Weblink:<br>http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document<br><br>NHS Choices – Laser Hair Removal<br>Weblink:<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx<br><br>Pan Mersey APC Guidance for Eflornithine:<br>http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=306706356201612211113329 |

## A14.8 Surgical Treatment for Pigeon Chest - Pectus Anomaly

Pectus anomaly describes a deformity with the sternum (breastbone). The condition is the most common congenital wall deformity.
There are two main types of anomaly:

- **Pectus excavatum** (also known as “funnel chest”/”sunken chest”) in which the sternum is sunken inwards and the chest looks hollow
- **Pectus carinatum** (also known as “pigeon chest”) in which the sternum is raised and the chest pushed out. There may sometimes be a depression (dip) on one side and a protrusion (bulge) on the other.

There is also a rare third type of anomaly called **pectus arcuatum**. This is where there is a ridge high across the upper part of the sternum and so the rest of the chest falls away to a flatter shape.

Pectus anomalies occur in around four people in every 1,000 and are more common in men. Anomalies vary from mild to very marked.

Pectus anomalies are thought to be caused by poorly co-ordinated and possibly excessive growth of the costal (rib) cartilages. The anomaly occurs between the ribs and sternum (breast bone) before a child is born and can be excessive.

As the cartilagea grow longer, they “buckle” and push the sternum either inwards (pectus excavatum) or outwards (pectus carinatum).
Certain conditions are associated with pectus anomaly, such as:

- scoliosis – where the spine curves and becomes deformed
- Marfan’s syndrome – an inherited disorder of the connective tissue
- Poland’s syndrome – a rare inherited condition which involves the absence or underdevelopment of the chest muscles on one side of the body

A pectus anomaly is often seen at birth but usually becomes more obvious during early adolescence when growth is rapid. Once growth is complete the anomaly remains the same.

A good summary of Pectus deformities can be found here:
http://www.pectus.org/livingwith.htm

| Intervention | Surgical Treatment for Pigeon Chest - Pectus Anomaly |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned |
| **Evidence for inclusion and threshold** | nice.org.uk/guidance/IPG310<br>NICE (2009). |

## A14.9 Surgical Revision of Scars

The different types of scars include:

- **Flat, pale scars** – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or dark and raised after the wound has healed, but will become paler and flatter naturally over time. This can take up to two years.
- **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years.
- **Keloid scars** – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed.
- **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance.
- **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.

**Treating scars**

Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include:

- pressure dressings
- corticosteroid injections
- cosmetic camouflage (make-up)
- surgery

It is often the case that a combination of treatments can be used.

| Intervention | Surgical Revision of Scars |
|---|---|
| **Minimum eligibility criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• For severe post burn cases or severe traumatic scarring<br>**OR**<br>• Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function<br><br>This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

| | |
|---|---|
| | NHS Choices – Scars - Treatment<br>http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx |

## A14.10 Laser Tattoo Removal

Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks.
The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all.

A good summary of Cosmetic Surgery is provided by NHS Choices.
Weblink:

http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Laser Tattoo Removal |
|---|---|
| **Minimum eligibility criteria** | Removal of Tattoos is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>NHS Choices – The NHS Guide to cosmetic procedures<br>Weblink:<br><br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx |

## A14.11 Abdominoplasty/Apronectomy (sometimes called 'tummy tuck')

Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.

A good summary of Cosmetic Surgery is provided by NHS Choices.

Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx
and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Abdominoplasty/Apronectomy (sometimes called 'tummy tuck') |
|---|---|
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).<br><br>Royal College of Surgeons - Cosmetic Surgery Categorisation<br>Weblink:<br>https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file<br><br>Royal College of Surgeons – Abdominplasty Guide<br>Weblink:<br>https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/<br><br>NHS Choices: Tummy Tuck (abdominoplasty<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.12 Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat

Thigh Lift, Buttock Lift and Arm Lift (Brachioplasty), Excision of Redundant Skin or Fat are surgical procedures performed to remove loose skin or excess fat to reshape body contours

A good summary of Cosmetic Surgery is provided by NHS Choices.

Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat |
|---|---|
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons (2013). https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/massive-weight-loss/<br><br>BAPRAS Commissioning Guide: Massive weight loss body contouring: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/body-contouring-surgery-commissioning-guide-published.pdf?sfvrsn=0<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.13 Surgical Treatments for hair Loss

**Alopecia**

Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.

In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour. Some people go on to develop a more severe form of hair loss, such as:

- Alopecia totalis (no scalp hair)
- Alopecia universalis (no hair on scalp or body)

Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It's more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome.

It's also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.

Alopecia areata can occur at any age, although it's more common in people aged 15-29. It affects one or two people in every 1,000 in the UK.

Further information can be found at following link:
http://www.alopeciaonline.org.uk/treatments-and-wigs.asp

**Hair transplantation**

A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. ,It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata.  A hair transplant isn't normally available on the NHS, as it is regarded as cosmetic surgery.

**Male Pattern Baldness**

Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties.

It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon.

Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone

| Intervention | Surgical Treatments for hair Loss |
|---|---|
| **Minimum eligibility criteria** | Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned.<br><br>The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx<br>The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - alopecia areata patient information leaflet<br>Weblink:<br>http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document<br><br>Interventions for alopecia areata – Cochrane Library 2008.<br><br>http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf<br>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.<br><br>No evidence of effective treatments for alopecia – Cochrane Pearls 2008.<br><br>NICE Clinical Knowledge Summaries 2014.<br>https://cks.nice.org.uk/alopecia-areata<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>Modernisation Agency's Action on Plastic Surgery 2005.<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>NHS Choices – Guide to Hair Loss Treatment<br>Weblink:<br>http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx<br><br>**Hair transplantation**<br>*A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. |

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|---|---|
| | Modernisation Agency's Action on Plastic Surgery 2005.<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 |

## A14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy

**Labiaplasty**
A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening.

**Vaginoplasty**
Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex.

**Hyenorrhaphy**
hymenorrhaphy or hymen reconstruction surgery, is a cosmetic procedure.

Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx

| Intervention | Labiaplasty, Vaginoplasty and Hymenorrhaphy |
|---|---|
| **Minimum eligibility criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6).<br><br>http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf<br><br>NHS Choices – Guide to Labiaplasty<br>Weblink:<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx<br><br>Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10.<br><br>Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature.<br><br>Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159* |

| | |
|---|---|
| | Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499.<br><br>Department for Education and Skills. (2004). *Local Authority Social Services Letter*. *LASSAL (2004)4,* London, DfES. |

## A14.17 Liposuction

Liposuction (also known as liposculpture) is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.

A good summary of Cosmetic Surgery is provided by NHS Choices.
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx

| Intervention | Liposuction |
|---|---|
| **Minimum eligibility criteria** | Liposuction is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Liposuction: Weblink https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/<br><br>NHS Choices: Liposuction http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx<br><br>Liposuction for chronic lymphoedema<br>NICE 2008.<br><br>Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

## A14.18 Rhytidectomy - Face or Brow Lift

A facelift (rhytidectomy) is cosmetic surgery to lift up and pull back the skin to make the face tighter and smoother. The procedure is designed to reduce flabby or sagging skin around the lower half of the face (mainly the jowls) and neck. If you're thinking of going ahead, be absolutely sure about your reasons for wanting a facelift and don't rush into it. The procedure can be expensive, the results can't be guaranteed, and there are risks to consider

Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

| Intervention | Face Lift or Brow Lift (Rhytidectomy) |
|---|---|
| **Minimum eligibility criteria** | Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below.<br><br>Recognised diagnosis of Congenital (present from birth) facial abnormalities<br>**OR**<br>Facial palsy (congenital or acquired paralysis)<br>**OR**<br>As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis |
| **Evidence for inclusion and threshold** | Modernisation Agency's Action on Plastic Surgery 2005.<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>Royal College of Surgeons – Rhytidectomy Weblink<br>https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/facelift/<br><br>NHS Choices: Facelift (Rhytidectomy)<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/Facelift.aspx |

## A16. Trauma and Orthopaedics

### A16.1 Policy for non-invasive interventions for low Back pain and sciatica

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer.

Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur. Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities.

For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that's the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery.

If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help.

You should seek early advice from your GP if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor.

| Intervention | Policy for non-invasive interventions for low Back pain and sciatica |
|---|---|
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | **Acupuncture**<br>Acupuncture for low back pain and sciatica is **not routinely commissioned**<br><br>**Manual Therapy**<br>The following procedures are **not routinely commissioned**:<br>• Lumbar traction<br>• Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)<br>• Manual therapy (spinal mobilisation, manipulation, soft tissue |

techniques and massage) in isolation.

Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

**Orthotics**

The following are **not routinely commissioned**:

- Foot orthotics
- Rocker shoes
- Belts and corsets

**Electrotherapy**

The following are **not routinely commissioned:**

- Transcutaneous electrical nerve stimulation (TENS)
- Percutaneous electrical nerve stimulation (PENS)
- Ultrasound
- Interferential
- Laser therapy

**Pharmacological interventions**

The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain:

- Paracetamol used alone
- Selective serotonin re-uptake inhibitors (**SSRIs**)
- Serotonin– norepinephrine reuptake inhibitors
- Tricyclic antidepressants
- Anti-convulsants
- Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)

Patients with neuropathic pain should be managed in line with NICE CG 173:

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)

1.1.9 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.

1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).

| | |
|---|---|
| | 1.1.11 Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.<br><br>***Treatments that should not be used***<br>1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:<br>• cannabis sativa extract<br>• capsaicin patch<br>• lacosamide<br>• lamotrigine<br>• levetiracetam<br>• morphine<br>• oxcarbazepine<br>• topiramate<br>• tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use)<br>• venlafaxine. |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>Osteoarthritis: the care and management of osteoarthritis in adults<br>https://www.nice.org.uk/guidance/cg59<br><br>The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012)<br>http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf<br>Final_TAMARS_report[1].pdf |

## A16.2 Imaging for patients presenting with low back pain

Imaging does not often change the initial management and outcomes of someone with back pain. This is because the reported imaging findings are usually common and not necessarily related to the person's symptoms. Many of the imaging findings (for example, disc and joint degeneration) are frequently found in asymptomatic people. Requests for imaging by non-specialist clinicians, where there is no suspicion of serious underlying pathology, can cause unnecessary distress and lead to further referrals for findings that are not clinically relevant.

| Intervention | Imaging for patients presenting with low back pain. |
|---|---|
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings.<br><br>For patients with non-urgent presentations consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery.<br><br>Imaging is only commissioned where patients present with red flags(see below) or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management.<br><br>Emergency Spinal Referral<br>• Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms)<br>• Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit)<br>• Major motor radiculopathy<br>• Suspected Spinal Infection<br>Priority Spine imaging (Protocol led MRI whole spine unless contraindicated)<br>• Past history of cancer *(new onset spinal pain)<br>• Recent unexplained weight loss<br>• Objectively unwell with spinal pain<br>• Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice)<br>• Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids).<br>• Prolonged steroid use *<br>• Known osteoporosis, with new severe spinal pain |

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| | Age <15, or >60 years new onset axial back pain<br>*Statistically significant red flags. Although the others listed may not be |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging<br>https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referrals-for-imaging<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 |

## A16.3 Injections for back pain

NICE 2016 recommend against repeated spinal injections for managing low back pain

| Intervention | Injections for back pain |
|---|---|
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned<br><br>**<u>Epidural</u>**<br><br>Single shot epidural steroid is of short-term benefit in acute and severe sciatica and may enable normal activity to resume. Benefits and risks should be discussed with the patient. Epidural injections should be targeted at the affected nerve root(s) and under image guidance where required.<br><br>Only one injection should be offered and this should only be offered where:<br>• symptoms are acute<br>AND<br>• The patient is experiencing severe sciatica.<br><br>Epidural Injection for Non-specific Low Back Pain of greater than 12 months, is not routinely commissioned.<br>Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned.<br><br>**Radiofrequency Facet Joint Denervation**<br><br>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)<br><br>The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when:<br>• comprehensive conservative treatment approach has not<br>• worked for them<br>AND<br>• the main source of pain is thought to come from structures supplied by the medial branch nerve<br>AND |

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| | • The clinical presentation is consistent with symptoms arising from the facet joint:<br>  ○ Increased pain unilaterally or bilaterally on lumbar paraspinal palpation<br>  ○ Increased back pain on 1 or more of the following: o extension (more than flexion); rotation; extension/side flexion; extension/rotation<br>  ○ No radicular symptoms<br>  ○ No sacroiliac joint pain elicited using a provocation test<br>AND<br>• 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<br>AND<br>• low back pain is chronic in nature<br>AND<br>• The patient has significant short term pain relief to a diagnostic medial branch block.<br><br>Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.<br><br>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 |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 |

## A16.4 Spinal Fusion

Spinal fusion is used to join two or more vertebrae together by placing an additional section of bone in the space between them.

This helps to prevent excessive movements between two adjacent vertebrae, lowering the risk of further irritation or compression of the nearby nerves and reducing pain and related symptoms.

The additional section of bone can be taken from somewhere else in your body (usually the hip) or from a donated bone. More recently, synthetic (man-made) bone substitutes have been used.

To improve the chance of fusion being successful, some surgeons may use screws and connecting rods to secure the bones.

Afterwards, the surgeon will close the incision with stitches or surgical staples.

http://www.nhs.uk/Conditions/Lumbardecompressivesurgery/Pages/surgery.aspx

| **Intervention** | **Spinal Fusion** |
|---|---|
| **Minimum eligibility criteria** | The following procedures are not routinely commissioned:<br>• Fusion<br>• Non-rigid stabilisation techniques<br>• Lateral body fusion in the lumbar spine<br>• Transaxial interbody lumbrosacral fusion<br>• Anterior lumbar interbody fusion (ALIF)<br>• Posterior lumbar interbody fusion (PLIF)<br>• Or any other combination of approach where surgical fixation is performed |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br><br>IPG 387: https://www.nice.org.uk/guidance/ipg387<br>Transaxial interbody lumbosacral fusion |

## A16.5 Disc and Decompression procedures

**Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.**

It's only recommended when non-surgical treatments haven't helped.

The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.

Lumbar decompression surgery is often used to treat:
•spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside
•a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve
•spinal injuries – such as a fracture or the swelling of tissue
•metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves

| Intervention | Disc and Decompression procedures |
|---|---|
| **Policy Statement** | Restricted |
| **Minimum eligibility criteria** | Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:<br>• Patient presents with severe and acute sciatica<br>AND<br>• have failed to respond to conservative intervention<br>AND<br>• have imaging findings concordant with clinical presentation<br>Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network.<br><br>The following procedures are NOT routinely commissioned:<br>• Endoscopic Laser Foraminoplasty<br>• Endoscopic Lumbar Decompression<br>• Percutaneous Disc Decompression using Coblation for Lower Back Pain<br>• Percutaneous Intradiscal Laser Ablation in the Lumbar Spine<br>• Automated Percutaneous Mechanical Lumbar Discectomy<br>• Prosthetic Intervertebral Disc Replacement in the Lumbar Spine<br>• Intradiscal Electro Thermal Annuloplasty (IDET)<br>• Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) |

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| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br><br>IPG31 Endoscopic laser foraminoplasty: guidance<br>NICE 2003 (confirmed 2009)<br>Reviewed October 2011 – Decision taken that this policy does not require update.<br><br>IPG570: https://www.nice.org.uk/guidance/ipg570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016)<br><br>IPG543: https://www.nice.org.uk/guidance/ipg543<br>Percutaneous coblation of the intervertebral disc for low back pain and sciatica<br><br>IPG:357 https://www.nice.org.uk/guidance/ipg357<br>Percutaneous intradiscal laser ablation in the lumbar spine<br><br>IPG141: https://www.nice.org.uk/guidance/ipg141<br>Automated percutaneous mechanical lumbar discectomy<br><br>IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine<br>NICE 2009. |

## A16.6 Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain

The lower back is commonly defined as the area between the bottom of the rib cage and the buttock creases. Chronic low back pain is tension, soreness and/or stiffness often worsened by movement lasting more than six weeks in the lower back region. Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Peripheral nerve-field stimulation involves implanting electrodes in the back, connected to a neurostimulator under the skin. The aim is to mask the back pain by modulating the transmission of pain signals to the brain. The patient uses a remote control to deliver low voltage electrical stimulation to the subcutaneous tissue layers of the lower back. The stimulation causes a tingling sensation (paraesthesia) in the area of the body associated with the pain, easing the discomfort.

https://www.nice.org.uk/guidance/ipg451

| Intervention | Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br>IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.<br><br>Current evidence on the efficacy of peripheral nerve-field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device |

## A16.7 Therapeutic endoscopic Division of epidural adhesions

Endoscopic epidural procedures are used to treat lower back pain, particularly when radiculopathy is present. The epidural space is examined with an endoscope and further interventions may then be performed, such as mobilising spinal adhesions or administering drugs to inflamed tissue.

| Intervention | Therapeutic Endoscopic Division of Epidural Adhesions |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Evidence for inclusion and threshold** | IPG333: https://www.nice.org.uk/guidance/ipg333<br>Therapeutic endoscopic division of epidural adhesions<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br><br>Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. |

## A16.19 Hyaluronic Acid and Derivatives Injections for Peripheral joint pain

| Intervention | Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain |
|---|---|
| **Minimum eligibility criteria** | This procedure is not routinely commissioned. |
| **Rationale** | Hyaluronic Acid and Derivatives Injections are not commissioned for joint injections.<br><br>**Do not offer intra-articular hyaluronan injections for the management of osteoarthritis** |
| **Evidence for inclusion and threshold** | **Do Not Do Recommendation**<br>https://www.nice.org.uk/donotdo/do-not-offer-intraarticular-hyaluronan-injections-for-the-management-of-osteoarthritis |

## A16.23a Hip Replacement Surgery

A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.

The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.
Some common reasons why a hip joint can become damaged include:

- osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other
- rheumatoid arthritis – this is caused by the immune system (the body's defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness
- hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it

Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.
The purpose of a new hip joint is to:

- relieve pain
- improve the function of your hip
- improve your ability to move around
- improve your quality of life

Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms-

- Pain
- Stiffness
- reduced function

Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time.

| Intervention | Hip Replacement Surgery |
|---|---|
| Minimum eligibility criteria | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.<br><br>**Referral criteria for Total Hip Replacements (THR)** should be based on the level of pain and functional impairment suffered by the |

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| | patient. Funding is available for patients who fulfil the following criteria;<br><br>1. Patient complains of severe joint pain.<br>AND<br>2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.<br>OR<br>3. Patient complains of mild to moderate joint pain 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.<br><br>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). |

**Guidance/evidence**

Royal College of Surgeons – Painful Hip Commissioning Guide
https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/

NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)
Weblink:
https://www.nice.org.uk/guidance/cg177

NHS Choices – Hip replacement
Weblink:
http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx

## A16.23b Policy for Knee Replacement Surgery

Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old.

For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain.

There are two main types of surgery, depending on the condition of the knee:

- total knee replacement (TKR) – both sides of your knee joint are replaced
- partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period

The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:

- rheumatoid arthritis
- haemophilia
- gout
- knee injury

A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven't helped reduce pain or improve mobility. You may be offered knee replacement surgery if:

- You have severe pain, swelling and stiffness in your knee joint and your mobility is reduced
- your knee pain is so severe that it interferes with your quality of life and sleep
- everyday tasks, such as shopping or getting out of the bath, are difficult or impossible
- you cannot work or have a normal social life

Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms;

- Pain
- Stiffness
- Reduced function

| Intervention | Knee Replacement Surgery |
|---|---|
| Minimum eligibility criteria | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.<br><br>**Funding for total or partial knee replacement surgery is available if the** |

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| | **following criteria are met**<br><br>1. Patients with BMI <40.<br>AND<br>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.<br>AND<br>3. Has radiological features of severe disease.<br>OR<br>4. Has radiological features of moderate disease with limited mobility or instability of the knee joint. |

**Guidance/evidence**

Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017)
Weblink:
https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en

NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)
Weblink:
https://www.nice.org.uk/guidance/cg177

Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review
Saif Salih* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25)
Weblink:
(http://www.biomedcentral.com/2052-1847/5/25)

NHS Choices – Knee replacement
Weblink:
http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx

## A16.30 Surgical Removal of Ganglions

A ganglion is a non-cancerous fluid-filled lump which can occur near joints or tendons. It is most commonly found on the wrist or hands. The cyst can range from the size of a pea to the size of a golf ball. Ganglions can occur alongside any joint in the body, but are most common on the wrist (particularly the back of the wrist), and the hand and fingers.

Ganglions are harmless, but can sometimes be painful. If they do not cause any pain or discomfort, they can be left alone and may disappear without treatment, although this can take a number of years.

The two main treatment options for a ganglion cyst are:

- draining fluid out of the cyst with a needle and syringe – the medical term for this is aspiration
- cutting the cyst out using surgery

| Intervention | Surgical Removal of Ganglions |
|---|---|
| **Policy Statement** | Aspiration and Surgery for ganglion (open or arthroscopic) is **not routinely commissioned.**<br><br>Reassurance that no treatment is required should be given to the patient. |
| **Rationale** | This is because a ganglion will often disappear on its own after a year or two. |
| **Evidence for inclusion and threshold** | Ganglion Cysts – British Society for Surgery of the Hand<br>http://www.bssh.ac.uk/patients/conditions/20/ganglion_cysts<br><br>NHS Choices - Ganglion cyst<br>Weblink:<br>http://www.nhs.uk/conditions/Excisionofganglion/Pages/Introduction.aspx |

## A17. Urology

### A17.1 Policy for Circumcision for medical reasons only

Male circumcision is the surgical removal of the foreskin.
The foreskin is the retractable fold of skin that covers the end of the penis. It's a continuation of the skin that covers the whole penis.

Further information can be found at:
http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx

| Intervention | Circumcision for medical reasons only |
|---|---|
| **Minimum eligibility criteria** | **Circumcision will be funded in the following medical circumstances**:<br>• Balantis xerotica obliterans.<br>• Traumatic foreskin injury/scarring where it cannot be salvaged.<br>• 3 or more episodes of balanitis/balanoposthitis.<br>• Pathological phimosis.<br>• Irreducible paraphimosis.<br>• Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract.<br>• Tight foreskin causing pain on arousal/ interfering with sexual function<br><br>This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk.<br><br>This procedure is not offered for social, cultural or religious reasons. |
| **Evidence for inclusion and threshold** | 2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008).<br><br>Balanitis<br>NICE Clinical Knowledge Summaries 2015<br><br>I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes<br>Sexually Transmitted Infections 2012;88:A55-A56.<br><br>Balanitis<br>Patient.co.uk.<br><br>https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions-- |

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|---|---|
| | commissioning-guide.pdf<br>Foreskin Conditions: Royal College of Surgeons guidance (2013).<br><br>NHS Choices – Circumcision<br>Weblink:<br>http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx<br><br>Male Circumcision: Guidance for Healthcare Practitioners<br>Royal College of Surgeons, 2000<br>https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/ |

## A18. Vascular Surgery

### A18.3 Policy for Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery

Varicose veins are veins that have become wider than normal and are unable to transport blood properly so that blood collects in them. This can cause heaviness, aching, throbbing, itching, cramps and fatigue in the legs. In severe cases, patients may develop skin discoloration or inflammation and skin ulcers.

• Varicose veins are common affecting 15% to 30% of the adult population.
• They are tortuous distended bulging veins lying beneath the skin in the legs.
• They commonly arise from incompetence in the long and short saphenous veins and their branches, though they may be secondary varicosities with associated deep venous disease.
• They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin.
• Complications from varicose veins include eczema, induration (lipodermatosclerosis), pigmentation, bleeding, thrombophlebitis and ulceration.
• Patients complain both of the appearance and report symptoms such as aching in the leg, pains in the leg, restlessness, cramps, itchiness, heaviness and swelling.
• Varicose eczema if severe or inflamed can be treated effectively with topical steroids.
• Thrombophlebitis usually responds to leg elevation, topical or systemic NSAID's and stockings. Antibiotics are occasionally required for secondary infection.

For most people, varicose veins do not present a serious health problem. They may have an unpleasant appearance, but should not affect circulation or cause long-term health problems. Most varicose veins do not require any treatment.
Before surgical treatment is necessary, your doctor may first provide advice on:
• weight loss (for guidance on weight management see Obesity [NICE clinical guideline 43]
• light to moderate physical activity
• avoiding factors that are known to make their symptoms worse if possible
• when and where to seek further medical help.

| Intervention | Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery |
|---|---|
| **Minimum eligibility criteria** | Treatment of varicose veins is only commissioned in the following circumstances:<br>• Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended).<br>***OR***<br>• A history of varicose ulceration<br>***OR***<br>• Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or |

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| | significant oedema associated with skin changes<br>***OR***<br>• Documented episodes of superficial thrombophlebitis in association with varicose veins<br><br>**Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is inappropriate or declined.<br><br>This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because if the above NICE and RCS criteria are met the Varicose Vein treatments detailed above are likely to reduce the likelihood of disease progression and improve quality of life by reducing symptoms |
| **Evidence for inclusion and threshold** | NICE - Clinical Guideline 168: Varicose veins in the legs: the diagnosis and management of varicose veins (2013):<br>Weblink:<br>http://guidance.nice.org.uk/CG168<br><br>Royal College of Surgeons - Commissioning guide: varicose veins (2013)<br>Weblink:<br>https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/varicose-veins-guide/<br><br>NHS Choices – Varicose veins<br>Weblink:<br>http://www.nhs.uk/conditions/Varicose-veins/Pages/Whatarevaricoseveins.aspx<br><br>Tassie E, Scotland G, Brittenden J, et al., on behalf of the CLASS Study team. Cost-effectiveness of ultrasound guided foam sclerotherapy (UGFS), endovenous laser ablation (EVLA), and surgery as treatments for primary varicose veins: results based on the CLASS trial. Br J Surg. 2014;101(12):1532-40.<br><br>Marsden, G; Perry, M; Bradbury, A; Hickey, N; Kelley, K; Trender, H; Wonderling, D; Davies, A H. A Cost-effectiveness Analysis of Surgery, Endothermal Ablation, Ultrasound-guided Foam Sclerotherapy and Compression Stockings for Symptomatic Varicose Veins. European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery; Dec 2015; vol. 50 (no. 6); p. 794-801 |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B1. Complementary Therapies** | | | |
| **B1.1 Complementary Therapies** | Not routinely commissioned unless recommended by NICE guidance. | *Complementary and alternative medicine* – NHS Choices 2012. http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/ | Individual CCG addendums apply. |
| **B2. Dermatology** | | | |
| **B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)** | Only be commissioned in the following circumstances:<br><br>Severe scarring following:<br>Acne once the active disease is controlled.<br>Chicken pox.<br>OR<br>Trauma (including post-surgical).<br><br>Procedures will only be performed on the head and neck area.<br><br>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br><br>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. | Modernisation Agency's Action on Plastic Surgery 2005.<br>Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. 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.<br>www.evidence.nhs.uk<br>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br>NHS England interim protocol<br>NHS England (2013)<br>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B2.4 Treatments for Skin Pigment Disorders** | NHS Cosmetic Camouflage is commissioned.<br><br>This is provided by Changing Faces formerly the Red Cross.*<br><br>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br><br>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. | http://www.changingfaces.org.uk/Skin-Camouflage<br><br>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br>NHS England interim protocol<br>NHS England (2013).<br><br>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. | Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only.<br><br>Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.<br><br>*Access available for Wirral patients via Dermatology Department. |
| **B2.5 Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers** | Will be commissioned in any of the following circumstances:<br><br>Severe pain substantially interfering with functional abilities.<br>Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.<br>Extensive warts (particularly in the immune-suppressed patient).<br>Facial warts.<br>Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist. | Modernisation Agency's Action on Plastic Surgery 2005.<br><br>Nongenital warts: recommended approaches to management<br>Prescriber 2007 18(4) p33-44.<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>patient.co.uk/doctor/viral-warts-excluding-verrucae<br><br>http://www.patient.co.uk/doctor/verrucae | Most viral warts will clear spontaneously or following application of topical treatments.<br><br>65% are likely to disappear spontaneously within 2 years.<br><br>There are numerous OTC preparations available.<br><br>Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care. |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
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## B3. Diabetes

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B3.1 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;<br><br>Type I diabetes.<br>AND<br>Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151.<br>AND<br>HbA1c which is equal to or greater than 69 (8.5%) mmol/OR experiencing severe hypoglycaemic attacks which require intervention by a carer.<br>AND<br>Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value.<br>AND<br>Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum).<br>AND<br>Motivated to comply with the requirements.<br>The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months.<br>All cases will be subject to individual approval by the IFR Team. | Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012.<br><br>Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials. – European Journal of Endocrinology. 2012 Apr; 166(4):567-74.<br><br>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.<br><br>Continuous Glucose Monitoring for Patients with Diabetes – Ontario: Health Quality Ontario, 2011.<br><br>Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British Society for Paediatric Endocrinology and Diabetes, 2009.<br><br>For further references please refer to Public Health Continuous Glucose Monitors Paper. | PH Continuous Glucose Monitors Pap<br><br>PH Continuous Glucose Monitors Add |

## B4. ENT

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B4.3a Insertion of Grommets for Glue Ear (otitis media with effusion) - CHILDREN** | CHILDREN<br>The CCG will commission treatment with grommets/myringotomy for children with otitis media with effusion (OME) where:<br>• 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.<br>OR<br>• 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).<br>AND<br>• OME persists after three months.<br>AND<br>• 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.<br>OR<br>• 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.<br><br>Children with Downs Syndrome are normally fitted with Hearing Aids.<br><br>Management of children with cleft palate is under specialist supervision.<br><br>Do not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 5.1 Adenoidectomy. | http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome<br>Royal College of Surgeons (2013).<br>NICE Pathway – Surgical management of Otitis Media with effusion in children<br>(2012).<br>CG60 Surgical management of children with otitis media with effusion (OME)<br>(February 2008).<br>The advice in the NICE guideline covers:<br>• The surgical management of OME in children younger than 12 years.<br>• Guidance for managing OME in children with Down's syndrome and in children with all types of cleft palate.<br>It does not specifically look at the management of OME in:<br>•Children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease).<br>•Children with multiple complex needs.<br>*Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children* - Cochrane Ear, Nose and Throat Disorders Group 2010.<br>http://pathways.nice.org.uk/pathways/surgical-management-of-otitis-media-with-effusion-in-children - path=view%3A/pathways/surgical-management-of-otitis-media-with-effusion-in-children/assessment-and-treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions<br>http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B4.3b Insertion of Grommets for Glue Ear (otitis media with effusion) - ADULTS** | ADULTS<br>Grommets in adults with OME will be funded only in the following circumstances:<br>• Significant negative middle ear pressure measured on two sequential appointments.<br>AND<br>• Significant ongoing associated pain.<br>OR<br>• Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy. | http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome<br>Royal College of Surgeons (2013).<br><br>http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf | |
| **B4.5 Surgical Remodelling of External Ear Lobe** | This is not routinely commissioned. | Modernisation Agency's Action on Plastic Surgery 2005. | Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. |
| **B4.6 Use of Sinus X-ray** | X-rays of sinuses are not routinely commissioned. | BSACI guidelines for the management of rhinosinusitis and nasal polyposis<br>Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007.<br><br>NHS Choices Sinusitis<br><br>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitus<br>Royal College of Surgeons (2013). | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B4.8 Surgery of Laser Treatment of Rhinophyma** | Not routinely commissioned. | Nuances in the management of rhinophyma<br>Facial Plastic Surgery, 2012 Apr;28(2):231-7.<br><br>http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm<br><br>http://www.nhs.uk/Conditions/Rosacea/Pages/Treatment.aspx | The first-line treatment of this condition of the nasal skin is medical. However response is poor.<br><br>Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances. |
| **B5. Equipment** | | | |
| **B5.1 Use of Lycra Suits** | Lycra Suits are not normally commissioned for postural management of cerebral palsy.<br><br>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.<br><br>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.<br><br>Public Health Recommendation:<br><br>Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.<br><br>Lycra suit orthoses for cerebral palsy should be assigned low priority.<br><br>Individual CCG addendums apply.<br><br>PH Lycra Suits Paper.pdf |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B6. Fertility** | | | |
| **B6.1 Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation** | See Cheshire & Merseyside Infertility Policy. | CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013.<br><br>Contraception – sterilization – NICE Clinical Knowledge Summaries 2012<br>http://cks.nice.org.uk/contraception-sterilization#!scenario | Individual CCG addendums apply. |
| **B7. General Surgery** | | | |
| **B7.4 Lithotripsy for Gallstones** | Lithotripsy not routinely commissioned. | | Lithotripsy rarely performed as rate recurrence high. |
| **B9. Mental Health** | | | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B9.1 Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)** | Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned.<br><br>If inpatient treatment is recommended an IFR referral will be required. | *Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53.<br><br>*Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008.<br><br>*Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137.<br><br>*Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012, 12:264. | Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.<br><br>NICE section 1.915 states:<br>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 an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital. |
| **B9.3 Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)** | This is not routinely commissioned. | Interventions to reduce substance misuse among vulnerable young people –<br>NICE Public Health Guidance 4 (2007)<br>Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007).<br>Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence –<br>NICE Clinical Guideline 115 (2011). | |

## B10. Neurology

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B10.1 Bobath Therapy** | Bobath Therapy is not routinely commissioned by the NHS.<br><br>The evidence base is poor for both children and adults. | The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97.<br>Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme<br>Physiotherapy Research International<br>Volume 16, Issue 2, pages 69–80, June 2011.<br>Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial<br>Clinical Rehabilitation, 2012 Aug;26(8):705-15.<br>http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf<br>Cambridge CCG (2013).<br>A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy<br>National Public Health Service for Wales (2008). | |
| **B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy** | Not routinely commissioned. | Physical therapy for Bell's palsy (idiopathic facial paralysis).<br>Cochrane Database of Systematic Reviews. Issue 12 (2011). | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B10.3 Functional Electrical Stimulation (FES)** | Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury.<br><br>It is not routinely commissioned for lower motor neurone lesions.<br><br>It is under review by NICE for dysphagia and muscle recovery chronic disease.<br><br>Patients must have receptive cognitive abilities.<br><br>Exclusion Criteria:<br>• Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin.<br>• Chronic oedema at site of stimulation.<br>• Diagnosis of deep vein thrombosis.<br>• Receptive dysphasia (unable to understand instructions).<br>• Complete peripheral nerve damage.<br>• Pacemaker in situ.<br>• Pregnancy or intention to become pregnant.<br>• Active cancer.<br>• Uncontrolled epilepsy.<br>• Metal in region of stimulation e.g.: pin and plate.<br>• Ataxic and polio patients are generally poor responders although there are exceptions. | Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness –<br>CADTH Rapid Response Service, 2011.<br><br>Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78.<br><br>Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10.<br><br>Functional electrical stimulation for drop foot of central neurological origin<br>NICE, 2009.<br><br>Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011. | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B11. Ophthalmology** | | | |
| **B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid** | Only commissioned in the following circumstances:<br>• Eyelid function interferes with visual field. | Eyelid Surgery<br>*The British Association of Aesthetic Plastic Surgeons 2011.*<br><br>Modernisation Agency's Action on Plastic Surgery 2005.<br><br>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base<br>London Health Observatory 2010. | Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.<br><br>Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment.<br><br>Impairment to visual field to be documented. |
| **B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.** | Only commissioned in any of the following circumstances:<br>• Correction of ectropion or entropion which threatens the health of the affected eye.<br>• Removal of lesions of eyelid skin or lid margin.<br>• Rehabilitative surgery for patients with thyroid eye disease. | *Eyelid Surgery*<br>The British Association of Aesthetic Plastic Surgeons 2011.<br><br>Local PCT consensus – review conducted 2007.<br><br>Modernisation Agency's Action on Plastic Surgery 2005.<br><br>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base -<br>London Health Observatory 2010. | 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. |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)** | Only commissioned for:<br>• Larger legions which satisfy all of the following:<br>  • Not responded to treatment for underlying familial lipoprotein lipase deficiency.<br>  • Failed topical treatment.<br>  • Causing significant disfigurement.<br>  • Causing functional impairment.<br>• Topical treatments may be available in a primary care or community setting. | Local PCT consensus – review conducted 2007.<br><br>DermNet NZ information resources<br>updated Jan 2013.<br><br>Commissioning Criteria – Plastic Surgery<br>Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br>Health Commission Wales (2008).<br><br>http://www.patient.co.uk/doctor/xanthelasma | The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy.<br><br>Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.<br><br>Lesions are harmless. |
| **B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)** | Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned. | | |
| **B11.6 Coloured (irlens) Filters for Treatment of Dyslexia** | 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 | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B11.7 Intra Ocular Telescope for Advanced Age-Related Macular Degeneration** | 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.<br><br>Intraocular telescope by Vision Care ™ for age-related macular degeneration<br>North East Treatment Advisory Group (2012). | |
| **B11.8 Surgical Removal of Chalazion or Meibomian Cysts** | Referral to secondary care will only be considered when all of the following are met:<br>• Present for six months or more.<br>• Conservative treatment has failed.<br>• Sited on upper eyelid.<br>AND<br>• Causes blurring or interference with vision.<br>OR<br>• Has required treatment with antibiotics due to infection at least twice in the preceding six months.<br>In Children under 10 this is commissioned as visual development may be at risk. | Guidance for the management of referrals for Meibomian Cysts<br><br>NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013).<br>http://www.kernowccg.nhs.uk/media/136633/chalazion__meibomian_cyst__guidance_16.01.2013.pdf<br>NHS Cornwall & Isles of Scilly, Devon, Plymouth and Torbay | Individual CCG addendums apply. |

## B12. Oral Surgery

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B12.1 Surgical Replacement of the Temporo-Mandibular Joint, Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement** | Only commissioned in the following circumstances:<br>Any or a combination of the following symptoms are present:<br>• Restricted mouth opening <35mm).<br>• Dietary score of< 5/10 (liquid scores 0, full diet scores 10).<br>• Occlusal collapse (anterior open bite or retrusion).<br>• Excessive condylar resorption and loss of height of vertical ramus.<br>• Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms).<br>• Other significant quality of life issues.<br>AND<br>• 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 symptoms. | Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.<br>  <br>TMJ Replacement Guidance .pdf<br><br>Total prosthetic replacement of the Temporomandibular joint (IPG329)<br>NICE 2009<br><br>http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes | |
| **B13. Paediatrics** | | | |
| **B13.1 Cranial Banding for Positional Plagiocephaly** | Not routinely commissioned. | Nonsurgical treatment of deformational plagiocephaly: a systematic review<br>Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27.<br><br>What is the role of helmet therapy in positional plagiocephaly?<br>BestBETS 2008. | Most childrens head shapes will improve naturally in their own time. |
| **B15. Respiratory** | | | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B15.1 Treatments for Snoring, Soft Palate Implants and Radiofrequency Ablation of the Soft Palate, Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty', Uvulopalatoplasty and Uvulopalatopharyngoplasy** | Not Routinely Commissioned. | Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007).<br><br>Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005).<br><br>Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults<br>SIGN (2003).<br><br>Surgery for obstructive sleep apnoea in adults<br>Cochrane Database of Systematic Reviews (2005).<br><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><br>Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36.<br><br>The British Snoring & Sleep Apnoea Association | 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 efficacy and outcomes is uncertain. UPPP may compromise the patient's subsequent ability to use nasal CPAP.<br><br>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. |

## B16. Trauma & Orthopaedics

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha** | Dibotermin alfa is commissioned in the following situation:<br>• The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation.<br>• Eptotermin alfa is commissioned in line with its licensed indication:<br>• Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible. | Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review<br>Health Technology Assessment NHS R&D HTA Programme, 2007.<br>Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI<br>Annals of Internal Medicine \| Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data<br>June 2013<br>BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16. | |
| **B16.18 Surgery for Trigger Finger** | Surgery not commissioned unless:<br>• Conservative treatments, (including at least 1 corticosteroid injections) have failed or are contraindicated<br>AND<br>• Fixed flexion deformity that cannot be corrected easily is present. | Nimigan AS, Ross DC, Bing SG. Steroid injections in the management of trigger fingers. American Journal of Physical Medicine and Rehabilitation 2006; 85(1):36-43.<br>BMJ review: Akhtar S, Bradley MJ, Quinton DN, Burke FD. Management and referral for trigger finder/thumb. BMJ 2005; 331(7507):30-33.<br><br>NHS Oxfordshire, Interim Treatment Threshold Statement: Surgery for trigger finger (stenosing tenovaginosis)<br><br>Corticosteroid injection for trigger finger in adults<br>Cochrane Database of Systematic Reviews (2008).<br><br>Trigger Finger Assessment<br>Map of Medicine (2012) – for North Mersey<br><br>Surgery versus ultrasound-guided steroid injections for trigger finger disease: protocol of a randomized controlled trial<br>Danish Medical Journal 2013;60(5):A4633. | Conservative management (including splinting, steroid injections, NSAIDS) is adequate in the majority of cases.<br><br>Local steroid injections should be the first line treatment unless the patient is diabetic (where surgery preferred). |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.20 Secondary Care Administered Steroid Joint Injections** | Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre. | Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012. | |
| **B16.21 Palmar Fasciectomy/Needle Faciotomy for Dupuytren's Disease** | Requests for treatment will be considered when:<br>• Metacarpophalangeal joint contracture of 30 degrees or more, (inability to place hand flat on table.<br>OR<br>• Any degree of proximal interphalangeal joint contracture.<br>OR<br>• Patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 100 or more.<br><br>There should be significant functional impairment. | IPG043 Needle fasciotomy for Dupuyren's contracture - guidance –<br>NICE 2004.<br><br>Dupuytrens disease<br>NICE Clinical Knowledge Summaries (2010).<br><br>British society hand surgeons<br>New guidelines awaited.<br><br>NHS North West London commissioning policy – Dupuytren's Disease<br>April 2013.<br><br>Common Hand Conditions<br>NHS Dorset Clinical Commissioning Group<br>(2011). | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.22 Radiotherapy Collagenase Injections for Dupytren's Disease** | These procedures are not commissioned. | IPG368: Radiation therapy for early Dupuytren's disease NICE 2010. | Individual CCG addendums apply. |
| **B16.24 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.<br><br>However it is not routinely commissioned for any of the following indications:<br>• Investigation of knee pain.<br>• Treatment of Osteo-Arthritis including Arthroscopic washout.<br>• 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.<br><br>If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered. | CG59 Osteoarthritis. Section 3.1 NICE 2008<br><br>Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007.<br><br>Knee replacement: A guide to good practice British Orthopaedic Association, 2000.<br><br>Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013).<br><br>http://guidance.nice.org.uk/CG177 CG177Osteoarthritis (NICE 2014) | |
| **B16.25 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). | | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.26 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<br>NICE, 2009 | Referral should be made to specialist centres only. |
| **B16.27 Patient Specific Total Knee Replacement** | This is not commissioned. | EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates<br>ECRI Institute (2012)<br><br>IPG 345: Mini-incision surgery for total knee replacement<br>NICE 2010 | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.28 Surgical Treatment for Carpal Tunnel Syndrome** | Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases.<br>Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied:<br>• Patients have not responded to 3 months of conservative treatments, including:<br>• 6 weeks of night-time use of wrist splints.<br>Corticosteroid injection in appropriate patients.<br>Conservative treatments contraindicated.<br>Severe cases:<br>• Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment.<br>The following treatments are not commissioned for carpal tunnel syndrome:<br>• Diuretics<br>• NSAIDS<br>• Vitamin B6<br>• Activity modification<br>• Heat treatment<br>• Botulinum toxin | Local corticosteroid injection for carpal tunnel syndrome<br>Cochrane Database of Systematic Reviews, 2007.<br>Clinical practice guideline on treatment of Carpal Tunnel Syndrome<br>American Academy of Orthopaedic Surgeons, 2008.<br>Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome<br>NHS Oxfordshire, 2009.<br>Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome - Cochrane Database of Systematic Reviews 2002.<br>Surgical treatment options for carpal tunnel syndrome<br>Cochrane Database of Systematic Reviews 2007.<br>Surgical versus non-surgical treatment for carpal tunnel syndrome<br>Cochrane Database of Systematic Reviews 2008.<br>Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review<br>Journal of Orthopaedic Surgery & Research 2011, 6:17.<br>Median Nerve Lesions and Carpal Tunnel Syndrome<br>Patient.co.uk.<br>Commissioning Guide: Painful tingling fingers<br>Royal College of Surgeons (2013). | Mild cases often resolve spontaneously after 6 months. |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.29 Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)** | Only commissioned for mucoid cysts under the following circumstance:<br>• Failure of conservative treatments including watchful waiting.<br>AND any of the following:<br>• Nail growth disturbed.<br>• Discharging, ulcerated or infected.<br>• Size interferes with normal hand function. | Digital Mucous Cyst<br>Overview of condition – Medscape. | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.31 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:<br>• A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.<br>• An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.<br>• The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.<br>• 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.<br>http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf<br>NHS Hull Clinical Commissioning Group 2012.<br><br>Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68.<br><br>Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).<br><br>Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345.<br><br>Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013).<br><br>IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance<br>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.<br><br>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. |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.32 Surgical Removal of Bunions/Surgery for Lesser Toe Deformity** | Requests for the removal of bunions will only be considered where:<br>• Conservative methods of management* have failed.<br>AND<br>• The patient suffers significant functional impairment** as a result of the bunions.<br>AND<br>• Radiographic evidence of joint damage (at point of referral).<br><br>*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.<br>**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.<br><br>Treatment will not be commissioned for cosmetic appearance only. | Bunions<br>NICE Clinical Knowledge Summaries (2012)<br><br>IPG 332: Surgical correction of hallux valgus using minimal access techniques<br>NICE (2010)<br><br>Commissioning Guide: Painful deformed great toe in adults<br>Royal College of Surgeons (2013) | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.33 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.<br><br>The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads.<br><br>Been referred to an orthotist or podiatrist for an assessment.<br><br>Had a trial of local corticosteroid injection. | Therapeutic massage 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.<br><br>Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9.<br><br>Morton's neuroma<br>NICE Clinical Knowledge Summaries (2010). | |
| **B16.34 Surgical Treatment of Plantar Fasciitis** | Surgical Treatment is not routinely commissioned unless the following pathway has been followed:<br>• Patient has documented evidence that they are not responding to conservative treatments<br>• Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following:<br>  • Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss<br>  • Been referred to a podiatrist or physiotherapist<br>  • Not responded to corticosteroid injections | Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.<br><br>Plantar fasciitis<br>NICE Clinical Knowledge Summaries (2009).<br><br>Plantar fasciitis<br>BMJ 2012;345:e6603. | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B16.35 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<br>NICE 2009.<br><br>IPG 312: Extracorporeal shockwave therapy for refractory Achilles<br>NICE 2009.<br><br>IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow<br>NICE 2009.<br><br>IPG 437: Autologous blood injection for plantar fasciitis<br>NICE 2013.<br><br>IPG 438: Autologous blood injection for tendinopathy<br>NICE 2013. | |
| **B17. Urology** | | | |
| **B17.3 Reversal of Male Sterilisation** | The NHS does not commission this service.<br><br>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. | CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013.<br><br>Contraception – sterilization – NICE Clinical Knowledge Summaries 2012<br>http://cks.nice.org.uk/contraception-sterilization#!scenario | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B17.4 ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome** | This is not commissioned as there is limited clinical evidence of effectiveness. | Guidelines on chronic pelvic pain<br>European Association of Urology (2012). | |
| **B17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome** | This is not commissioned as there is limited evidence of effectiveness. | Guidelines on chronic pelvic pain<br>European Association of Urology (2012).<br><br>https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf | |
| **B17.6 Surgery for Prostatism** | Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances:<br>• International prostate symptom score >7; dysuria;<br>• Post voided residual volume >150ml;<br>• Recurrent proven Urinary Tract Infections (UTI);<br>• Deranged renal function;<br>• Prostate-specific antigen (PSA) > age adjusted normal values. | CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men<br>NICE 2010.<br><br>LUTS in men, age-related (prostatism)<br>NICE Clinical Knowledge Summaries (2010).<br><br>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts<br>Royal College of Surgeons (2013). | No references to treatment thresholds found. |
| **B18. Vascular** | | | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B18.1 Surgery for Extreme Sweating (Hyperhydrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy)** | Treatment is medical.<br>Treatment of hyperhidrosis with surgery is not routinely commissioned.<br>Risk of compensatory hyperhidrosis elsewhere is very high. | Hyperhidrosis –<br>NICE Clinical Knowledge Summaries (2013).<br>Hyperhidrosis<br>Patient.co.uk. | |
| **B18.2 Chelation Therapy for Vascular Occlusions** | This is not commissioned. | Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006.<br>Effect of Disodium EDTA Chelation Regimenon Cardiovascular Events in Patients With Previous Myocardial Infarction<br>The TACT Randomized Trial<br>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. |

## B19. Other

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| **B19.1 Botulinum Toxin A & B**<br>Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane. | The use of botulinum toxin type A is commissioned in the following indications:<br>• 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.<br>• Blepharospasm and hemifacial spasm.<br>• Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8<br>• Focal dystonia, where other measures are inappropriate or ineffective.<br>• 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 measures are inappropriate or ineffective.<br>• Idiopathic cervical dystonia (spasmodic torticollis).<br>• 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<br>• 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 where conservative therapy and conventional drug treatment has failed to control symptoms.<br>• Sialorrhoea (excessive salivary drooling), when all other treatments have failed. | NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260<br><br>Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections.<br><br>Diagnosis and management of hyperhidrosis British Medical Journal. | |

| Treatment/Procedure | Exceptionality – Prior Approval – Criteria | Evidence | Comments |
|---|---|---|---|
| | Botulinum toxin type A is not routinely commissioned in the following indications:<br>• Canthal lines (crow's feet) and glabellar (frown) lines.<br>• Hyperhidrosis.<br>• Any other indication that is not listed above<br><br>The use of Botulinum Type B is not routinely commissioned.<br><br>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.<br><br>For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside 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 & Merseyside. 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.<br><br>If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated. | | |