Procedures of Low Clinical Priority (Cheshire Commissioning Policy)

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

2019/20

NOTE:
April 2023 – Document updated to reference Cheshire and Merseyside Integrated Care Board (ICB) harmonized policies.
September 2023 – Document updated to include hyperlinks to ICB harmonized policies.

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Version:	4
Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
Supersedes:	Procedures of Low Clinical Priority (Cheshire Commissioning Policy) Cheshire Clinical Commissioning Group (CCG) Policy issued 2019/20 (First Publication Date NHS Eastern Cheshire and NHS West Cheshire 8 April 2017 NHS South Cheshire and NHS Vale Royal CCGs 14 August 2017) Updated April 2019 (Publication Date 29 April 2019) Updated April 2023
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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
2017	1	First published by individual CCG organisations NHS Eastern Cheshire, NHS West Cheshire, NHS South Cheshire and NHS Vale Royal.
April 2019	2	Single policy adopted and ratified by NHS Cheshire CCG
April 2023	3	Policy amended to illustrate removal of policy positions as superseded by Cheshire and Merseyside ICB policies 01/04/2023 as referenced and as listed in Appendix 5. Readers should note the following standalone NHS Cheshire CCG commissioning policies are documented separately, outside of this document, these will be subject to review and update as part of the ICB's policy harmonisation programme of work: • Continuous Glucose Monitoring • Gluten Free • Subfertility
September 2023	4	Policy document amended to include hyperlinks to ICB policies.

Contents

A. INTRODUCTION

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

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

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

The NHS Standard Contract requires that the provider must manage referrals in accordance with the terms of any Prior Approval Scheme. If the provider does not comply with the terms of any Prior Approval Scheme in providing a service, the commissioners will not be liable to pay for that service. This includes compliance with terms SC28 to SC31 of the contract which specifically reference procedures included in this policy.

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

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

B. CORE CLINICAL ELIGIBILITY

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

- All NICE Technology Appraisals will be implemented.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis. Any patient who needs urgent treatment will always be treated.
- No treatment is completely ruled out if an individual patient's circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patient's responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.
- Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

C. REFERRAL & APPROVAL PROCESS

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

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

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

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

Have received prior approval by the CCG.
OR
Clearly state how the patient meets the criteria.
OR
Be for a clinical opinion to obtain further information to assess the patient's eligibility.

GPs should not refer unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. In cases where there may be an element of doubt the GP should discuss the case with the IFR Team in the first instance.

If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information and the CCG notified. Where a GP requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given to the GP and the patient returned to the GP's care, in order for the GP to make a decision on future treatment.

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

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

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

D. EXCEPTIONALITY

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

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

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

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

E. PSYCHOLOGICAL DISTRESS

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

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

F. PERSONAL DATA (INCLUDING PHOTOGRAPHS)

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

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence: Clearly label the envelope to a named individual i.e. first name & surname, and job title.
Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

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

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

G. MEDICINES MANAGEMENT

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

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

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

NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.

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

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

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

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

H. EVIDENCE

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

I. POLICIES

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
1. Complementary Therapies				
1.1	**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-/	
2. Dermatology				
2.1	**Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)**	Only be commissioned in the following circumstances: Severe scarring following: • Acne once the active disease is controlled. • Chicken pox. OR • Trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for	Modernisation Agency's Action on Plastic Surgery 2005. 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. www.evidence.nhs.uk	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
2.2	**Surgical or Laser Therapy Treatments for Minor Benign Skin Lesions e.g. sebaceous cyst**	This policy has been superseded by ICB Policy CMICB_Clin005 – Benign skin lesions, removal v1 01/04/2023		
2.4	**Treatments for Skin Pigment Disorders**	This policy has been superseded by ICB Policy CMICB_Clin009 – Camouflage Treatment for Skin Pigmentation and other disorders v1 01/04/2023		
2.5	**Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Intermediate Tier/ Secondary Care Providers**	Will be commissioned in any of the following circumstances: • Severe pain substantially interfering with functional abilities. • Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. • Extensive warts (particularly in the immune-suppressed patient). • Facial warts. Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae	Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			http://www.patient.co.uk/doctor/verrucae	considered before referral to secondary care.
2.6	**Secondary Care treatment for Acne Vulgaris**	Will be commissioned in any of the following circumstances: • Patient has severe acne that is unresponsive to oral antibacterials • Patient has moderate to severe acne that is partially unresponsive to treatment that is starting to scar • Patients with acne who have failed two full courses of oral antibiotic treatment combined with appropriate topical treatment for a minimum of 6 months • Patients with severe nodulo-cystic, conglobate acne • Patients at risk of post-inflammatory hyperpigmentation • Patients with associated and severe psychological symptoms regardless of severity of acne Patients that do not meet this criteria should be managed in Primary Care.	https://cks.nice.org.uk/acne-vulgaris http://www.nhs.uk/conditions/acne/pages/treatmentoptions.aspx	ACNE VULGARIS.docx
2.7	**PMLE (Polymorphic Light Eruption) Treatment - Desensitising Light Therapy using UVB (ultra-violet shortwave) or PUVA (Psoralen combined**	Will be commissioned if ALL of the following criteria are met: • Diagnosis by Dermatology Consultant • Severe with symptoms causing significant functional impairment (Symptoms preventing the patient fulfilling vital work or educational	http://www.bad.org.uk/shared/get-file.ashx?id=117&itemtype=document http://www.nhs.uk/conditions/polymorphic-light-eruption/Pages/Introduction.aspx	Clinical discussion with the patient should include educating patients not to use sunbeds as an alternative. It is not comparable to desensitising light therapy and carries additional health risks.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	with UVA)	responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities) • Symptoms remain severe despite preventative treatments • Light therapy deemed likely to make significant improvement to patients symptoms		
3. Diabetes				
3.1	**Continuous Glucose Monitoring (CGM) Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus**	This policy has been superseded by a CCG standalone policy		
3.2	**Monogenic Diabetes Testing Maturity Onset Diabetes of the Young (MODY)**	This policy has been superseded by ICB Policy CMICB_Clin031 – Monogenic Diabetes Testing v1 01/04/2023		
4. ENT				
4.1	**Adenoidectomy**	This policy has been superseded by ICB Policy CMICB_Clin002 – Adenoidectomy v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.2	**Pinnaplasty – for Correction of Prominent Ears**	May be commissioned in the following circumstances: Surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged up to18 years at the time of referral. AND 2. With very significant ear deformity or asymmetry. AND 3. Patients present with significant detrimental impact on child's ability to lead a normal life Patients not meeting these criteria should not be routinely referred for surgery. Incisionless otoplasty is not commissioned.	Pinnaplasty Department of Health (2007). Local PCT consensus - review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. IPG 422: Incisionless otoplasty NICE 2012. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty Royal College of Surgeons (2013).	
4.3	**Insertion of Grommets for Glue Ear (otitis media with effusion)**	This policy has been superseded by ICB Policy CMICB_Clin023 – Grommets for glue ear in children v1 1/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.4	**Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children**	This policy has been superseded by ICB Policy CMICB_Clin046 – Tonsillectomy v1 1/04/2023		
4.5	**Surgical Remodelling of External Ear Lobe**	This policy has been superseded by ICB Policy CMICB_Clin45 – Split (cleft) Earlobe, surgical repair v1 1/04/2023		
4.6	**Use of Sinus X-ray**	This policy has been superseded by ICB Policy CMICB_Clin44 – Sinus X-Ray v1 1/04/2023		
4.7	**Rhinoplasty - Surgery to Reshape the Nose**	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.8	**Surgery of Laser Treatment of Rhinophyma**	This policy has been superseded by ICB Policy CMICB_Clin41 - Rhinophyma, surgical management v1 1/04/2023		
4.9	**Septorhinoplasty**	Only commissioned where: • patient has a deviated septum causing significant and persistent nasal blockage AND • septoplasty alone will not improve functional impairment OR • significant symptoms post trauma/cancer treatment/ severe congenital abnormality This procedure is not commissioned for cosmetic reasons	http://www.lnwh.nhs.uk/services/a-z-services/e/ent-ear-nose-and-throat/ent-operations/nose-operations/septorhinoplasty/	
4.10	**Ear Wax removal including microsuction (excluding primary care)**	Only commissioned where: • Perforated ear drum OR • Otitis Externa OR • Hearing loss and all other methods of wax removal have been tried and failed OR • Enable inspection of ear drum due to clinical concern of other pathologies and other methods of wax removal have failed OR • Clinical risk of other methods of removal •	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907972/	Ear wax removal should be managed in primary care and does not require onward referral.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
5. Equipment				
5.1	**Use of Lycra Suits**	Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.	What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. For further references please refer to Public Health Lycra Suits Paper.	Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames. Public Health Recommendation: Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. Lycra suit orthoses for cerebral palsy should be assigned low priority. Individual CCG addendums apply.  PH Lycra Suits Paper.pdf

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
6. Fertility				
6.1	**Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation.**	See Infertility Treatment for Subfertility Policy for Cheshire CCGs.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	Individual CCG addendums apply.
7. General Surgery				
7.1	**Haemorrhoidectomy - Rectal Surgery** **Removal of Haemorrhoidal Skin Tags**	This policy has been superseded by ICB Policy CMICB_Clin024 – Haemorrhoids, surgical management v1 01/04/2023		
7.2	**Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias** **Surgical correction of Diastasis of the Recti**	This policy has been superseded by ICB Policy CMICB_Clin014 – Diastasis (divarication) of the Recti Repair v1 1/04/2023		
7.3	**Surgery for Asymptomatic Gallstones**	This policy has been superseded by ICB Policy CMICB_Clin021 – Gallstones (Asymptomatic), Surgical Management v1 1/04/2023		
7.4	**Lithotripsy for Gallstones**	Lithotripsy not routinely commissioned.		Lithotripsy rarely performed as rate recurrence high.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
7.5	**Rectopexy and STARR (Stapled Transanal Resection of the Rectum)**	Only be commissioned if patient meets the threshold below: • case has been discussed by MDT with agreement that this is best option for patient • conservative management has been tried and failed - This includes a selection of the following appropriate for the individual: dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback. • patient has faecal incontinence or obstructed defecation syndrome • symptoms cause significant functional impairment defined by the BNSSG Health Community as: - Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities. • the risks, benefits and side effects of surgery have been discussed and agreed with patient	https://www.bristolccg.nhs.uk/media/medialibrary/2016/09/rectopexy_and_STARR_policy_.pdf http://patient.info/doctor/rectal-prolapse	
8. Gynaecology				
8.1	**Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding**	This policy has been superseded by ICB Policy CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Hysterectomy with or without Oophrectomy			
8.2	**D&C (dilatation and curettage)**	This policy has been superseded by ICB Policy CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage v1 1/04/2023		
8.3	**Hysteroscopy**	Hysteroscopy is only commissioned as a second line option once all appropriate investigations have been undertaken including physical pelvic examination and endometrial pipelle biopsy		
8.4	**Fibroid Embolisation / uterine artery embolisation**	This procedure is only commissioned in line with current NICE guidance	https://www.nice.org.uk/guidance/IPG367/chapter/1-guidance	
8.6	**Secondary Care follow up of mirena coil insertion**	Secondary care checking mirena coil insertion is not routinely commissioned.		
9. Mental Health				
9.1	**Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)**	Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned. If inpatient treatment is recommended an IFR referral will be required.	Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children – NICE 2007, CG53. Cognitive behaviour therapy for chronic fatigue syndrome in adults - Cochrane Depression, Anxiety and Neurosis Group 2008. Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome:	Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			A cost-effectiveness analysis - . PLoS ONE 7(8): e40808. doi:10.137. 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.	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.
9.2	**Treatment of Gender Dysphoria**	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at Charring Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Where the provision of ''non-core surgery'' is appropriate the GIC should apply for treatment funding through the CCG. Liverpool, Sefton and Knowsley have a local support service in place at LCH.
9.3	**Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)**	This is not routinely commissioned.	Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007) Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007). Alcohol-use disorders: diagnosis,	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
9.4	**Private Mental Health (MH) Care - Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care,post-traumatic stress adolescent mental health**	This will not normally be funded. Most mental health conditions can be managed in the community with input from Community Mental Health teams. NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD. There is also a specialist NHS MH service provided for affective disorders. A request for private MH care should be initiated by a consultant psychiatrist and give full explanation as to why NHS care is inappropriate or unavailable.	Veterans' post traumatic stress disorder programme (Adult) Service Specification NHS England Specialised Commissioning 2013. Post –traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care NICE Clinical Guideline 26 (2005). Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification NHS England Specialised Commissioning (2013) The use of motivational interviewing in eating disorders: a systematic review. Psychiatry Research, 2012 Nov 30;200(1):1-11. Depression in children and young people: Identification and management in primary, community and secondary care. NICE Clinical Guideline 2005.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013.	
10. Neurology				
10.1	**Bobath Therapy**	Bobath Therapy is not routinely commissioned by the NHS. 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. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme Physiotherapy Research International Volume 16, Issue 2, pages 69–80, June 2011. Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15. http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf Cambridge CCG (2013). A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			palsy National Public Health Service for Wales (2008).	
10.2	**Trophic Electrical Stimulation for Facial/Bells Palsy**	Not routinely commissioned.	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).	
10.3	**Functional Electrical Stimulation (FES)**	Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities. Exclusion Criteria: • Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions).	Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10. Functional electrical stimulation for drop foot of central neurological origin NICE, 2009. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. Ataxic and polio patients are generally poor responders although there are exceptions.		
11. Ophthalmology				
11.1	**Upper Lid Blepharoplasty - Surgery on the Upper Eyelid**	Only commissioned in the following circumstances: Eyelid function interferes with visual field.	Eyelid Surgery *The British Association of Aesthetic Plastic Surgeons 2011.* Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.
11.2	**Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.**	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye.	Eyelid Surgery The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted	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

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	correction.
11.3	**Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)**	Only commissioned for: Larger legions which satisfy all of the following: 1. Not responded to treatment for underlying familial lipoprotein lipase deficiency. 2. Failed topical treatment. 3. Causing significant disfigurement. 4. Causing functional impairment. Topical treatments may be available in a primary care or community setting.	Local PCT consensus – review conducted 2007. DermNet NZ information resources updated Jan 2013. Commissioning Criteria – Plastic Surgery Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). http://www.patient.co.uk/doctor/xanthelasma	The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy. Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist. Lesions are harmless.
11.4	**Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)**	This policy has been superseded by ICB Policy CMICB_Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
11.5	**Cataract Surgery**	See appendix 1 for details of Cheshire Referral Guidance template. There is good evidence that bilateral cataract replacement is beneficial.	Thresholds for cataract surgery – Shropshire and Telford Hospital NHS Trust, 2012. NHS Atlas of Variation, (cataract spend, cataract admissions) Don't turn back the clock: Cataract surgery - the need for patient centred care. RNIB / Royal College of Ophthalmologists (2011). Cataract surgery guidelines The Royal College of Ophthalmologists (RCOphth) 2010. Action on cataracts good practice guidance Department of Health (2000). Cataract care pathway Map of Medicine (2013). NHS UK - http://www.nhs.uk/conditions/Cataracts-age related/Pages/Introduction.aspx For further references please refer to Public Health Cataracts Paper.	PH Cataract Paper.pdf
11.6	**Coloured (irlens) Filters for Treatment of Dyslexia**	This policy has been superseded by ICB Policy CMICB_Clin017 - Dyslexia Treatment using Coloured (Irlen) Filters v1 01/04/2023		
11.7	**Intra Ocular Telescope for Advanced Age-Related Macular Degeneration**	This policy has been superseded by ICB Policy CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT) v1 01/04/2023		
11.8	**Surgical Removal of Chalazion or Meibomian Cysts**	This policy has been superseded by ICB Policy CMICB_Clin011 - Chalazia (meibomian cysts), removal v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
11.9	**Surgical treatment for Proptosis/ Dysthyroid eye disease**	Only commissioned if: • condition caused by thyroid disease • artificial tears have been tried for at least 6 months and failed	http://patient.info/doctor/thyroid-eye-disease-pro	
11.10	**Photodynamic Therapy for ARMD**	Photodynamic Therapy for ARMD is not routinely commissioned.		
11.11	**Multifocal (non-accommodative) intraocular lenses**	Multifocal (non-accommodative) intraocular lenses are not routinely commissioned.		
12. Oral Surgery				
12.1	**Surgical Replacement of the Temporo-Mandibular Joint** **Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement**	Only commissioned in the following circumstances: • Any or a combination of the following symptoms are present: ○ Restricted mouth opening <35mm). ○ Dietary score of< 5/10 (liquid scores 0, full diet scores 10). ○ Occlusal collapse (anterior open bite or retrusion). ○ Excessive condylar resorption and loss of height of vertical ramus. ○ Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). ○ Other significant quality of life issues. AND • Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.	Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Wirral and Wirral/Cheshire Commissioners when considering funding requests. TMJ Replacement Guidance .pdf Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
13. Paediatrics				
13.1	**Cranial Banding for Positional Plagiocephaly**	This policy has been superseded by ICB Policy CMICB_Clin039 - Positional Plagiocephaly/brachycephaly in children, helmet therapy v1 1/04/2023		
14. Plastic & Cosmetic Surgery				
14.1	**Reduction Mammoplasty - Female Breast Reduction**	This policy has been superseded by ICB Policy CMICB_Clin007 – Breast Reduction v1 1/04/2023		
14.2	**Augmentation Mammoplasty - Breast Enlargement**	This procedure is not routinely commissioned. The following exceptions apply: In all cases: • The BMI is <25 and stable for at least twelve months. AND • Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. Patients requiring reconstructive surgery post cancer treatment are excluded from this policy. All non-surgical options must have been explored e.g. padded bra. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines	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 . Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7.	Patients should be made aware that: 1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		2013/14.	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. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.
14.4	**Mastopexy - Breast Lift**	This policy has been superseded by ICB Policy CMICB_Clin030 – Mastopexy (breast lift) v1 1/04/2023		
14.5	**Surgical Correction of Nipple Inversion**	This policy has been superseded by ICB Policy CMICB_Clin035 – Nipple inversion, surgical correction v1 1/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
14.6	**Male Breast Reduction Surgery for Gynaecomastia**	Not routinely commissioned. The following exception will apply: • gynaecomastia caused by cancer treatment Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer.
14.7	**Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism**	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances not routinely commissioned. Will be considered via Individual Funding Request if all of the	Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70).	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist). Photographs will also be required to allow the CCG's to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines	cks.nice.org.uk/hirsutism#!scenario - NICE: Clinical Knowledge Summaries 2010. Laser and photoepilation for unwanted hair growth – Cochrane Library 2009. Management of hirsutism – Koulouri et al *BMJ* 2009; 338:b847. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.		
14.8	**Surgical Treatment for Pigeon Chest**	This policy has been superseded by ICB Policy CMICB_Clin038 – Pectus Deformity, surgical treatment v1 01/04/2023		
14.9	**Surgical Revision of Scars**	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.10	**Laser Tattoo Removal**	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). • An individual funding request will be required.	Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
14.11	**Apronectomy or Abdominoplasty (Tummy Tuck)**	Not routinely commissioned other than if all of the following criteria are met: Patient is aged 18 years or above The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 24 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Or Patient has lost 50% of their original body weight and maintained weight loss for 24 months. Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions).	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service 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).	Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced. Poor level of evidence of positive outcomes.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made). IFR information ***must*** contain the following information: • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight/BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
14.12	**Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)**	This policy has been superseded by ICB Policy CMICB_Clin006 – Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty) v1 01/04/2023		
14.13	**Treatments to Correct Hair Loss for Alopecia**	Only commissioned in either of the following circumstances: • Result of previous surgery. • Result of trauma, including burns. Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 Interventions for alopecia areata – Cochrane Library 2008. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. Alopecia areata – NICE Clinical Knowledge Summaries 2008. Health Commission Wales. 2008	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.14	**Hair Transplantation**	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. Non-core procedure Interim Gender	A trial on subcutaneous pedicle island flap for eyebrow reconstruction – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	further evidence provided within this document by Islington PCT to support funding. Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.15	**Treatments to Correct Male Pattern Baldness**	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	
14.16	**Labiaplasty, Vaginoplasty and Hymenorrhaphy**	This is not routinely commissioned.	Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499. Department for Education and Skills. (2004). Local Authority Social Services Letter. *LASSAL (2004)4,* London, DfES. Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159.* Liao, L-M; Michala, L; Creighton, SM.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			(2010). Labial Surgery for Well Women; a review of the literature. *BJOG: An International Journal of Obstetrics & Gynaecology; Volume 117: 20-25.* Labiaplasty for labia minora hypertrophy - *Centre for Reviews and Dissemination 2013.* Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6). http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf	
14.17	**Liposuction**	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophies or non-excisable clinically significant lipomata. An individual funding request will be required.	Liposuction for chronic lymphoedema NICE 2008. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.18	**Rhytidectomy - Face or Brow Lift**	This policy has been superseded by ICB Policy CMICB_Clin042 – Rhytidectomy v1 01/04/2023		
14.19	**All procedures undertaken on cosmetic grounds**	This policy has been superseded by ICB Policy CMICB_Clin013 – Cosmetic Procedures v1 01/04/2023		
15. Respiratory				
15.1	**Treatments for Snoring Soft Palate Implants and Radiofrequency Ablation of the Soft Palate** **Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty'** **Uvulopalatoplasty and**	This policy has been superseded by ICB Policy CMICB_Clin043 – Simple snoring, surgical management v1 1/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Uvulopalatopharyngopl asy			
15.2	**Investigations and treatment for Sleep Apnoea**	Only commissioned if any of the following; • suspected sleep apnoea if below threshold met: ▪ excessive daytime sleepiness affecting work/social activities/driving and Epworth score of ≥11 or patients with a score <11 if deemed high risk/ clinically exceptional e.g. neurological condition) OR ▪ sleep apnoea must be ruled out prior to surgery AND • weight management advice/referral has been given if BMI above 30	http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/service-restriction-policy/1562-1-0-service-restriction-policy-july-2015-v2	Please do not refer patients for snoring. Epworth Score.pdf
15.3	**Sleep studies/ Hypersomnia**	Sleep studies are only commissioned if any of the following apply: • suspected sleep apnoea (see above) • complex sleep disorder • suspected narcolepsy Please note, sleep studies are not commissioned for the investigation of hypersomnia related to Chronic Fatigue Syndrome, periodic limb movement disorder, parasomnia or chronic insomnia		
16. Trauma & Orthopaedics				

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.1	**Low back pain and sciatica in over 16's Diagnostic, Interventions and Treatments for acute and chronic low back pain. Excluding spinal pathology, radiculopathy and children.** **Pharmacological Intervention for lower back pain** **Pharmacological intervention for sciatica (neuropathic pain in adults)**	Diagnostic imaging should not be routinely offered unless: • in a specialist setting where the results are likely to change clinical management OR • Diagnostic imaging is required prior to referral for surgical intervention Management should be in line with NICE Guidance and should consist of advice and information to enable self-management. Patients should be encouraged to continue with normal activities. Structured exercise programmes (including group exercise), psychological therapies and manual therapy should be considered. Manual therapy should only be offered as part of a treatment package, including exercise with or without psychological therapy. Spinal injections of local anaesthetic and steroid should not be offered for patients with non- specific low back pain. For people with non-specific low back pain the following injections should not be offered:	https://www.nice.org.uk/guidance/NG59	Amendments made based on version developed by Lancashire & Midlands CSU in collaboration with the Walton Centre

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Facet joint injections • Therapeutic medial branch blocks Intradiscal therapy • Prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis Any other spinal injections not specifically covered above Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block. Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Consider oral non-steroidal anti-inflammatory drugs (NSAIDS) at lowest effective dose for shortest possible time. If NSAIDS are contraindicated/ not tolerated or ineffective, consider weak opiods. **Do <u>not</u>** offer: • Paracetamol alone • Opioids for acute low back pain (unless NSAIDs are contraindicated) • Opioids for chronic low back pain • Selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine, reuptake inhibitors or • tricyclic antidepressants • Anticonvulsants Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia). If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. Consider tramadol only if acute rescue therapy is needed (see NICE Guidance CG173 for long term use).		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use) • venlafaxine		
16.2	**Radiofrequency Facet Joint Denervation**	Treatments for low back pain will only be commissioned in line with NICE guidance NG59 'Low back pain and sciatica in over 16s: assessment and management' (November 2016). The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when: • comprehensive conservative treatment approach has not worked for them AND	https://www.nice.org.uk/guidance/NG59 IPG 319: Percutaneous intradiscal electrothermal therapy for low back pain NICE 2009. IPG83: Percutaneous intradiscal radiofrequency thermocoagulation NICE 2004. http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf Final_TAMARS_report[1].pdf	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• the main source of pain is thought to come from structures supplied by the medial branch nerve AND • The clinical presentation is consistent with symptoms arising from the facet joint: ○ Increased pain unilaterally or bilaterally on lumbar paraspinal palpation ○ Increased back pain on 1 or more of the following: o extension (more than flexion); rotation; extension/side flexion; extension/rotation ○ No radicular symptoms ○ No sacroiliac joint pain elicited using a provocation test AND • they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral AND • low back pain is chronic in nature AND • The patient has significant short term pain relief to a diagnostic medial branch block. Do not offer imaging for people with low back pain with specific facet join pain as a		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		prerequisite for radiofrequency denervation. Providers who offer radiofrequency denervation will be expected to submit patient outcome data to the UK National Spinal RF Registry http://cl1.n3-dendrite.com/csp/spinalrf/FrontPages/index.html Intra Discal Electro Thermal Annuloplasty (**IDET**) Percutaneous intradiscal radiofrequency thermocoagulation (**PIRFT**) and Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) are not routinely commissioned.		
16.3	**Fusion**	This procedure is NOT routinely commissioned however there are clinical exceptions to this. Please see appendix 4.	https://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-pain-commissioning-guide	Appendix 4 - PLCP.docx
16.4	**Epidural Injection**	Do not use epidural for neurogenic claudication in people who have central spinal canal stenosis. Consider a single epidural injection or single trans foraminal nerve root injection of local anaesthetic and steroid as appropriate in people with acute and severe sciatica 'Non Specific Back Pain – Not routinely commissioned'.	http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf	Appendix 4 - PLCP.docx

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.5	**Spinal Decompression**	Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.		
16.6	**Endoscopic Laser Foraminoplasty**	This policy has been superseded by ICB Policy CMICB_Clin018 – Endoscopic Laser Foraminoplasty v1 01/04/2023		
16.7	**Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain**	This policy has been superseded by ICB Policy CMICB_Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation v1 01/04/2023		
16.8	**Endoscopic Lumbar Decompression**	This procedure is NOT routinely commissioned.	IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009	
16.9	**Percutaneous Disc Decompression using Coblation for Lower Back Pain**	This procedure is NOT routinely commissioned.	IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006	
16.10	**Non-Rigid Stabilisation Techniques**	This procedure is NOT routinely commissioned.	IPG 366: Non-rigid stabilisation techniques NICE 2010	
16.11	**Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine**	This procedure is NOT routinely commissioned however there are clinical exceptions to this. Please see appendix 4.	IPG 321: Lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. NICE 2009.	
16.12	**Percutaneous Intradiscal Laser Ablation in the Lumbar Spine**	This procedure is NOT routinely commissioned.	IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.13	**Transaxial Interbody Lumbosacral Fusion**	This procedure is NOT routinely commissioned.	IPG 387: Transaxial interbody lumbosacral fusion NICE 2011.	
16.14	**Therapeutic Endoscopic Division of Epidural Adhesions**	This policy has been superseded by ICB Policy CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division v1 01/04/2023		
16.15	**Automated Percutaneous Mechanical Lumbar Discectomy**	This procedure is NOT routinely commissioned.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	
16.16	**Prosthetic Intervertebral Disc Replacement in the Lumbar Spine**	This procedure is NOT routinely commissioned.	IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009. Commissioning Guide – Low Back Pain. Royal College of Surgeons (2013). Total disc replacement for chronic back pain in the presence of disc degeneration The Cochrane Database of Systematic Reviews, Issue 9 (2012).	As effective as discectomy in the short term 2-3 years. but after that outcomes are similar. Long term follow-up data on efficacy and safety is lacking.
16.17	**Bone Morphogenetic Proteins - Dibotermin Alfa; Eptotermin Alpha**	Dibotermin alfa is commissioned in the following situation: The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. Eptotermin alfa is commissioned in line with its licensed indication:	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		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.	Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
16.18	**Surgery for Trigger Finger**	This policy has been superseded by ICB Policy CMICB_Clin048 – Trigger Finger release in adults v1 01/04/2023		
16.19	**Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain**	This policy has been superseded by ICB Policy CMICB_Clin036 – Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid) v1 01/04/2023		
16.20	**Secondary Care Administered Steroid Joint Injections**	This policy has been superseded by ICB Policy CMICB_Clin037 – Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids v1 01/04/2023		
16.21	**Dupuytren's Disease Palmar Fasciectomy/Needle Faciotomy** **Radiotherapy Collagenase Injections for Dupuytren's Disease**	This policy has been superseded by ICB Policy CMICB_Clin016 – Dupuytren's Contracture release in adults v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Dupuytren's Disease Surgical treatment **Dupuytrens Contracture – conservative treatment**			
16.24	**Hip and Knee Replacement Surgery & Hip Resurfacing**	Referral is based on local referral pathways. **Funding for total or partial knee replacement surgery is available if the following criteria are met** 1. Patients with BMI <40. AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.	NHS North West London commissioning policy – Hip Replacement (Total) April 2013. NHS North West London commissioning policy – Knee Replacement (Total) April 2013. Clinical thresholds knee replacement York & Humber Health Intelligence (2011). Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Relevant NICE Guidance (TA44) as referred to above http://www.nice.org.uk/guidance/ta304	A hip and knee score threshold can form part of a demand management approach.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Referral criteria for <u>Total Hip Replacements (THR)</u> should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria; 1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. OR 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).		
16.25	**Diagnostic Arthroscopy for Arthritis of the Knee**	This policy has been superseded by ICB Policy CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.26	**Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee**	This policy has been superseded by ICB Policy CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023		
16.27	**Patient Specific Unicompartmental Knee Replacement**	This is not commissioned.	IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009	Referral should be made to specialist centres only.
16.28	**Patient Specific Total Knee Replacement**	This policy has been superseded by ICB Policy CMICB_Clin047 – Total Knee Arthroplasty, patient specific instrumentation/implants v1 01/04/2023		
16.29	**Surgical Treatment for Carpal Tunnel Syndrome**	This policy has been superseded by ICB Policy CMICB_Clin010 – Carpal Tunnel interventions and surgery v1 01/04/2023		
16.30	**Nerve Conduction Studies for Carpal Tunnel Syndrome**	This policy has been superseded by ICB Policy CMICB_Clin010 – Carpal Tunnel interventions and surgery v1 01/04/2023		
16.31	**Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)**	This policy has been superseded by ICB Policy CMICB_Clin033 – Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal v1 01/04/2023		
16.32	**Surgical Removal of Ganglions**	This policy has been superseded by ICB Policy CMICB_Clin022 – Ganglia, surgical removal and general management v2 01/04/2023		
16.33	**Hip Arthroscopy for Femoro–Acetabular Impingement**	CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		following criteria: A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months. The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. 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). 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. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.
16.34	**Surgical Removal of Bunions/Surgery for Lesser Toe Deformity**	This policy has been superseded by ICB Policy CMICB_Clin008 – Bunions, surgical removal v1 01/04/2023		
16.35	**Surgical Treatment of Morton's Neuroma**	This policy has been superseded by ICB Policy CMICB_Clin032 – Morton's Neuroma, surgical treatment v1 01/04/2023		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.36	**Surgical Treatment of Plantar Fasciitis**	Surgical Treatment is not routinely commissioned unless the following pathway has been followed: 1. Patient has documented evidence that they are not responding to conservative treatments 2. Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following. 3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss. 4. Been referred to a podiatrist or physiotherapist. 5. 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. Plantar fasciitis NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.	
16.37	**Treatment of Tendinopathies Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection**	This policy has been superseded by ICB Policy CMICB_Clin001 - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections v1 01/04/2023		
16.38	**Injections for Tendonitis (Jumpers Knee)**	Injections for Tendonitis (Jumpers Knee) are not routinely commissioned.	http://www.nhs.uk/Conditions/Tendonitis/Pages/Treatment.aspx	
16.39	**Shoulder Arthroscopy (including arthroscopic**	Not routinely commissioned. Only commissioned if: • Frozen shoulder has been persistent for at least 12 months	http://www.dbc.fi/new-evidence-questioning-the-effectiveness-of-shoulder-arthroscopy-for-degenerative-shoulder-disorders/	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	shoulder decompression for subacromial shoulder pain)	AND the following have all been tried and failed: • Activity modification • Physiotherapy and exercise programme • Oral analgesia • Intra-articular joint injections • Manipulation Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases. For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		surgical intervention.		
16.40	**Hip Injections**	Commissioned if below threshold is met: • Diagnostic aid (single injection) • Part of hip arthogram • Inflammatory arthropathy • Bursitis Commissioned for therapeutic intervention in early disease if: • Significant pain causing functional impairment AND • Conservative management (including pharmaceutical) not improving symptoms Hip injections are not commissioned for long term management.		
17. Urology				
17.1	**Circumcision**	Indicated for the following condition; • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. Circumcision is **not** commissioned for cultural or religious reasons.	Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2002. 2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis NICE Clinical Knowledge Summaries 2009.	.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions Royal College of Surgeons guidance (2013).	
17.2	**Penile Implant: A Surgical Procedure to Implant a Device into the Penis**	This policy has been superseded by ICB Policy CMICB_Clin020 – Erectile dysfunction, penile prosthesis surgery v1 01/04/2023		
17.3	**Erectile Dysfunction – secondary care**	Not routinely commissioned. Only commissioned for certain medical conditions e.g. • post cancer • discussion about injectable prostaglandins (if other treatments unsuccessful). • As part of assessment of ED when combined with Peyronies Disease	Guidelines Male Sexual Dysfunction European Association Urology (2010). Guidelines on the Management of ED British Society for Sexual Medicine (2007). CG175: Prostate Cancer NICE 2008. http://guidance.nice.org.uk/CG175 NICE 2014. Please refer to Public Health Penile Implants Paper	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
17.4	**Male sterilisation under Local Anaesthetic**	This is currently routinely commissioned via community providers ONLY (list of providers available from the Local CCG - unless attempted in community services but failed procedure due to patient discomfort or technical difficulty preventing completion. Direct referral will then be made by Community Provider to secondary care.		
	Male sterilisation under General Anaesthetic	This is not routinely commissioned and would require IFR. Criteria would include- significant scrotal/hemiscrotal pathology that would prevent safe management under local anaesthetic. Personal preference of patient for General Anaesthetic is not a reason for NHS funded care.		
17.5	**Reversal of Male Sterilisation**	This policy has been superseded by ICB Policy CMICB_Clin040 – Reversal of Male Sterilisation v1 01/04/2023		
17.6	**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 European Association of Urology (2012).	
17.7	**Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome**	This is not commissioned as there is limited evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012). https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
17.8	**Surgery for Prostatism**	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: International prostate symptom score >7; dysuria; • Post voided residual volume >150ml; • Recurrent proven Urinary Tract Infections (UTI); • Deranged renal function; • Prostate-specific antigen (PSA) > age adjusted normal values.	CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts Royal College of Surgeons (2013).	No references to treatment thresholds found.
17.9	**Surgical treatment for Hydroceles – adults and children**	Only commissioned if: In the case of communicating hydrocele: • patient is aged over 18 months of age In the case of non-communicating hydrocele, the patient is experiencing: • discomfort and/or disfigurement resulting in functional impairment preventing individual fulfilling work/study/carer or domestic duties (adult) or • discomfort and/or disfigurement resulting in inability to participate in normal social and educational activity (adolescent)	http://patient.info/health/hydrocele-in-adults	
17.10	**Surgical removal of benign epididymal cysts**	Not routinely commissioned. Exclusion apply only if **ALL** the following criteria are met: • it is large enough to cause change in	http://patient.info/health/epididymal-cyst	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		shape and size of scrotum • cyst is putting pressure on other structures in the testes • cyst is causing prolonged or significant pain		
18. Vascular				
18.1	**Surgery for Extreme Sweating** **Hyperhydrosis – all areas** **Surgical Resection Endoscopic Thoracic Sympathectomy**	This policy has been superseded by ICB Policy CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management v1 01/04/2023		
18.2	**Chelation Therapy for Vascular Occlusions**	This policy has been superseded by ICB Policy CMICB_Clin015 – Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction v1 01/04/2023		
18.3	**Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery**	This policy has been superseded by ICB Policy CMICB_Clin049 – Varicose Veins v1 01/04/2023		
19. Other				
19.1	**Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle**	The use of botulinum toxin type A is commissioned in the following indications: • Anal fissures only following a minimum of two months with standard treatment	NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	disorders, excessive sweating hyperhidrosis) and migraine.	(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. • Blepharospasm and hemifacial spasm. • 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 • Focal dystonia, where other measures are inappropriate or ineffective. • 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. • Idiopathic cervical dystonia (spasmodic torticollis). • Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260	Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 Diagnosis and management of hyperhidrosis British Medical Journal.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• 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. • Sialorrhoea (excessive salivary drooling), when all other treatments have failed. Botulinum toxin type A is not routinely commissioned in the following indications: • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. • Any other indication that is not listed above The use of Botulinum Type B is not routinely commissioned. Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Wirral Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Wirral. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.		
19.2	**Correction of privately funded treatment**	Correction of privately funded treatment is not routinely commissioned unless in an emergency.		
19.3	**Open MRI**	Referral for open MRI scanning of greater than 0.5T as an alternative to conventional MRI in secondary care is commissioned only for: • patients who suffer from claustrophobia where an oral prescription sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be	CADTH. Open Magnetic Resonance Scanner. Issue 92. November 2006 CIGNA. Magnetic Resonance Imaging-low field. CIGNA coverage policy 0444 Paakko E, Reinikainen H, Lindholm EL, Rissanen T. Low-field versus high-field MRI in diagnosing breast disorders. Eur Radiol. 2005 Jul;15(7):1361-8. Epub 2005 Feb 12.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		appropriate) OR • patients who are obese or cannot fit comfortably in conventional MRI scanners Standing, upright, weight-bearing or positional MRI will not be commissioned.	Klein HM, Meyners W, Neeb B, Labenz J, Truümmler KH. Cardiac magnetic resonance imaging using an open 0.35 T system. J Comput Assist Tomogr. 2007 May-Jun;31(3):430-4. Rupprecht T, Nitz W, Wagner M, Kreissler P, Rascher W, et al. Determination of the pressure gradient in children with coarctation of the aorta by low-field magnetic resonance imaging. Pediatr Cardiol. 2002 Mar-Apr;23(2):127-31. Epub 2002 Feb 19. Terada H, Gomi T, Harada H, Chiba T, Nakamura T, Iwabuchi S, et al. Development of diffusion-weighted image using a 0.3T open MRI. J Neuroradiol. 2006 Feb;33(1):57-61. Mehdizade A, Somon T, Wetzel S, Kelekis A, Martin JB, Scheidegger JR, et al. Diffusion weighted MR imaging on a low-field open magnet. Comparison with findings at 1.5T in 18 patients with cerebral ischemia. J Neuroradiol. 2003 Jan;30(1):25-30. Abolmaali ND, Schmitt J, Krauss S, Bretz F, Deimling M, Jacobi V, et al. MRI of lung parenchyma at 0.2 T: evaluation	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			of imaging techniques, comparative study with chest radiography and interobserver analysis. Eur Radiol. 2004 Apr;14(4):703-8. Epub 2004 Feb 10. Wagner M, Bowing B, Kuth R, Deimling M, Rascher W, Rupprecht T. Low field thoracic MRI--a fast and radiation free routine imaging modality in children. Magn Reson Imaging. 2001 Sep;19(7):975-83 Stecco A, Oronzo P, Armienti F, Borraccino C, Fossaceca R, Canalis L, et al. Contrast- bolus MR angiography of the transplanted kidney with a low-field (0.5-T) scanner: diagnostic accuracy, sensitivity and specificity of images and reconstructions in the evaluation of vascular complications. Radiol Med (Torino). 2007 Oct;112(7):1026-35. Epub 2007 Oct 21. Kajander S, Kallio T, Alanen A, Komu M, Forsstrom J. Imaging end-stage kidney disease in adults. Low-field MRI with magnetization transfer vs. ultrasonography. Acta Radiol. 2000 Jul;41(4):357-60. Ertl-Wagner BB, Reith W, Sartor K. Low field-low cost: can low- field magnetic	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			resonance systems replace high-field magnetic resonance systems in the diagnostic assessment of multiple sclerosis patients? Eur Radiol. 2001;11(8):1490-4. Dubrulle F, Delomez J, Kiaei A, Berger P, Vincent C, Vaneecloo FM, et al. Mass screening for retrocochlear disorders: low-field- strength (0.2-T) versus high-field-strength (1.5-T) MRI. AJNR Am J Neuroradiol. 2002 Jun-Jul;23(6):918-23. Merl T, et al. Eur J Radiol 1999;30(1):43-53. Loew R, et al. Eur Radiol 2000;10(6):989-96. Michel SC, et al. Eur Radiol 2002;12(12):2898-905. Spouse E, et al. Br J Radiol 2000;73(866):146-51. Washington State Department of Labor and Industries, Office of the Medical Director. Standing, weight-bearing, positional or upright MRI. Health Technology Assessment. Olympia Washington State Department of Labor and Industries; May 31 2006	

J. Appendix 1 – Cataract Referral Guide

Referral Criteria Exceptions -

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

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

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

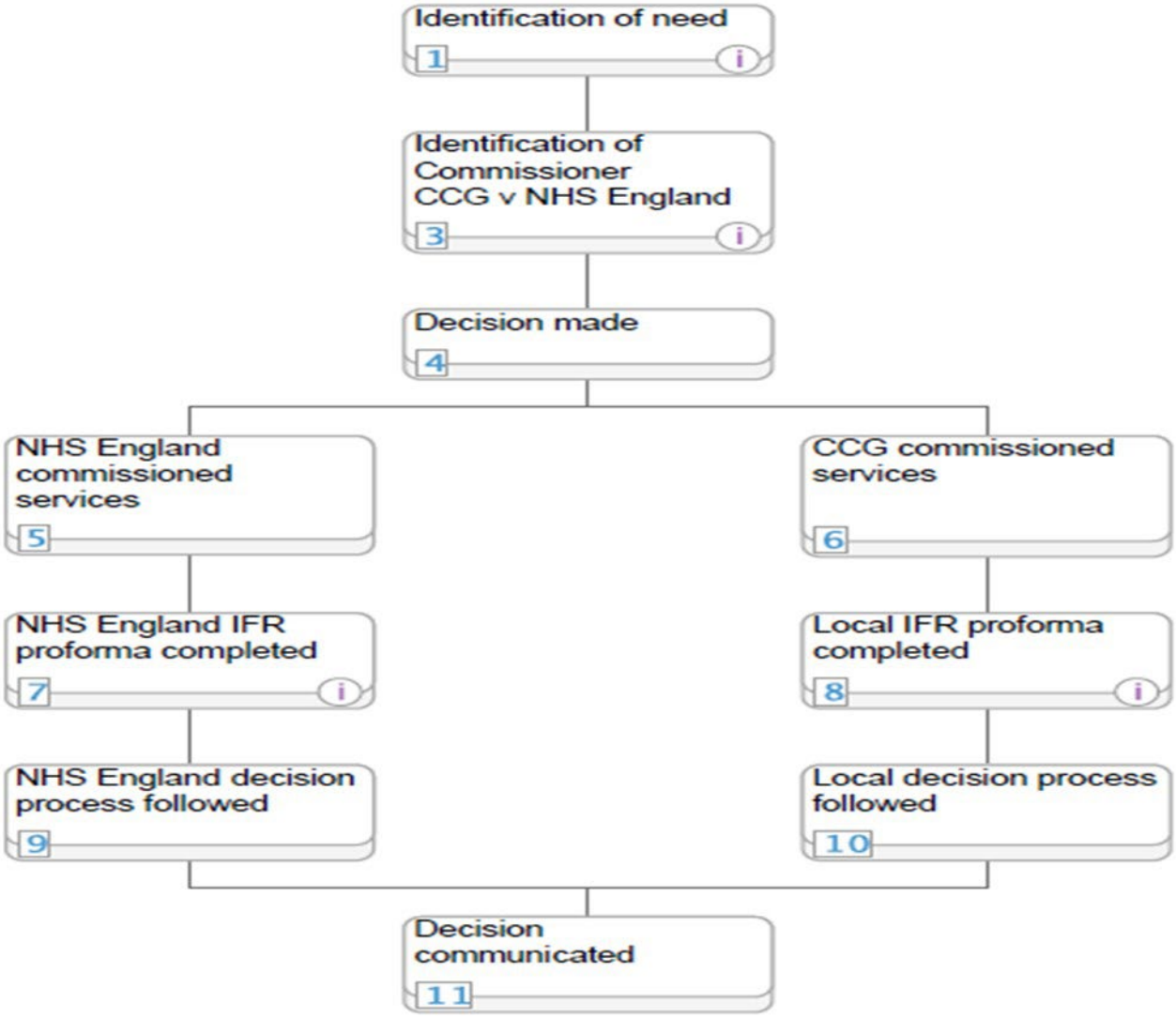
The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test), and it is anticipated that the threshold set out below will not render the majority of people unable to drive. This policy also recognises the increasing body of evidence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

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

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

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

K. Appendix 2 – IEFR Process



L. Appendix 3 – IFER Panel Contact Details

Telephone: 01244 650
305

CCG	Email Address
West Cheshire CCG	Westcheshireccg.IFR@nhs.net
Eastern Cheshire CCG	Eastern Cheshireccg.IFR@nhs.net
South Cheshire CCG	southcheshireccg.ifr@nhs.net
Vale Royal CCG	valeroyalccg.ifr@nhs.net

M. Appendix 4 – Fusion Surgery – Clinical exceptions permitted

- Fusion surgery for non-specific low back pain should be performed only as part of a randomised controlled trial. Such a trial may investigate any aspect of selection, prognostic factors, comparison to other treatments, approaches, techniques, use of instrumentation, adjuncts to fusion or similar.
- Fusion surgery may still be considered as a necessary adjunct to another procedure performed for conditions other than non-specific low back pain, e.g. decompression for spinal stenosis with symptoms of claudication, radicular pain or other indication.
- Fusion surgery in the lumbar spine may still be considered for specific pathologies such as spondylolysis and significant spondylolisthesis (Grade 2 or greater).
- Fusion surgery in the lumbar spine may be considered for deformity in adults
- Fusion surgery may be considered for causes other than non-specific back pain e.g. post-surgical back pain

The following are not permitted:

- Total disc replacement is not permitted
- (flexible stabilisation) – discredited
- Spinal injections for managing low back pain

http://www.ukssb.com/assets/PDFs/2017/May/National-Low-Back-and-Radicular-Pain-Pathway-May-2017_final.pdf

N. Appendix 5 - List of Clinical Commissioning Group policies superseded by Cheshire and Merseyside Integrated Care Board (ICB)

Cheshire CCG Ref	ICB Policy Ref	ICB Version Number	ICB Date Published	ICB Policy Title
16.37	CMICB_Clin001	1	01/04/2023	Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections
4.1	CMICB_Clin002	1	01/04/2023	Adenoidectomy
11.7	CMICB_Clin003	1	01/04/2023	Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT)
16.25	CMICB_Clin004	1	01/04/2023	Arthroscopic Surgery of the Knee for Meniscal Tears
2.2	CMICB_Clin005	1	01/04/2023	Benign skin lesions, removal
14.12	CMICB_Clin006	1	01/04/2023	Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty)
14.1/14.6	CMICB_Clin007	1	01/04/2023	Breast Reduction
16.34	CMICB_Clin008	1	01/04/2023	Bunions, surgical removal
2.4	CMICB_Clin009	1	01/04/2023	Camouflage Treatment for Skin Pigmentation and other disorders
16.29	CMICB_Clin010	1	01/04/2023	Carpal Tunnel interventions and surgery
11.8	CMICB_Clin011	1	01/04/2023	Chalazia (meibomian cysts), removal
16.7	CMICB_Clin012	1	01/04/2023	Chronic Low Back Pain, Peripheral Nerve Field Stimulation
14.19	CMICB_Clin013	1	01/04/2023	Cosmetic Procedures
7.2	CMICB_Clin014	1	01/04/2023	Diastasis (divarication) of the Recti Repair
18.2	CMICB_Clin015	1	01/04/2023	Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction

Cheshire CCG Ref	ICB Policy Ref	ICB Version Number	ICB Date Published	ICB Policy Title
16.21	CMICB_Clin016	1	01/04/2023	Dupuytren's Contracture release in adults
11.6	CMICB_Clin017	1	01/04/2023	Dyslexia Treatment using Coloured (Irlen) Filters
16.6	CMICB_Clin018	1	01/04/2023	Endoscopic Laser Foraminoplasty
16.14	CMICB_Clin019	1	01/04/2023	Epidural Adhesions, Therapeutic Endoscopic Division
17.2	CMICB_Clin020	1	01/04/2023	Erectile dysfunction, penile prosthesis surgery
7.3/7.4	CMICB_Clin021	1	01/04/2023	Gallstones (Asymptomatic), Surgical Management
16.32	CMICB_Clin022	2	27/09/2023	Ganglia, surgical removal and general management
4.3	CMICB_Clin023	1	01/04/2023	Grommets for glue ear in children
7.1	CMICB_Clin024	1	01/04/2023	Haemorrhoids, surgical management
8.2	CMICB_Clin025	1	01/04/2023	Heavy Menstrual Bleeding, Dilatation and Curettage
8.1	CMICB_Clin026	1	01/04/2023	Heavy Menstrual Bleeding, Hysterectomy
18.1	CMICB_Clin027	1	01/04/2023	Hyperhidrosis (excessive sweating), Surgical Management
16.26	CMICB_Clin028	1	01/04/2023	Knee Osteoarthritis, Arthroscopic Lavage and Debridement
16.16	CMICB_Clin029	1	01/04/2023	Low back pain, disc replacement
14.4	CMICB_Clin030	1	01/04/2023	Mastopexy (breast lift)
3.2	CMICB_Clin031	1	01/04/2023	Monogenic Diabetes Testing
16.35	CMICB_Clin032	1	01/04/2023	Morton's Neuroma, surgical treatment
16.31	CMICB_Clin033	1	01/04/2023	Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal
11.4	CMICB_Clin034	1	01/04/2023	Myopia, Hyperopia and Astigmatism, Laser Treatment

Cheshire CCG Ref	ICB Policy Ref	ICB Version Number	ICB Date Published	ICB Policy Title
14.5	CMICB_Clin035	1	01/04/2023	Nipple inversion, surgical correction
16.19	CMICB_Clin036	1	01/04/2023	Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid)
16.20	CMICB_Clin037	1	01/04/2023	Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids
14.8	CMICB_Clin038	1	01/04/2023	Pectus Deformity, surgical treatment
13.1	CMICB_Clin039	1	01/04/2023	Positional Plagiocephaly/brachycephaly in children, helmet therapy
17.5	CMICB_Clin040	1	01/04/2023	Reversal of Male Sterilisation
4.8	CMICB_Clin041	1	01/04/2023	Rhinophyma, surgical management
14.18	CMICB_Clin042	1	01/04/2023	Rhytidectomy
15.1	CMICB_Clin043	1	01/04/2023	Simple Snoring, surgical management
4.6	CMICB_Clin044	1	01/04/2023	Sinus X-Ray
4.5	CMICB_Clin045	1	01/04/2023	Split (cleft) Earlobe, surgical repair
4.4	CMICB_Clin046	1	01/04/2023	Tonsillectomy
16.28	CMICB_Clin047	1	01/04/2023	Total Knee Arthroplasty, patient specific instrumentation/implants
16.18	CMICB_Clin048	1	01/04/2023	Trigger Finger release in adults
18.3	CMICB_Clin049	1	01/04/2023	Varicose Veins