

Wirral

Commissioning Policy

CRITERIA

2019/2020

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1. Introduction

Wirral CCG is 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 Wirral. This document is intended to be a statement of such arrangements made by Wirral CCG 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 Wirral CCGs will commission the service, either via existing contracts or on an individual basis. It gives guidance to referrers on the policies of the CCG 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, Wirral CCG has had regard to relevant law and guidance, including 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.

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

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

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

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

2. Core Clinical Eligibility

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

All NICE Technology Appraisals will be implemented.

In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2 week rule.

Reconstructive surgery post cancer or trauma including burns.

Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.

Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.

Any patient who needs urgent treatment will always be treated.

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

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

3. Referral & Approval Process

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

If a General Practitioner/Optometrists/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/Optometrists/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. 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, explaining why the patient is not eligible for treatment.

Should a patient not fulfil the clinical criteria but the 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.

4. Exceptionality

In dealing with exceptional case requests for an intervention that is considered to be a poor use of NHS resources, Wirral CCG has 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.*

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

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

5. Psychological Distress

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

Unless specifically stated otherwise in the policy, any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to

alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

6. Personal Data (including photographs)

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

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

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

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

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

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

7. Medicines Management

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

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

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

NOTE: Funding for all solid and haematological cancers is 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.

8. Evidence


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

	Treatment/ Procedure	Exceptionality - Prior Approval - 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: <u>Severe</u> scarring following: <ul style="list-style-type: none"> • Acne once the active disease is controlled. • Chicken pox. OR <ul style="list-style-type: none"> • 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 treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	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. <i>Journal of the European Academy of Dermatology and Venereology</i> , 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 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	UPDATED Surgical or Laser Therapy Treatments for Minor Benign Skin Lesions e.g. sebaceous cyst	Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined below. Risks from the procedure can include bleeding, pain, infection, and scarring. This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below: benign moles (excluding large congenital naevi) <ul style="list-style-type: none"> • solar comedones 	Higgins JC, Maher MH, Douglas MS. Diagnosing Common Benign Skin Tumors. <i>Am Fam Physician</i> . 2015 Oct 1;92(7):601-7. PubMed PMID: 26447443. Tan E, Levell NJ, Garioch JJ. The effect of a dermatology restricted-referral list upon the volume of referrals. <i>Clin Exp Dermatol</i> . 2007 Jan;32(1):114-5. PubMed PMID: 17305918.	A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred 22 OFFICIAL according to NICE skin cancer

		<ul style="list-style-type: none"> • corn/callous • dermatofibroma • lipomas <ul style="list-style-type: none"> • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags <ul style="list-style-type: none"> • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata <p>The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:</p> <ul style="list-style-type: none"> • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year <ul style="list-style-type: none"> • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity <ul style="list-style-type: none"> • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue • If left untreated, more invasive intervention would be required for removal <ul style="list-style-type: none"> • Facial viral warts • Facial spider naevi in children causing significant psychological impact 		<p>guidelines. This policy does not refer to premalignant lesions and other lesions with potential to cause harm.</p>
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		<ul style="list-style-type: none"> • Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic. <p>The following are outside the scope of this policy recommendation:</p> <ul style="list-style-type: none"> • Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines. • Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred or, where appropriate, treated in primary care. • Removal of lesions other than those listed above. <p>Referral to appropriate speciality service (eg dermatology or plastic surgery):</p> <ul style="list-style-type: none"> • The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria. • This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwr), independent providers, and community or intermediate services. 		
2.3	Surgical Treatment for Removal of Lipoma in Secondary Care.	<p>Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position.</p> <p>Lipomas that are under 5cms should be observed only unless the above applies.</p>	<p>Noninvasive lipoma size reduction using high-intensity focused ultrasound – Dermatologic Surgery 2013 Oct;39(10):1446-51.</p>	<p>Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which have also shown rapid growth and are painful should</p>

				be referred to an appropriate skin cancer clinic.
2.4	Treatments for Skin Pigment Disorders	<p>NHS Cosmetic Camouflage is commissioned.</p> <p>This is provided by Changing Faces formerly the Red Cross.*</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>http://www.changingfaces.org.uk/Skin-Camouflage</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	<p>Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only.</p> <p>Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.</p> <p>*Access available for Wirral patients via Dermatology Department.</p>
2.5	Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers	<p>Will be commissioned in any of the following circumstances:</p> <ul style="list-style-type: none"> • 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 	<p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>patient.co.uk/doctor/viral-warts-excluding-verrucae</p> <p>http://www.patient.co.uk/doctor/verrucae</p>	<p>Most viral warts will clear spontaneously or following application of topical treatments.</p> <p>65% are likely to disappear spontaneously within 2 years.</p> <p>There are numerous OTC preparations</p>

		dermatologist.		available. Community treatments such as cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.
2.6	Secondary Care treatment for Acne Vulgaris (Mild to Moderate)	<p>Will be commissioned in any of the following circumstances:</p> <ul style="list-style-type: none"> • 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 <p>Patients that do not meet this criteria should be managed in Primary Care.</p>	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 with UVA)	Will be commissioned if ALL of the following criteria are met: <ul style="list-style-type: none"> • Diagnosis by Dermatology Consultant • Severe with symptoms causing significant functional impairment (Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities) • Symptoms remain severe despite preventative treatments • Light therapy deemed likely to make significant improvement to patients symptoms 	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.
3. Diabetes				
3.1 UPDATED	Continuous Glucose Monitoring (CGM) Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus	<p>Restricted</p> <p>Adults with type 1 diabetes</p> <p>CGM is not routinely commissioned.</p> <p>CGM will only be considered for patients when all of the following criteria are met:</p> <p>Currently using a continuous subcutaneous insulin pump of high specification in strict accordance with NICE appraisal TAG 151 and the local insulin pump policy.</p> <p>AND</p> <p>Managed by a recognised adult specialist centre of expertise. This will have a multidisciplinary team comprising a trained diabetes nurse specialist, physician and dietician with all patients trained to count carbohydrates.</p> <p>AND</p> <p>Willing to commit to using CGM at least 70% of the time and to calibrate it as needed.</p> <p>PLUS</p> <p>HbA1c≥75mmol/mol (9%) that persists despite blood glucose testing at least 10 times a day **</p>	<ol style="list-style-type: none"> 1. Benkhadra K, Alahdab F, Tamhane S, Wang Z, Prokop LJ, Hirsch IB, et al. Real-time continuous glucose monitoring in type 1 diabetes: a systematic review and individual patient data meta-analysis. <i>Clinical endocrinology</i>. 2017;86(3):354-60. 2. Lind M, Polonsky W, Hirsch IB, Heise T, Bolinder J, Dahlqvist S, et al. Continuous Glucose Monitoring vs Conventional Therapy for Glycemic Control in Adults With Type 1 Diabetes Treated With Multiple Daily Insulin Injections: The GOLD Randomized Clinical Trial. <i>JAMA</i>. 2017;317(4):379-87. 3. Kesavadev J, Vigersky R, Shin J, Pillai PBS, Shankar A, Sanal G, et al. Assessing the Therapeutic Utility of Professional Continuous Glucose Monitoring in Type 2 Diabetes Across Various Therapies: A Retrospective Evaluation. <i>Advances in therapy</i>. 2017. 4. Beck RW, Riddlesworth T, Ruedy K, Ahmann A, Bergenstal R, Haller S, et al. Effect of Continuous Glucose Monitoring on Glycemic Control in Adults With Type 1 Diabetes Using Insulin Injections: The DIAMOND Randomized Clinical Trial. <i>JAMA</i>. 2017;317(4):371-8. 5. Ruedy KJ, Parkin CG, Riddlesworth TD, Graham C, Group DS. Continuous Glucose Monitoring in Older Adults With Type 1 and Type 2 Diabetes Using Multiple Daily Injections of Insulin: Results From the DIAMOND Trial. <i>Journal of diabetes science and technology</i>. 2017:1932296817704445. 6. van Beers CAJ, DeVries JH, Kleijer SJ, Smits MM, Geelhoed-Duijvestijn PH, Kramer MHH, et al. Continuous glucose monitoring 	<p>Reason for proposed change(s)</p> <p>The National Institute for Health and Care Excellence (NICE) states there isn't enough evidence to show continuous glucose monitors are cost-effective enough for everyone with type 1 diabetes.</p> <p>Also see: NICE Technology Appraisal 151: https://www.nice.org.uk/guidance/ta151 NICE Guideline 17 (Type 1 diabetes</p>

		<p>OR Experiencing more than one severe hypoglycaemic episode a year with no obviously preventable precipitating cause. (Severe hypoglycaemia is generally recognised as hypoglycaemia involving convulsions/unconsciousness)</p> <p>OR Experiencing more than 2 episodes of hypoglycaemia per week that the patients has been unable to manage themselves and are causing problems with daily activities.</p> <p>OR Complete loss of awareness of hypoglycaemia</p> <p>OR Inability to recognise or communicate about symptoms of hypoglycaemia e.g. because of cognitive or neurological disabilities where other forms of glucose monitoring are not appropriate.</p> <p>Pregnancy CGM is not routinely commissioned in pregnancy unless all criteria for CGM in adults are met. Where CGM in pregnancy is used, funding is only for the duration of the pregnancy. Insulin doses are reduced to pre-pregnancy levels as soon as the baby is delivered and CGM should not be continued beyond this point.</p> <p>FOR ALL PATIENTS A CGM system with a low Mean Absolute Relative Difference (MARD) value should be chosen. Where there is a CGM system with alarm function that will integrate and communicate directly with the patient's established insulin pump, then this CGM system should generally be used. However, an appropriate real-time Dexcom CGM System with alarm function may be considered for patients using other insulin pumps, or those individuals where the integrated system is not the most clinically appropriate CGM system.</p>	<p>for patients with type 1 diabetes and impaired awareness of hypoglycaemia (IN CONTROL): a</p>	<p>in adults: diagnosis and management): https://www.nice.org.uk/guidance/ng17</p> <p>Impact of proposed change(s) People with type 1 diabetes</p> <p>EIA - As this is a new policy, the assessment identified that there could be possible adverse impact on protected groups (disability and those who are less able to manage their condition, e.g children and people with a learning disability and therefore recommended further engagement.</p>
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		<p>The device should be withdrawn from patients who fail to achieve a clinically significant response after 6 months*.</p> <p>There should also be an annual review to assure the clinically significant response is maintained and that CGM is still the most appropriate method of glucose monitoring for the patient. Consideration should be given to switching to an integrated insulin pump/CGM system when seeking to replace the insulin pump at warranty expiry, if appropriate.</p> <p>Children and young people with type 1 diabetes CGM is not routinely commissioned. CGM will only be considered for patients when the following criteria are met:</p> <p>Currently using a continuous subcutaneous insulin pump of high specification, in strict accordance with NICE appraisal TAG 151 and the local insulin pump policy.</p> <p>AND When provided by a specialist centre with a multidisciplinary team including an active member who attends at least 67% (2/3) of the North West children and young people's diabetes network meetings. In addition, the specialist centre is achieving best practice tariff in paediatric diabetes and is also engaged with the national peer review programme in paediatric diabetes, to monitor the quality of its service.</p> <p>AND Willing to commit to using CGM at least 70% of the time and to calibrate it as needed.</p> <p>PLUS Experiencing more than 2 episodes per week of severe hypoglycaemia. This is defined as having low blood glucose levels that require assistance from another person to treat and that are</p>		
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		<p>happening often enough to have a significant impact on school work or quality of life.</p> <p>OR</p> <p>Inability to recognise or communicate about symptoms of hypoglycaemia e.g. because of cognitive or neurological disabilities, or less than 4 years of age.</p> <p>OR</p> <p>Impaired awareness of hypoglycaemia which is associated with significant adverse consequences e.g. seizures or severe anxiety. Prior to transition to adult services, the child should be counselled on the transition process and advised that their CGM will be reviewed as part of the transition and their ongoing adult diabetes care. On transition to adult services there should be a review to assure there is still a clinically significant response* and that CGM is still the most appropriate method of glucose monitoring for the patient.</p> <p>Ongoing continuation of CGM</p> <p>* A clinically significant response is considered to be:</p> <ul style="list-style-type: none"> • When the patient demonstrates wearing the sensor for at least 70% of the time. <p>PLUS</p> <p>A reduction in the frequency and/or severity of hypoglycaemic episodes.</p> <p>OR</p> <ul style="list-style-type: none"> • A reduction in the need for third party intervention during hypoglycaemic episodes. <p>AND/OR</p> <ul style="list-style-type: none"> • Achievement of a clinically significant reduction in HbA1c, that demonstrates the patient is moving towards their individually agreed HbA1c target. <p>**Where CGM is initiated due to hyperglycaemia in adults, it should only be continued longer-term if HbA1c can be sustained at or below 53 mmol/mol (7%) and/or there has been a fall in HbA1c of 27 mmol/mol (2.5%) or more, in accordance with NICE CG17</p>		
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3.2	<p>Monogenic Diabetes Testing</p> <p>Maturity Onset Diabetes of the Young (MODY)</p>	<p>Only commissioned in the following circumstances:</p> <ul style="list-style-type: none"> • patient has been assessed using the probability calculator with documentation of the outcome: http://diabetesgenes.org/content/mody-probability-calculator • assessment/discussion with diabetes team to whether patient would benefit from testing and test recommended • outcome of the test will change clinical management of the patient 	<p>http://www.diabetesgenes.org/content/guidelines-genetic-testing-mody</p> <p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363133/</p> <p>http://www.bmj.com/content/343/bmj.d6044</p>	
4. ENT				
4.1	Adenoidectomy	<p>Commissioned only in either of the following clinical situations.</p> <p><u>In Children</u> For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy.</p> <p>In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 4.3</p> <p>Or</p> <p>Recurrent glue ear following removal of grommets</p> <p>Adenoidectomy is not routinely commissioned as an isolated procedure however funding can be requested via an IFR for clinical exceptions</p>	<p>http://www.journalslibrary.nihr.ac.uk/_data/assets/pdf_file/0010/98659/FullReport-hta18050.pdf Health Technology Assessment Volume:18 Issue: 5</p> <p>Tonsillectomy and Adenoidectomy in Children with Sleep Related Breathing Disorders – The Royal College of Anaesthetists - July 2010.</p> <p>Adenoidectomy for recurrent or chronic nasal symptoms in children The Cochrane Library 2010.</p> <p>Adenoidectomy for otitis media in children The Cochrane Library 2010.</p> <p>Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract) Centre for Reviews and Dissemination 2013.</p> <p>NICE “Do not do” recommendation: “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper</p>	

			respiratory tract symptoms.” http://www.journalslibrary.nihr.ac.uk/_data/assets/pdf_file/0004/98869/FullReport-hta18050.pdf Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ. Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis. Health Technology Assessment 2014;18(5)	
4.2	Pinnaplasty – for Correction of Prominent Ears	<p>May be commissioned in the following circumstances:</p> <p>Surgical “correction” of prominent ear(s) only when all of the following criteria are met:</p> <ol style="list-style-type: none"> 1. Referral only for children aged up to 18 years at the time of referral. <p>AND</p> <ol style="list-style-type: none"> 2. With very significant ear deformity or asymmetry. <p>AND</p> <ol style="list-style-type: none"> 3. Patients present with significant detrimental impact on child’s ability to lead a normal life <p>Patients not meeting these criteria should not be routinely referred for surgery.</p> <p>Incisionless otoplasty is not commissioned.</p>	<p>Pinnaplasty Department of Health (2007).</p> <p>Local PCT consensus - review conducted 2007.</p> <p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>IPG 422: Incisionless otoplasty NICE 2012.</p> <p>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty Royal College of Surgeons (2013).</p>	
4.3 UPDA TED	Insertion of Grommets for Glue Ear (otitis media with effusion)	<p>The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met:</p> <ul style="list-style-type: none"> • All children must have had specialist audiology and ENT assessment. • Persistent bilateral otitis media with effusion over a period of 3 months. • Hearing level in the better ear of 25-30dBHL or worse averaged at 0.5, 1, 2, & 4kHz 	<p>NICE guidance: https://www.nice.org.uk/Guidance/CG60</p> <p>Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3</p>	

• Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

• Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

• The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.

• It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

For further information, please see:
<https://www.nice.org.uk/Guidance/CG60>

ADULTS

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


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

		<p>OR Evidence of retracted ear drum</p> <p>OR</p> <ul style="list-style-type: none"> • Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy. 		
4.4 UPDA TED	Tonsillectomy for Recurrent Tonsillitis (excluding peritonsillar abscess) Adults and Children	<p>The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance:</p> <ul style="list-style-type: none"> • Sore throats are due to acute tonsillitis <p>AND</p> <ul style="list-style-type: none"> • The episodes are disabling and prevent normal functioning <p>AND</p> <ul style="list-style-type: none"> • Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year <p>OR</p> <ul style="list-style-type: none"> • Five or more such episodes in each of the preceding two years <p>OR</p> <ul style="list-style-type: none"> • Three or more such episodes in each of the preceding three years. 	<p>Rubie I, Haighton C, O'Hara J, Rousseau N, Steen N, Stocken DD, Sullivan F, Vale L, Wilkes S, Wilson J. The National randomised controlled Trial of Tonsillectomy IN Adults (NATTINA): a clinical and cost-effectiveness study: study protocol for a randomised control trial. <i>Trials</i>. 2015 Jun 6;16:263. https://www.ncbi.nlm.nih.gov/pubmed/26047934</p> <p>http://www.sign.ac.uk/assets/sign117.pdf</p> <p>Osbourne MS, Clark MPA. The surgical arrest of post-tonsillectomy haemorrhage: Hospital Episode Statistics 12 years on. <i>Annals RCS</i>. 2018. May (100) 5: 406-408</p>	<p>There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:</p> <ul style="list-style-type: none"> • Acute and chronic renal disease resulting from acute bacterial tonsillitis. • As part of the treatment of severe guttate psoriasis. <ul style="list-style-type: none"> • Metabolic disorders where periods of reduced oral intake could be dangerous to

				<p>health.</p> <ul style="list-style-type: none"> • PFAPA (Periodic fever, Aphthous stomatitis, Pharyngitis, Cervical adenitis) • Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous <p>Further information on the Scottish Intercollegiate Guidelines Network guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf</p> <p>There is no alternative treatment for recurrent sore throats that is known to be beneficial, however sometimes symptoms improve with a period of observation.</p>
4.5	Surgical Remodelling	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	Correction of split

	of External Ear Lobe			earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
4.6	Use of Sinus X-ray	X-rays of sinuses are not routinely commissioned.	BSACI guidelines for the management of rhinosinusitis and nasal polyposis Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007. NHS Choices Sinusitis http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitis Royal College of Surgeons (2013).	
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: <ul style="list-style-type: none"> • 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.
4.8	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Nuances in the management of rhinophyma Facial Plastic Surgery, 2012 Apr;28(2):231-7. http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm http://www.nhs.uk/Conditions/Rosacea/Pages/Treatment.aspx	The first-line treatment of this condition of the nasal skin is medical. However response is poor. Severe cases that

				do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances.
4.9	Septorhinoplasty	<p>Only commissioned where:</p> <ul style="list-style-type: none"> • 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 <p>This procedure is not commissioned for cosmetic reasons</p>	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)	<p>Only commissioned where:</p> <ul style="list-style-type: none"> • 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.
5. Equipment				
5.1	Use of Lycra Suits	<p>Lycra Suits are not normally commissioned for postural management of cerebral palsy.</p> <p>Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.</p>	<p>What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013.</p> <p>For further references please refer to Public Health Lycra Suits Paper.</p>	Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames.

				<p>Public Health Recommendation:</p> <p>Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.</p> <p>Lycra suit orthoses for cerebral palsy should be assigned low priority.</p> <p>Individual CCG addendums apply.</p> <p> PH Lycra Suits Paper.pdf</p>
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 Wirral Subfertility Policy.	<p>CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013.</p> <p>Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario</p>	Individual CCG addendums apply.
7. General Surgery				
7.1 UPDA TED	Haemorrhoidectomy - Rectal Surgery: Removal of Haemorrhoidal Skin Tags	<p>Surgical treatment should only be considered for those that do not respond to non-operative measures or if the haemorrhoids are more severe, specifically:</p> <ul style="list-style-type: none"> • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent 	<p>Watson AJM, Bruhn H, MacLeod K, et al. A pragmatic, multicentre, randomised controlled trial comparing stapled haemorrhoidopexy to traditional excisional surgery for haemorrhoidal disease (eTHoS): study protocol for a randomised controlled trial. <i>Trials</i>. 2014;15:439. doi:10.1186/1745-6215-15-439.</p>	Numerous interventions exist for the management of haemorrhoids (piles). The evidence

		<p>pain or bleeding; or</p> <ul style="list-style-type: none"> • Irreducible and large external haemorrhoids <p>In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.</p> <p>Removal of skin tags is not routinely commissioned.</p>	<p>Watson AJM, Hudson J, Wood J, et al. Comparison of stapled haemorrhoidopexy with traditional excisional surgery for haemorrhoidal disease (eTHoS): a pragmatic, multicentre, randomised controlled trial. <i>Lancet</i> (London, England). 2016;388(10058):2375-2385. doi:10.1016/S0140-6736(16)31803-7.</p> <p>Brown SR. Haemorrhoids: an update on management. <i>Therapeutic Advances in Chronic Disease</i>. 2017;8(10):141-147. doi:10.1177/2040622317713957. 4. NHS website: https://www.nhs.uk/conditions/piles-haemorrhoids/</p> <p>Royal College of Surgeons: https://www.rcseng.ac.uk/-/media/files/rcs/standards-andresearch/commissioning/rcsacpgbirectalbleeding2017documentfinal_jan18 .pdf</p> <p>Health Technol Assess. 2016 Nov;20(88):1-150. The HubBLE Trial: haemorrhoidal artery ligation (HAL) versus rubber band ligation (RBL) for symptomatic second- and third-degree haemorrhoids: a multicentre randomised controlled trial and health-economic evaluation. Brown S et al.</p>	<p>recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less severe haemorrhoids</p>
7.2	<p>Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias</p> <p>Surgical correction of Diastasis of the Recti</p>	<p>Surgery: not commissioned if no symptoms, easily reducible (i.e. can be 'pushed back in') and not at significant risk of complications.</p> <p>Surgical repair is not routinely commissioned.</p>	<p>A systematic review on the outcomes of correction of diastasis of the recti Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.</p>	<p>Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect.</p>
7.3	<p>Surgery for Asymptomatic Gallstones</p>	<p>This procedure is not routinely commissioned.</p>	<p>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones Royal College of Surgeons (2013).</p>	<p>This procedure is considered a Low clinical priority for <u>asymptomatic</u> gallstones.</p> <p>Asymptomatic gallstones are</p>

				usually diagnosed incidentally when they are seen on imaging which is done for unrelated reasons.
7.4	Lithotripsy for Gallstones	Lithotripsy not routinely commissioned.		Lithotripsy rarely performed as rate recurrence high.
7.5	Rectopexy and STARR (Stapled Transanal Resection of the Rectum)	<p>Only be commissioned if patient meets the threshold below:</p> <ul style="list-style-type: none"> • 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 	<p>https://www.bristolccg.nhs.uk/media/medialibrary/2016/09/rectopexy_and_STARR_policy_.pdf</p> <p>http://patient.info/doctor/rectal-prolapse</p>	
8. Gynaecology				
8.1 UPDAT ED	<p>Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding</p> <p>Hysterectomy with or without Oophrectomy</p>	<p>Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.</p>	<p>NICE guidance: https://www.nice.org.uk/guidance/ng88.</p> <p>NHS website: https://www.nhs.uk/conditions/heavy-periods/#Causes</p> <p>Hurskainen R, Teperi J, Rissanen P, et al. Clinical outcomes and costs with the levonorgestrel-releasing intrauterine system or hysterectomy for treatment of menorrhagia: randomized trial 5-</p>	

		<p>Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.</p>	<p>year follow-up. JAMA: the journal of the American Medical Association 2004;291(12):1456–63.</p> <p>Learman LA, Summitt Jr RL, Varner RE, et al. Hysterectomy versus expanded medical treatment for abnormal uterine bleeding: Clinical outcomes in the medicine or surgery trial. Obstetrics and Gynecology 2004;103(5 1):824–33.</p> <p>Zupi E, Zullo F, Marconi D, et al. Hysteroscopic endometrial resection versus laparoscopic supracervical hysterectomy for menorrhagia: a prospective randomized trial. American Journal of Obstetrics and Gynecology 2003;188(1):7–12.</p> <p>Lethaby A, Hickey M, Garry R. Endometrial destruction techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2005 Oct 19;(4):CD001501. Review. Update in: Cochrane Database Syst Rev. 2009;(4):CD001501. PubMed PMID: 16235284.</p> <p>Hehenkamp WJ, Volkers NA, Donderwinkel PF, et al. Uterine artery embolization versus hysterectomy in the treatment of symptomatic uterine fibroids (EMMY trial): peri- and postprocedural results from a randomized controlled trial. American Journal of Obstetrics and Gynecology 2005;193(5):1618–29.</p> <p>Pinto I, Chimeno P, Romo A, et al. Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment – a prospective, randomized, and controlled clinical trial. Radiology 2003;226(2):425–31.</p>	
8.2 UPDA TED	D&C (dilatation and curettage)	<p>Not routinely commissioned</p> <p>D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.</p> <p>Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to</p>	<p>NICE guidance: https://www.nice.org.uk/guidance/ng88</p> <p>NHSadvice:https://www.nhs.uk/conditions/hysteroscopy/#alternatives-tohysteroscopy.</p> <p>MacKenzie IZ, Bibby JG. Critical assessment of dilatation and curettage in 1029 women. Lancet 1978;2(8089):566–8. 4. Ben-Baruch G, Seidman DS, Schiff E, et al. Outpatient endometrial sampling with the Pipelle curette. Gynecologic and Obstetric</p>	<p>NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that</p>

		investigate heavy periods. Medication and intrauterine systems (IUS) can be used to treat heavy periods.	Investigation 1994;37(4):260–2. Gimpelson RJ, Rappold HO. A comparative study between panoramic hysteroscopy with directed biopsies and dilatation and curettage. A review of 276 cases. American Journal of Obstetrics and Gynecology 1988;158(3 Pt 1):489–92. Haynes PJ, Hodgson H, Anderson AB, et al. Measurement of menstrual blood loss in patients complaining of menorrhagia. British Journal of Obstetrics and Gynaecology 1977;84(10):763–8.	D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. Complications following D&C are rare but include uterine perforation, infection, adhesions (scar tissue) inside the uterus and damage to the cervix.
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 not routinely commissioned.	http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/service-restriction-policy/1562-1-0-service-restriction-policy-july-2015-v2 https://www.nice.org.uk/guidance/IPG367/chapter/1-guidance	
8.5	Surgical correction of vaginal/ uterovaginal prolapse	This will only be commissioned if: <ul style="list-style-type: none"> • symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence) or • Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence AND <ul style="list-style-type: none"> • Evidence that conservative management 	http://www.nhs.uk/conditions/Prolapse-of-the-uterus/Pages/Introduction.aspx	

		<p>has been trialled in primary care and failed including; lifestyle modification, pelvic floor exercises, vaginal pessary, local oestrogen creams and oral treatments unless contraindicated,</p> <p>AND</p> <ul style="list-style-type: none"> • Symptoms cause significant functional impairment (Symptoms preventing the patient fulfilling vital work or educational responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities) <p>AND</p> <ul style="list-style-type: none"> • Patient has confirmed that they do want surgery to correct 		
8.6	Secondary Care follow up of mirenia coil insertion	Secondary care checking mirenia coil insertion is not routinely commissioned.		
9. Mental Health				
9.1	Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)	<p>Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned.</p> <p>If inpatient treatment is recommended an IFR referral will be required.</p>	<p>Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children – NICE 2007, CG53.</p> <p>Cognitive behaviour therapy for chronic fatigue syndrome in adults - Cochrane Depression, Anxiety and Neurosis Group 2008.</p> <p>Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis - . PLoS ONE 7(8): e40808. doi:10.137.</p> <p>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.</p>	<p>Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.</p> <p>NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be</p>

				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, assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
9.4	Private Mental Health (MH) Care - Non-NHS	This will not normally be funded.	Veterans' post traumatic stress disorder programme (Adult) Service Specification	


	<p>Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health</p>	<p>Most mental health conditions can be managed in the community with input from Community Mental Health teams.</p> <p>NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD.</p> <p>There is also a specialist NHS MH service provided for affective disorders.</p> <p>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.</p>	<p>NHS England Specialised Commissioning 2013.</p> <p>Post –traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care NICE Clinical Guideline 26 (2005).</p> <p>Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification NHS England Specialised Commissioning (2013)</p> <p>The use of motivational interviewing in eating disorders: a systematic review. Psychiatry Research, 2012 Nov 30;200(1):1-11.</p> <p>Depression in children and young people: Identification and management in primary, community and secondary care. NICE Clinical Guideline 2005.</p> <p>Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013.</p>	
10. Neurology				
10.1	Bobath Therapy	<p>Bobath Therapy is not routinely commissioned by the NHS.</p> <p>The evidence base is poor for both children and adults.</p>	<p>The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy</p>	

			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)	<p>Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury.</p> <p>It is not routinely commissioned for lower motor neurone lesions.</p> <p>It is under review by NICE for dysphagia and muscle recovery chronic disease.</p> <p>Patients must have receptive cognitive abilities.</p> <p>Exclusion Criteria:</p> <ul style="list-style-type: none"> • Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. • Ataxic and polio patients are generally poor responders although there are exceptions. 	<p>Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011.</p> <p>Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78.</p> <p>Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10.</p> <p>Functional electrical stimulation for drop foot of central neurological origin NICE, 2009.</p> <p>Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.</p>	
11. Ophthalmology				
11.1	Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	<p>Only commissioned in the following circumstances:</p> <ul style="list-style-type: none"> • Eyelid function interferes with visual field. 	<p>Eyelid Surgery <i>The British Association of Aesthetic Plastic Surgeons 2011.</i></p> <p>Modernisation Agency's Action on Plastic Surgery 2005.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 -</p>	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.

			Consolidation and repository of the existing evidence-base London Health Observatory 2010.	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: <ul style="list-style-type: none"> • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease. 	Eyelid Surgery The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted 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.	Excessive skin in the lower lid may cause “eye bags” but does not affect function of the eyelid or vision and therefore does not need correction.
11.3	Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)	Only commissioned for: Larger lesions which satisfy all of the following: <ol style="list-style-type: none"> 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)	Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely <u>not</u> commissioned.		
11.5	Cataract Surgery	See appendix 1 for details of Wirral Referral Guidance template. There is good evidence that bilateral cataract replacement is beneficial.	<p>Thresholds for cataract surgery – Shropshire and Telford Hospital NHS Trust, 2012.</p> <p>NHS Atlas of Variation, (cataract spend, cataract admissions)</p> <p>Don't turn back the clock: Cataract surgery - the need for patient centred care. RNIB / Royal College of Ophthalmologists (2011).</p> <p>Cataract surgery guidelines The Royal College of Ophthalmologists (RCOphth) 2010.</p> <p>Action on cataracts good practice guidance Department of Health (2000).</p> <p>Cataract care pathway Map of Medicine (2013).</p> <p>NHS UK - http://www.nhs.uk/conditions/Cataracts-age-related/Pages/Introduction.aspx</p> <p>For further references please refer to Public Health Cataracts Paper.</p>	 PH Cataract Paper.pdf  Wirral Referral Criteria.docx
11.6	Coloured (irlens) Filters for Treatment of Dyslexia	There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.	Coloured filters for reading disability:A systematic review WMHTAC 2008	
11.7	Intra Ocular Telescope for Advanced Age-Related Macular Degeneration	This is not routinely commissioned as there is limited published evidence of effectiveness.	<p>Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008.</p> <p>Intraocular telescope by Vision Care™ for age-related macular degeneration North East Treatment Advisory Group (2012).</p>	
11.8 UPDA TED	Surgical Removal of Chalazion or Meibomian Cysts	Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:	NICE clinical knowledge summaries, https://cks.nice.org.uk/meibomian-cystchalazion .	Individual CCG addendums apply.

		<ul style="list-style-type: none"> • Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a six month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected eg. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions 	<p>Moorfield's Eye Hospital Patient Information, https://www.moorfields.nhs.uk/sites/default/files/chalazion-adult.pdf.</p> <p>Wu AY, Gervasio KA, Gergoudis KN, Wei C, Oestreicher JH, Harvey JT. Conservative therapy for chalazia: is it really effective? Acta Ophthalmol. 2018 Jan 16. doi: 10.1111/aos.13675. [Epub ahead of print] PubMed PMID: 29338124.</p> <p>Goawalla A, Lee V. A prospective randomized treatment study comparing three treatment options for chalazia: triamcinolone acetate injections, incision and curettage and treatment with hot compresses. Clin Exp Ophthalmol. 2007 Nov;35(8):706-12. PubMed PMID: 17997772</p> <p>Watson P, Austin DJ. Treatment of chalazions with injection of a steroid Suspension. British Journal of Ophthalmology, 1984, 68, 833-835.</p> <p>Ben Simon, G.J., Huang, L., Nakra, T. et al. Intralesional triamcinolone acetate injection for primary and recurrent chalazia (is it really effective?) . Ophthalmology. 2005; 112: 913–917.</p> <p>Papalkar D, Francis IC. Injections for Chalazia? Ophthalmology 2006; 113:355–356. Incision and curettage vs steroid injection for the treatment of chalazia: a metaanalysis. Aycinena A, Achrion A et al. Ophthalmic Plastic and reconstructive surgery. 2016;32:220-224.</p> <p>McStay. Stye and Chalazion. BMJ Best Practice https://bestpractice.bmj.com/topics/en-gb/214 (accessed 18/10/18)</p>	
11.9	Surgical treatment for Proptosis/ Dysthyroid eye disease	<p>Only commissioned if:</p> <ul style="list-style-type: none"> • 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. This is only available via IFR		

11.11	Multifocal (non-accommodative) intraocular lenses	Multifocal (non-accommodative) intraocular lenses are not routinely commissioned. This is only available via IFR		
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: <ul style="list-style-type: none"> Any or a combination of the following symptoms are present: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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	
13. Paediatrics				
13.1	Cranial Banding for Positional Plagiocephaly	Not routinely commissioned.	Nonsurgical treatment of deformational plagiocephaly: a systematic review Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27. What is the role of helmet therapy in positional plagiocephaly? BestBETS 2008.	Most childrens head shapes will improve naturally in their own time.
14. Plastic & Cosmetic Surgery				
14.1	Reduction Mammoplasty -	Not routinely commissioned.	An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010).	

<p>UPDA TED</p>	<p>Female Breast Reduction</p>	<p>Unilateral breast reduction for asymmetric breasts is not routinely commissioned.</p> <p>The NHS will only provide breast reduction for women if all the following criteria are met:</p> <p>The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.</p> <p>In cases of thoracic/girdle discomfort, a physiotherapy assessment has been provided</p> <p>Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).</p> <p>Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.</p> <p>Body mass index (BMI) is <27 and stable for at least twelve months.</p> <p>Women must be provided with written information to allow her to balance the risks and benefits of breast surgery.</p> <p>Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.</p> <p>Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.</p> <p>Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as</p>	<p>Pages 13 & 14</p> <p>Royal College of Surgeons – https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/breastreduction--commissioning-guide.pdf .</p> <p>Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammoplasty. <i>British Journal of Plastic Surgery</i>, 56(3), 230–236. 21 OFFICIAL</p> <p>Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. <i>Chiropractic & Osteopathy</i>, 16(1), 1-7.</p> <p>Singh KA, Losken A. Additional benefits of reduction mammoplasty: a systematic review of the literature. <i>Plast Reconstr Surg</i>. 2012 Mar;129(3):562-70. PubMed: PM22090252</p> <p>Strong B, Hall-Findlay EJ. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammoplasty Patients? <i>Ann Plast Surg</i>. 2014 Apr 10. PubMed: PM24727444</p> <p>Valtonen JP, Setälä LP, Mustonen PK, Blom M. Can the efficacy of reduction mammoplasty be predicted? The applicability and predictive value of breast-related symptoms questionnaire in measuring breast-related symptoms pre- and postoperatively. <i>J Plast Reconstr Aesthet Surg</i>. 2014 May;67(5):676-81. PubMed: PM24508223</p> <p>Foreman KB, Dibble LE, Droge J, Carson R, Rockwell WB. The impact of breast reduction surgery on low-back compressive forces and function in individuals with macromastia. <i>Plast Reconstr Surg</i>. 2009 Nov;124(5):1393-9. PubMed: PM20009823</p> <p>Shah R, Al-Ajam Y, Stott D, Kang N. Obesity in mammoplasty: a study of complications following breast reduction. <i>J Plast Reconstr Aesthet Surg</i>. 2011 Apr;64(4):508-14. doi: 10.1016/j.bjps.2010.07.001. Epub 2010 Aug 3. PubMed PMID: 20682461.</p> <p>Oo M, Wang Z, Sakakibara T, Kasai Y. Relationship Between Brassiere Cup Size and Shoulder-Neck Pain in Women. <i>The</i></p>	
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		<p>per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months.</p> <p>Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.</p> <p>This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.</p> <p>Gynaecomastia: Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.</p>	<p>Open Orthopaedics Journal. 2012;6:140-142. doi:10.2174/1874325001206010140.</p> <p>https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/ 13.</p> <p>Plast Reconstr Surg. 2011 Nov;128(5):395e-402e. doi:10.1097/PRS.0b013e3182284c05. The impact of obesity on breast surgery complications. Chen CL(1), Shore AD, Johns R, Clark JM, Manahan M, Makary MA</p>	
14.2	Augmentation Mammoplasty - Breast Enlargement	<p>This procedure is not routinely commissioned. The following exceptions apply:</p> <p>In all cases:</p> <ul style="list-style-type: none"> • The BMI is <25 and stable for at least twelve months. <p>AND</p> <ul style="list-style-type: none"> • Congenital absence i.e. no obvious breast tissue. <p>In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.</p> <p>Patients requiring reconstructive surgery post</p>	<p>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</p> <p>Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46.</p> <p>Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45.</p> <p>Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64.</p> <p>North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy</p>	<p>Patients should be made aware that:</p> <p>1 in 5 implants need replacing within 10 years regardless of make.</p> <p>Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span,</p>

		<p>cancer treatment are excluded from this policy.</p> <p>All non-surgical options must have been explored e.g. padded bra.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p>	<p>– specialist plastic surgery procedures”, 5-7.</p> <p>Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, <i>Plast Reconstruct Surg</i>, April, 115(4), 1039-1050.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	<p>the need for possible removal of the implant at a future date and that future policy may differ from current policy.</p> <p>Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.</p> <p>Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.</p>
14.3	Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	<p>Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention.</p> <p>If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the <u>clinical</u> need for replacement and whether the patient meets the policy for augmentation at the time of revision.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment</p>	<p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG</p>	<p>1 in 5 implants need replacing within 10 years regardless of make.</p> <p>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</p>

		funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	commissioning responsibilities.	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.
14.4	Mastopexy - Breast Lift	<p>Not routinely commissioned.</p> <p>May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.5	Surgical Correction of Nipple Inversion	<p>This is not routinely commissioned.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	<p>Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule.</p> <p>This condition responds well to</p>

				non-invasive suction device e.g. Nipplette device, for up to three months.
14.6	Male Breast Reduction Surgery for Gynaecomastia	<p>Not routinely commissioned.</p> <p>The following exception will apply:</p> <ul style="list-style-type: none"> • gynaecomastia caused by cancer treatment <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Dickson, G. (2012). Gynecomastia. <i>American Family Physician</i>, 85(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	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	<p>Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence.</p> <p>In other circumstances not routinely commissioned. Will be considered via Individual Funding Request if all of the following clinical circumstances are met;</p> <ul style="list-style-type: none"> • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. <p>1. Ferryman Gallwey (<i>A method of evaluating and quantifying hirsutism in women</i>) Score 3 or more per area to be</p>	<p>Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. <i>Human Reproduction Update</i>, 03-04 2012, vol./is. 18/2(146-70).</p> <p>cks.nice.org.uk/hirsutism#!scenario - NICE: Clinical Knowledge Summaries 2010.</p> <p>Laser and photoepilation for unwanted hair growth – Cochrane Library 2009.</p> <p>Management of hirsutism – Koulouri et al <i>BMJ</i> 2009; 338:b847.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.

		<p>treated.</p> <ol style="list-style-type: none"> 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. <p>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).</p> <p>Photographs will also be required to allow the CCG's to visibly assess the severity equitably.</p> <p>Funded for 6 treatments only at an NHS commissioned premises.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.8	Surgical Treatment for Pigeon Chest	This procedure is <u>not</u> routinely commissioned by the NHS on cosmetic grounds.	nice.org.uk/guidance/IPG310 NICE (2009).	
14.9	Surgical Revision of Scars	<p>Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.10	Laser Tattoo Removal	<p>Only commissioned in any of the following circumstances:</p> <ul style="list-style-type: none"> • Tattoo is result of trauma inflicted against the 	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	

		<p>patient's will.</p> <ul style="list-style-type: none"> • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). <p>An individual funding request will be required.</p>	<p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Modernisation Agency's Action on Plastic Surgery 2005.</p>	
14.11	Apronectomy or Abdominoplasty (Tummy Tuck)	<p>Not routinely commissioned other than if all of the following criteria are met: Patient is aged 18 years or above</p> <p>The flap hangs at or below the level of the symphysis pubis.</p> <p>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.</p> <p>Bariatric surgery (if performed) was performed at least 3 years previously.</p> <p>AND any of the following:</p> <p>Causes significant problems with activities of daily life (e.g. ambulatory restrictions).</p> <p>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.</p>	<p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>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).</p>	<p>Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced.</p> <p>Poor level of evidence of positive outcomes.</p>

		<p>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).</p> <p>IFR information must contain the following information:-</p> <ul style="list-style-type: none"> • 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. 		
14.12	Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	<p>Not routinely commissioned.</p> <p>If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered.</p> <p>Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).</p> <p>Bariatric surgery (if performed) was performed at least 3 years previously.</p> <p>AND any of the following:</p> <p>Causes significant problems with activities of daily life (e.g. ambulatory restrictions).</p> <p>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</p>	<p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring</p> <p>Royal College of Surgeons (2013).</p>	<p>The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is less likely to be indicated except for appearance. Therefore it will not be available on the NHS.</p>


		<p>addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.</p> <p>IFR information must contain the following information;</p> <ul style="list-style-type: none"> • 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. <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.13	Treatments to Correct Hair Loss for Alopecia	<p>Only commissioned in either of the following circumstances:</p> <ul style="list-style-type: none"> • Result of previous surgery. • Result of trauma, including burns. <p>Hair Intralace System is not commissioned.</p> <p>Dermatography is not commissioned.</p> <p>NHS wigs will be available according to NHS policy.</p>	<p>British Association of Dermatologists' guidelines for the management of alopecia areata 2012</p> <p>Interventions for alopecia areata – Cochrane Library 2008.</p> <p>http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf</p> <p>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.</p> <p>No evidence of effective treatments for alopecia – Cochrane</p>	

		<p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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</p>	<p>Pearls 2008.</p> <p>Alopecia areata – NICE Clinical Knowledge Summaries 2008.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding).</p> <p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.14	Hair Transplantation	<p>Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma.</p> <p>Dermatography may be an acceptable alternative in eyebrow reconstruction.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>A trial on subcutaneous pedicle island flap for eyebrow reconstruction – Mahmood & Mehri. <i>Burns</i>, 2010, Vol. 36(5), p692-697.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 further evidence provided within this document by Islington PCT to support funding.</p> <p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	
14.15	Treatments to Correct	This is not routinely commissioned.	Modernisation Agency’s Action on Plastic Surgery 2005.	

14.16	Male Pattern Baldness Labiaplasty, Vaginoplasty and Hymenorrhaphy	This is not routinely commissioned.	<p>Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. <i>BJOG</i> 2007; 114:1493-1499.</p> <p>Department for Education and Skills. (2004). Local Authority Social Services Letter. LASSAL (2004)4, London, DfES.</p> <p>Goodman, M. P. (2009). Female Cosmetic Genital Surgery. <i>Obstetrics and Gynaecology</i>; 113: 154-159.</p> <p>Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature. <i>BJOG: An International Journal of Obstetrics & Gynaecology</i>; Volume 117: 20-25. Labiaplasty for labia minora hypertrophy - Centre for Reviews and Dissemination 2013.</p> <p>Clinical characteristics of well women seeking labial reduction surgery: a prospective study. <i>BJOG</i>; 2011 Nov;118(12):1507-10.</p> <p>rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6).</p> <p>http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf</p>	
14.17	Liposuction	<p>Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap.</p> <p>Not commissioned simply to correct fat distribution.</p> <p>May be commissioned as part of the management of true lipodystrophies or non-excisable clinically significant lipomata. An individual funding request will be required.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment</p>	<p>Liposuction for chronic lymphoedema NICE 2008.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG</p>	

		funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	commissioning responsibilities.	
14.18	Rhytidectomy - Face or Brow Lift	<p>This procedure is not available under the NHS on cosmetic grounds.</p> <p>Routinely commissioned in the following circumstances:</p> <p>Congenital facial abnormalities causing significant functional impairment or impairment of normal emotional development i.e. symptoms preventing patient fulfilling routine work/ educational responsibilities or domestic/carer responsibilities.</p> <p>Facial palsy.</p> <p>Treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis.</p> <ul style="list-style-type: none"> To correct consequences of trauma. To correct deformity following surgery. <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>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.</p>	<p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).</p> <p>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>	Changes to the face and brow result due to normal ageing; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.
14.19	All procedures undertaken on cosmetic grounds	<p>Not routinely commissioned. The following exclusions will apply:</p> <ul style="list-style-type: none"> Procedure related to cancer treatment Burns/accident victim Severe birth defects 	http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/is-cosmetic-surgery-available-on-the-NHS.aspx	
15. Respiratory				
15.1	Treatments for Snoring	Not routinely Commissioned.	Franklin KA, Anttila H, Axelsson S, Gislason T, Maasilta P, Myhre KI, Rehnqvist N. Effects and side-effects of surgery for snoring and obstructive sleep apnoea systematic review. Sleep. 2009 Jan. 32(1):27-36	There are a number of alternatives to surgery that can improve the
UPDA TED	Soft Palate Implants and Radiofrequency Ablation of the Soft			

	<p>Palate</p> <p>Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty'</p> <p>Uvulopalatoplasty and Uvulopalatopharyngoplasty</p>		<p>Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs. Health Technol Assess 2009;13(3). https://www.ncbi.nlm.nih.gov/pubmed/19091167</p> <p>Jones TM, Earis JE, Calverley PM, De S, Swift AC. Snoring surgery: A retrospective review. Laryngoscope. 2005 Nov 115(11): 2015-20. https://www.ncbi.nlm.nih.gov/pubmed/16319615</p>	<p>symptom of snoring. These include: Weight loss, stopping smoking, reducing alcohol intake, medical treatment of nasal congestion (rhinitis), mouth splints (to move jaw forward when sleeping).</p> <p>In two systematic reviews of 72 primary research studies there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery; this is not longstanding (> 2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and</p>
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				<p>surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned.</p>
15.2	Investigations and treatment for Sleep Apnoea	<p>Only commissioned if any of the following;</p> <ul style="list-style-type: none"> • suspected sleep apnoea if below threshold met: <ul style="list-style-type: none"> ▪ 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 <p>AND</p>	<p>http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/service-restriction-policy/1562-1-0-service-restriction-policy-july-2015-v2</p>	<p>Please do not refer patients for snoring.</p> <p> Epworth Score.pdf</p>

		<ul style="list-style-type: none"> ▪ weight management advice/referral has been given if BMI above 30 		
15.3	Sleep studies/ Hypersomnia	<p>Sleep studies are only commissioned if any of the following;</p> <ul style="list-style-type: none"> • suspected sleep apnoea (see above) • complex sleep disorder • suspected narcolepsy <p>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</p>		
16. Trauma & Orthopaedics				
16.1 UPDA TED	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.	<p>Diagnostic imaging should not be routinely offered unless:</p> <ul style="list-style-type: none"> • in a specialist setting where the results are likely to change clinical management <p>OR</p> <ul style="list-style-type: none"> • Diagnostic imaging is required prior to referral for surgical intervention <p>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</p>	https://www.nice.org.uk/guidance/NG59	Amendments made based on version developed by Lancashire & Midlands CSU in collaboration with the Walton Centre

	<p>Pharmacological Intervention for lower back pain</p>	<p>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.</p> <p>Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.</p> <p>For people with non-specific low back pain the following injections should not be offered:</p> <p>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</p> <p>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.</p> <p>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.</p> <p>Alternative options are suggested in line with the National Back Pain Pathway.</p>		
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	<p>Pharmacological intervention for sciatica (neuropathic pain in adults)</p>	<p>Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) at lowest effective dose for shortest possible time. If NSAIDs are contraindicated/ not tolerated or ineffective, consider weak opioids.</p> <p>Do not offer:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia). If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. • Consider tramadol only if acute rescue therapy is needed (see NICE Guidance CG173 for long term use). • Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. <p>Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:</p> <ul style="list-style-type: none"> • cannabis sativa extract • capsaicin patch 		
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		<ul style="list-style-type: none"> • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use) • venlafaxine 		
16.2	Radiofrequency Facet Joint Denervation	<p>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).</p> <p>The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when:</p> <ul style="list-style-type: none"> • comprehensive conservative treatment approach has not worked for them AND • the main source of pain is thought to come from structures supplied by the medial branch nerve AND • The clinical presentation is consistent with symptoms arising from the facet joint: <ul style="list-style-type: none"> ○ Increased pain unilaterally or bilaterally on lumbar paraspinal palpation ○ Increased back pain on 1 or more of the following: <ul style="list-style-type: none"> ○ extension (more than flexion); rotation; extension/side flexion; extension/rotation ○ No radicular symptoms ○ No sacroiliac joint pain elicited using a provocation test 	https://www.nice.org.uk/guidance/NG59	

	<p>Intra Discal Electro Thermal Annuloplasty (IDET Percutaneous intradiscal radiofrequency thermocoagulation PIRFT) TAMARS (technology assisted micromobilisation and reflex stimulation)</p>	<p>AND</p> <ul style="list-style-type: none"> 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 <p>AND</p> <ul style="list-style-type: none"> low back pain is chronic in nature <p>AND</p> <ul style="list-style-type: none"> The patient has significant short term pain relief to a diagnostic medial branch block. <p>Do not offer imaging for people with low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation.</p> <p>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</p> <p>Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) and Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) are not routinely commissioned.</p>	<p>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</p>	
16.3	Fusion	<p>This procedure is NOT routinely commissioned however there are clinical exceptions to this. Please see appendix 4.</p>	<p>https://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-pain-commissioning-guide</p>	 Appendix 4 - PLCP.docx
16.4	Epidural Injection	<p>Do not use epidural for neurogenic claudication in people who have central spinal canal stenosis</p> <p>Consider a single epidural injection or single trans foraminal nerve root injection of</p>	<p>http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf</p>	 Appendix 4 - PLCP.docx

		local anaesthetic and steroid as appropriate in people with acute and severe sciatica 'Non Specific Back Pain – Not routinely commissioned'.		
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 procedure is NOT routinely commissioned.	IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011.	
16.7	Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned.	IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.	
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.	
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 procedure is NOT routinely commissioned.	IPG 333: Therapeutic endoscopic division of epidural adhesions NICE 2010	
16.15	Automated Percutaneous Mechanical Lumbar	This procedure is NOT routinely commissioned.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	

	Discectomy			
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: Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI 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 UPD ATED	Surgery for Trigger Finger	Cases interfering with activities or causing pain should first be treated with: a. one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics; or b. splinting of the affected finger for 3-12 weeks (weak evidence). Surgery should be considered if: a. the triggering persists or recurs after one of the above measures (particularly steroid injections); or	https://www.nhs.uk/conditions/trigger-finger/treatment/ Amirfeyz R, McNinch R, Watts A, Rodrigues J, Davis TRC, Glassey N, Bullock J. Evidence-based management of adult trigger digits. J Hand Surg Eur Vol. 2017 Jun;42(5):473-480. doi: 10.1177/1753193416682917. Epub 2016 Dec 21. British Society for Surgery of the Hand Evidence for Surgical Treatment (BEST). http://www.bssh.ac.uk/_userfiles/pages/files/professionals/BEST%20Guidelines/BEST%20trigger%20finger%20PUBLISHED(1).pdf 4. Chang CJ, Chang SP, Kao LT, Tai TW, Jou IM. A meta-analysis of corticosteroid injection for trigger digits among patients with diabetes. Orthopedics. 2018, 41: e8-e14.	Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously

		<p>b. the finger is permanently locked in the palm; or</p> <p>c. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods; or</p> <p>d. diabetics.</p>	<p>Everding NG, Bishop GB, Belyea CM, Soong MC. Risk factors for complications of open trigger finger release. Hand (N Y). 2015, 10: 297-300.</p> <p>Fiorini HJ, Tamaoki MJ, Lenza M, Gomes Dos Santos JB, Faloppa F, Belloti JC. Surgery for trigger finger. Cochrane Database Syst Rev. 2018 Feb 20;2:CD009860. doi: 10.1002/14651858.CD009860.pub2. Review.</p> <p>Hansen RL, Sondergaard M, Lange J. Open Surgery Versus UltrasoundGuided Corticosteroid Injection for Trigger Finger: A Randomized Controlled Trial With 1-Year Follow-up. J Hand Surg Am. 2017;42(5):359-66.</p> <p>Lunsford D, Valdes K, Hengy S. Conservative management of trigger finger: A systematic review. J Hand Ther. 2017.</p> <p>Peters-Veluthamaningal C, Winters JC, Groenier KH, Jong BM. Corticosteroid injections effective for trigger finger in adults in general practice: a double-blinded randomised placebo controlled trial. Ann Rheum Dis. 2008 Sep;67(9):1262-6. Epub 2008 Jan 7 A4633.</p>	
16.19	Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection.	http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3a%2f%2fsearch.nice.org.uk%2fusingguidance%2fdonotdorecommendations%2fdetail.jsp%3faction%3ddetails%26ndid%3d961	
16.20	Secondary Care Administered Steroid Joint Injections	Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre.	Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012.	
16.21	<p>UPDA TED</p> <p>Dupuytren's Disease Palmar Fasciectomy/Needle Faciotomy</p> <p>Radiotherapy Collagenase Injections for Dupuytren's Disease</p> <p>Dupuytren's Disease</p>	<p>Not routinely commissioned.</p> <p>Not routinely commissioned.</p> <p>Not routinely commissioned. Only</p>	<p>IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004.</p> <p>Dupuytren's disease NICE Clinical Knowledge Summaries (2010).</p> <p>British society hand surgeons New guidelines awaited.</p> <p>NHS North West London commissioning policy – Dupuytren's</p>	

		appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon		
16.22	Hip and Knee Replacement Surgery & Hip Resurfacing	<p>Referral is based on local referral pathways.</p> <p>Funding for <u>total or partial knee replacement surgery</u> is available if the following criteria are met</p> <p>1. Patients with BMI <40. AND</p> <p>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</p> <p>3. Has radiological features of severe disease. OR</p> <p>4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.</p> <p>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;</p> <p>1. Patient complains of severe joint pain. AND</p> <p>2. Functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. OR</p>	<p>NHS North West London commissioning policy – Hip Replacement (Total) April 2013.</p> <p>NHS North West London commissioning policy – Knee Replacement (Total) April 2013.</p> <p>Clinical thresholds knee replacement York & Humber Health Intelligence (2011).</p> <p>Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013).</p> <p>http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Relevant NICE Guidance (TA44) as referred to above http://www.nice.org.uk/guidance/ta304</p>	A hip and knee score threshold can form part of a demand management approach.

		<p>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.</p> <p>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).</p>		
16.23	Diagnostic Arthroscopy for Arthritis of the Knee	<p>Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate.</p> <p>However it is not routinely commissioned for any of the following indications:</p> <ul style="list-style-type: none"> • Investigation of knee pain. • Treatment of Osteo-Arthritis including Arthroscopic washout. • If there is diagnostic uncertainty despite a competent examination or if there are "red flag" symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. <p>If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.</p>	<p>CG59 Osteoarthritis. Section 3.1 NICE 2008</p> <p>Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007.</p> <p>Knee replacement: A guide to good practice British Orthopaedic Association, 2000.</p> <p>Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013).</p> <p>http://guidance.nice.org.uk/CG177 CG177Osteoarthritis (NICE 2014)</p>	
16.24 UPDA TED	Diagnostic Arthroscopy for Arthritis of the Knee	<p>Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate.</p> <p>However it is not routinely commissioned for any of the following indications:</p>	<p>CG59 Osteoarthritis. Section 3.1 NICE 2008</p> <p>Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007.</p> <p>Knee replacement: A guide to good practice British Orthopaedic</p>	

		<ul style="list-style-type: none"> Investigation of knee pain. Treatment of Osteo-Arthritis including Arthroscopic washout.(New Guidance C Page 15) If there is diagnostic uncertainty despite a competent examination or if there are "red flag" symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. <p>If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.</p>	<p>Association, 2000.</p> <p>Commissioning Guide: <u>Painful osteoarthritis of the knee</u> Royal College of Surgeons (2013).</p>	
16.25 UPDA TED	Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee	<p>Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.</p> <p>Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.</p> <p>More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups.</p> <p>Where symptoms do not resolve after nonoperative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.</p>	<p>NICE guidance: https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf492463117</p> <p>NICE guidance: https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance</p> <p>NICE guidance: https://www.nice.org.uk/donotdo/referral-forarthroscopic-lavage-and-debridement-should-not-be-offered-as-partof-treatment-for-osteoarthritis-unless-the-person-has-kneeosteoarthritis-with-a-clear-history-of-mechanical-locking-not</p> <p>British Orthopaedic Association and the Royal College of Surgeons: https://www.rcseng.ac.uk/-/media/files/rcs/standards-andresearch/commissioning/boa--painful-oa-knee-guide-final-2017.pdf</p> <p>5. Siemieniuk Reed A C, Harris Ian A, Agoritsas Thomas, Poolman Rudolf W, Brignardello-Petersen Romina, Van de Velde Stijn et al. Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline BMJ 2017; 357 :j1982</p> <p>Brignardello-Petersen R, Guyatt GH, Buchbinder R, et al Knee arthroscopy versus conservative management in patients with degenerative knee disease: a systematic review BMJ Open 2017;7:e016114. doi: 10.1136/bmjopen-2017-016114</p>	

			<p>Moseley JB, O'Malley K, Petersen NJ et al. (2002) A controlled trial of arthroscopic surgery for osteoarthritis of the knee. The New England Journal of Medicine 347: 81–8.</p> <p>Hubbard MJS. (1996) Articular debridement versus washout for degeneration of the medial femoral condyle. Journal of Bone and Joint Surgery (British) 78-B: 217–19.</p> <p>Kalunian KC, Moreland LW, Klashman DJ et al. (2000) Visuallyguided irrigation in patients with early knee osteoarthritis: a multicentre randomized controlled trial. Osteoarthritis and Cartilage 8:412–18.</p> <p>Chang RW, Falconer J, Stulberg SD et al. (1993) A randomized, controlled trial of arthroscopic surgery versus closed-needle joint lavage for patients with osteoarthritis of the knee. Arthritis & Rheumatism 36: 289–96.</p> <p>Forster MC, Straw R. (2003) A prospective randomised trial comparing intra-articular Hyalgan injection and arthroscopic washout for knee osteoarthritis. The Knee 10: 291–3.</p> <p>Jackson RW, Dieterichs C. (2003) The results of arthroscopic lavage and debridement of osteoarthritic knees based on the severity of degeneration: a 4- to 6-year symptomatic follow-up. Arthroscopy: The Journal of Arthroscopic and Related Surgery 19: 13–20.</p> <p>13. Bernard J, Lemon M, Patterson MH. (2004) Arthroscopic washout of the knee – a 5-year survival analysis. The Knee 11: 233–5.</p>	
16.26	Patient Specific Total Knee Replacement	This is not commissioned.	<p>EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates ECRI Institute (2012) IPG 345: Mini-incision surgery for total knee replacement NICE 2010</p>	

<p>16.27 UPDA TED</p>	<p>Surgical Treatment for Carpal Tunnel Syndrome</p>	<p>Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.</p> <p>Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:</p> <ul style="list-style-type: none"> a. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness) or b. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections) <p>Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:</p> <ul style="list-style-type: none"> a. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks; or b. There is either: i. a permanent (ever-present) reduction in sensation in the median nerve distribution; or ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand). <p>Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.</p>	<p>References</p> <p>Atroshi I, Flondell M, Hofer M, Ranstam J. Methylprednisolone injections for the carpal tunnel syndrome: a randomized, placebo-controlled trial. <i>Annals of internal medicine</i>. 2013;159(5):309-17.</p> <p>Chesterton LS, Blagojevic-Bucknall M, Burton C et al. The clinical and costeffectiveness of corticosteroid injection versus night splints for carpal tunnel syndrome (instincts trial): An open-label, parallel group, randomised controlled trial. <i>Lancet</i>. 2018, 392: 1423-33.</p> <p>Gerritsen AA, de Vet HC, Scholten RJ, Bertelsmann FW, de Krom MC, Bouter LM. Splinting vs surgery in the treatment of carpal tunnel syndrome: A randomized controlled trial. <i>JAMA</i>. 2002, 288: 1245-51.</p> <p>Korthals-de Bos IB, Gerritsen AA, van Tulder MW et al. Surgery is more cost-effective than splinting for carpal tunnel syndrome in the Netherlands: Results of an economic evaluation alongside a randomized controlled trial. <i>BMC Musculoskelet Disord</i>. 2006, 7: 86.</p> <p>Louie D , Earp B & Philip Blazar P Long-term outcomes of carpal tunnel release: a critical review of the literature <i>HAND</i> (2012) 7:242–246</p> <p>Marshall S, Tardif G, Ashworth N. Local corticosteroid injection for carpal tunnel syndrome. <i>Cochrane Database Syst Rev</i>. 2007(2):CD001554.</p> <p>Page MJ, Massy-Westropp N, O'Connor D, Pitt V. Splinting for carpal tunnel syndrome. <i>Cochrane Database Syst Rev</i>. 2012(7):CD010003.</p> <p>Shi Q, MacDermid JC. Is surgical intervention more effective than nonsurgical treatment for carpal tunnel syndrome? A systematic review. <i>J Orthop Surg Res</i>. 2011;6:17. 38 OFFICIAL</p> <p>Stark H, Amirfeyz R. Cochrane corner: local corticosteroid injection for carpal tunnel syndrome. <i>J Hand Surg Eur Vol</i>. 2013;38(8):911-4.</p>	<p>Mild cases often resolve spontaneously after 6 months.</p>
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			<p>Royal College of Surgeons: https://publishing.rcseng.ac.uk/doi/10.1308/rcsbull.2017.28</p> <p>Verdugo RJ, Salinas RA, Castillo JL, Cea JG. Surgical versus non-surgical treatment for carpal tunnel syndrome. Cochrane Database Syst Rev. 2008(4):CD001552.</p>	
16.28	Nerve Conduction Studies for Carpal Tunnel Syndrome	Nerve conduction studies (EMG) are NOT generally commissioned to confirm the diagnosis if patient is exhibiting classic symptoms e.g. pins and needles and numbness in the median nerve distribution and a median nerve compression test positive within 30 seconds.		
16.29	Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)	<p>Only commissioned for mucoid cysts under the following circumstance:</p> <p>Failure of conservative treatments including watchful waiting.</p> <p>AND any of the following:</p> <ul style="list-style-type: none"> • Nail growth disturbed. • Discharging, ulcerated or infected. • Size interferes with normal hand function. 	<p>Digital Mucous Cyst Overview of condition – Medscape.</p>	
16.30 UPDA TED	Surgical Removal of Ganglions	<p>Wrist ganglia:</p> <p>No treatment unless causing pain or tingling/numbness or concern (worried it is a cancer); Aspiration if causing pain, tingling/numbness or concern Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.</p> <p>Seed ganglia that are painful:</p>	<p>Head L, Gencarelli JR, Allen M, Boyd KU. Wrist ganglion treatment: Systematic review and meta-analysis. J Hand Surg Am. 2015, 40: 546-53 e8.</p> <p>Naam NH, Carr SB, Massoud AH. Intra-neural Ganglions of the Hand and Wrist. J Hand Surg Am. 2015 Aug;40(8):1625-30. doi: 10.1016/j.jhsa.2015.05.025. PubMed PMID: 26213199.</p> <p>http://www.bssh.ac.uk/_userfiles/pages/files/Patients/Conditions/Elective/ganglion_cyst_leaflet-2016.pdf</p>	16.32

		<p>Puncture/aspirate the ganglion using a hypodermic needle Surgical excision only considered if ganglion persists or recurs after puncture/aspiration.</p> <p>Mucous cysts:</p> <p>No surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity</p> <p>Note: The same treatment criteria will be applied for ganglia on other parts of the body.</p>		
16.31	Hip Arthroscopy for Femoro–Acetabular Impingement	<p>CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria:</p> <p>A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.</p> <p>An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.</p> <p>The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.</p> <p>The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.</p>	<p>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 NHS Hull Clinical Commissioning Group 2012.</p> <p>Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68.</p> <p>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).</p> <p>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.</p> <p>Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013).</p> <p>IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011</p>	<p>Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term.</p> <p>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.</p>
16.32	Surgical Removal of	Requests for the removal of bunions will only be	Bunions	

	<p>Bunions/Surgery for Lesser Toe Deformity</p>	<p>considered where:</p> <p>Conservative methods of management* have failed.</p> <p>AND</p> <p>The patient suffers significant functional impairment** as a result of the bunions.</p> <p>AND</p> <p>Radiographic evidence of joint damage (at point of referral).</p> <p>AND</p> <p>Severe deformity</p> <p>*Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate.</p> <p>**Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living.</p> <p>Treatment will not be commissioned for cosmetic appearance only.</p>	<p>NICE Clinical Knowledge Summaries (2012)</p> <p>IPG 332: Surgical correction of hallux valgus using minimal access techniques NICE (2010)</p> <p>Commissioning Guide: Painful deformed great toe in adults Royal College of Surgeons (2013)</p>	
16.33	<p>Surgical Treatment of Morton's Neuroma</p>	<p>Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway.</p> <ul style="list-style-type: none"> The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal 	<p>Therapeutic massage provides pain relief to a client with Morton's Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012.</p> <p>Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9.</p> <p>Morton's neuroma NICE Clinical Knowledge Summaries (2010).</p>	

		<p>pads.</p> <ul style="list-style-type: none"> • Been referred to an orthotist or podiatrist for an assessment. • Had a trial of local corticosteroid injection. 		
16.34	Surgical Treatment of Plantar Fasciitis	<p>Surgical Treatment is not routinely commissioned unless the following pathway has been followed:</p> <ol style="list-style-type: none"> 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. 	<p>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.</p> <p>Plantar fasciitis NICE Clinical Knowledge Summaries (2009).</p> <p>Plantar fasciitis BMJ 2012;345:e6603.</p>	
16.35	Treatment of Tendinopathies Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection	<p>These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.</p>	<p>IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis NICE 2009.</p> <p>IPG 312: Extracorporeal shockwave therapy for refractory Achilles NICE 2009.</p> <p>IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow NICE 2009.</p> <p>IPG 437: Autologous blood injection for plantar fasciitis NICE 2013.</p> <p>IPG 438: Autologous blood injection for tendinopathy NICE 2013.</p>	
16.36 NEW	Injections for Tendonitis (Jumpers Knee)	<p>Injections for Tendonitis (Jumpers Knee) are not routinely commissioned.</p>	<p>http://www.nhs.uk/Conditions/Tendonitis/Pages/Treatment.aspx</p>	
16.37	Shoulder Arthroscop	<p>Not routinely commissioned.</p>	<p>http://www.dbc.fi/new-evidence-questioning-the-effectiveness-of-</p>	

NEW	(including arthroscopic shoulder decompression for subacromial shoulder pain)	<p>Only commissioned if:</p> <ul style="list-style-type: none"> • Frozen shoulder has been persistent for at least 12 months AND the following have all been tried and failed: <ul style="list-style-type: none"> • Activity modification • Physiotherapy and exercise programme • Oral analgesia • Intra-articular joint injections • Manipulation <p>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.</p> <p>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.</p> <p>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 surgical intervention.</p>	<u>shoulder-arthroscopy-for-degenerative-shoulder-disorders/</u>	
16.38	Hip Injections	<p>Commissioned if below threshold is met:</p> <ul style="list-style-type: none"> • Diagnostic aid (single injection) • Part of hip arthogram • Inflammatory arthropathy • Bursitis <p>Commissioned for therapeutic intervention in early disease if:</p> <ul style="list-style-type: none"> • Significant pain causing functional impairment AND 		

		<ul style="list-style-type: none"> Conservative management (including pharmaceutical) not improving symptoms <p>Hip injections are not commissioned for long term management.</p>		
17. Urology				
17.1	Circumcision	<p>Indicated for the following condition;</p> <ul style="list-style-type: none"> Balanitis 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. <p>Circumcision is not commissioned for cultural or religious reasons.</p>	<p>Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2002.</p> <p>2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008).</p> <p>Balanitis NICE Clinical Knowledge Summaries 2009.</p> <p>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.</p> <p>Balanitis Patient.co.uk.</p> <p>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions Royal College of Surgeons guidance (2013).</p>	
17.2	Penile Implant: A Surgical Procedure to Implant a Device into the Penis	<p>Penile prostheses for erectile dysfunction are not routinely commissioned.</p> <p>In rare circumstances, funding will be available for men who have failed to respond to the British Society for Sexual Medicine guidelines first and second line recommended treatments and who have one of the following conditions:</p> <p>Peyronie's disease. Post – priapism. Malformation of the penis.</p>	<p>Penile implants NHS NWL policy 2012. Telford and Wrekin CCG Penile Implants 2012.</p> <p>Guidelines Male Sexual Dysfunction European Association Urology (2010).</p> <p>Guidelines on the Management of ED British Society for Sexual Medicine(2007).</p> <p>CG175: Prostate Cancer NICE 2008.</p> <p>http://guidance.nice.org.uk/CG175 NICE 2014. Please refer to Public Health Penile Implants Paper</p>	 <p>PH Penile Prosthesis Paper.pdf</p> <p>Individual CCG addendums apply.</p>

17.3	Male sterilisation under general anaesthetic	Not routinely commissioned.		
17.4	Reversal of Male Sterilisation	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.	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	
17.5	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).	
17.6	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_4_1.pdf	
17.7	Surgery for Prostatism	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: <ul style="list-style-type: none"> • 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.
17.8	Surgical treatment for Hydroceles – adults and children	Only commissioned if: In the case of communicating hydrocele: <ul style="list-style-type: none"> • patient is aged over 18 months of age In the case of non-communicating hydrocele, the patient is experiencing: <ul style="list-style-type: none"> • discomfort and/or disfigurement resulting in functional impairment preventing individual fulfilling work/study/carer or domestic duties (adult) or	http://patient.info/health/hydrocele-in-adults	

		<ul style="list-style-type: none"> discomfort and/or disfigurement resulting in inability to participate in normal social and educational activity (adolescent) 		
17.9	Surgical removal of benign epididymal cysts	<p>Only commissioned if ALL the following criteria are met:</p> <ul style="list-style-type: none"> it is large enough to cause change in shape and size of scrotum cyst is putting pressure on other structures in the testes cyst is causing prolonged or significant pain 	http://patient.info/health/epididymal-cyst	
18. Vascular				
18.1	<p>Surgery for Extreme Sweating</p> <p>Hyperhidrosis – all areas</p> <p>Surgical Resection Endoscopic Thoracic Sympathectomy</p>	<p>Treatment is medical.</p> <p>Treatment of hyperhidrosis with surgery is not routinely commissioned.</p> <p>Risk of compensatory hyperhidrosis elsewhere is very high.</p>	<p>Hyperhidrosis – NICE Clinical Knowledge Summaries (2013).</p> <p>Hyperhidrosis Patient.co.uk.</p>	
18.2	Chelation Therapy for Vascular Occlusions	This is not commissioned.	<p>Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006.</p> <p>Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.</p>	A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.
18.3 UPDA TED	Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery.	Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is	<p>NICE Guidance: https://www.guidelinesinpractice.co.uk/nice-referral-advice11-varicose-veins/300594.article</p> <p>NICE Guidance: https://www.nice.org.uk/guidance/cg168</p> <p>NICE Quality Standard: https://www.nice.org.uk/guidance/qs67</p> <p>Editor's Choice - Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). Wittens C, Davies AH, Bækgaard N, Broholm R,</p>	

		<p>endothermal ablation then ultrasound guided foam, then conventional surgery.</p> <p>Refer people to a vascular service if they have any of the following;-</p> <ol style="list-style-type: none"> 1. Symptomatic * primary or recurrent varicose veins. 2. Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. 3. Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence 4. A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). 5. A healed venous leg ulcer. <p>*Symptomatic: "Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching)." For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment</p> <p>Refer people with bleeding varicose veins to a vascular service immediately.</p> <p>Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.</p>	<p>Cavezzi A, Chastanet S, de Wolf 46 OFFICIAL M, Eggen C, Giannoukas A, Gohel M, Kakkos S, Lawson J, Noppeney T, Onida S, Pittaluga P, Thomis S, Toonder I, Vuylsteke M, Esvs Guidelines Committee, Kolh P, de Borst GJ, Chakfé N, Debus S, Hinchliffe R, Koncar I, Lindholt J, de Ceniga MV, Vermassen F, Verzini F, Document Reviewers, De Maeseneer MG, Blomgren L, Hartung O, Kalodiki E, Korten E, Lugli M, Naylor R, Nicolini P, Rosales A Eur J Vasc Endovasc Surg. 2015 Jun;49(6):678-737. doi: 10.1016/j.ejvs.2015.02.007. Epub 2015 Apr 25.</p> <p>The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. Gloviczki P1, Comerota AJ, Dalsing MC, Eklof BG, Gillespie DL, Gloviczki ML, Lohr JM, McLafferty RB, Meissner MH, Murad MH, Padberg FT, Pappas PJ, Passman MA, Raffetto JD, Vasquez MA, Wakefield TW; Society for Vascular Surgery; American Venous Forum. J Vasc Surg. 2011 May;53(5 Suppl):2S-48S. doi: 10.1016/j.jvs.2011.01.079.</p> <p>A Randomized Trial of Early Endovenous Ablation in Venous Ulceration. Gohel MS1, Heatley F1, Liu X1, Bradbury A1, Bulbulia R1, Cullum N1, Epstein DM1, Nyamekye I1, Poskitt KR1, Renton S1, Warwick J1, Davies AH1; EVRA Trial Investigators. N Engl J Med. 2018 May 31;378(22):2105-2114. doi: 10.1056/NEJMoa1801214. Epub 2018 Apr 24</p>	
19. Other				
19.1	Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and	The use of botulinum toxin type A is commissioned in the following indications: <ul style="list-style-type: none"> • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of 	NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171	

	<p>migrane.</p>	<p>injections.</p> <ul style="list-style-type: none"> • 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 • Refractory detrusor 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. <p>Botulinum toxin type A is not routinely commissioned in the following indications:</p> <ul style="list-style-type: none"> • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. 	<p>Diagnosis and management of hyperhidrosis British Medical Journal.</p>	
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		<ul style="list-style-type: none"> • Any other indication that is not listed above <p>The use of Botulinum Type B is not routinely commissioned.</p> <p>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.</p> <p>For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Wirral Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Wirral. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes.</p> <p>If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.</p>		
19.2 NEW	Correction of privately funded treatment	<p>Correction of privately funded treatment is not routinely commissioned unless in an emergency.</p> <p>This is only available via IFR.</p>		

9. Appendix 1 Cataract Referral Guide

Referral Criteria Exceptions - Wirral CCG

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

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

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

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

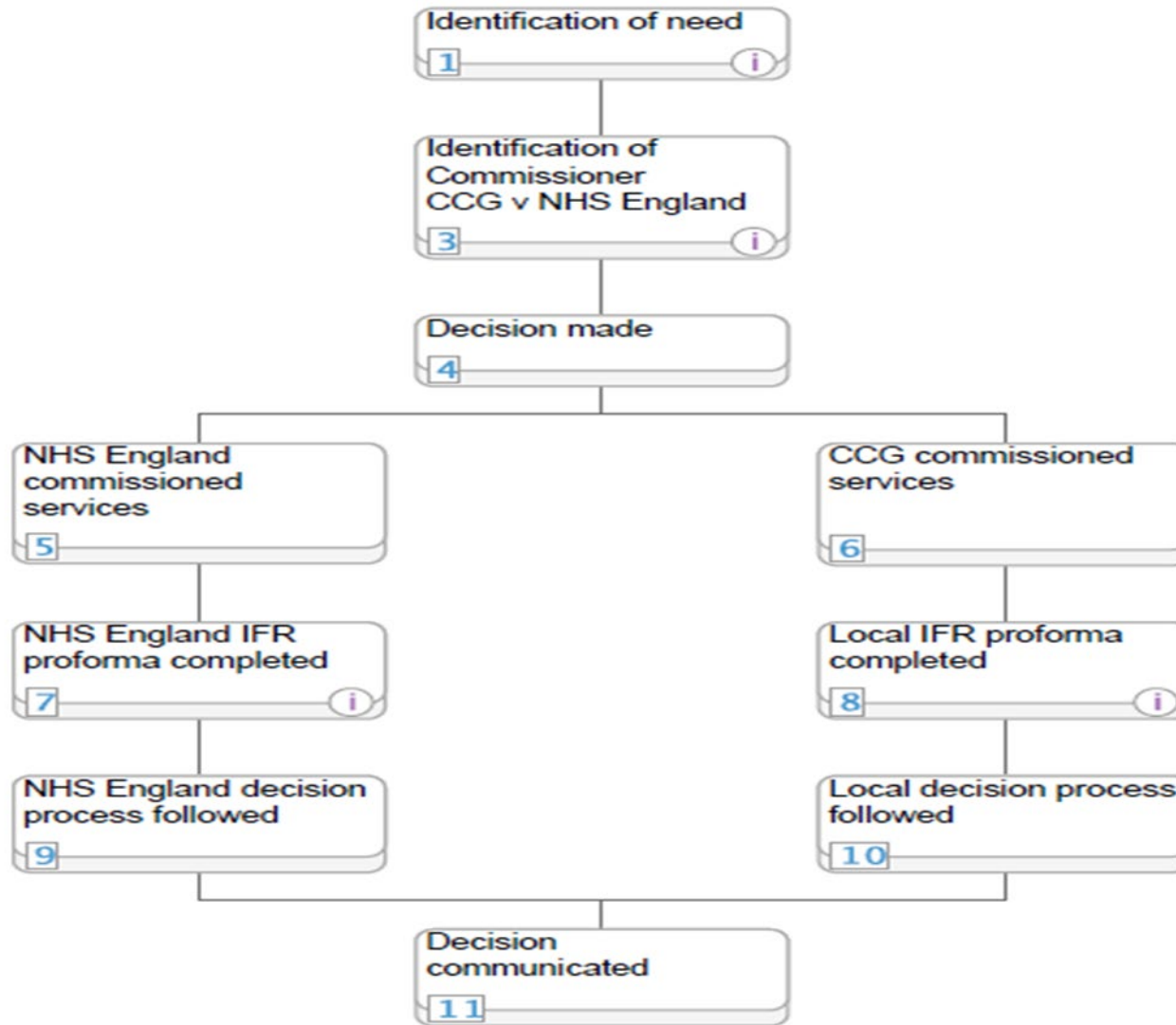
Unless one or more of the following criteria are met, a best corrected visual acuity of **better** than 6/12 in the affected eye will not normally be funded:

- Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) **OR**
- Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in daylight or bright conditions **OR**
- Patients who need to drive at night who experience significant glare due to cataracts which affects driving **OR**
- Difficulty with reading due to lens opacities **OR**
- Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field **OR**
- Significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye **OR**
- Patients with glaucoma who require cataract surgery to control 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.

10. Appendix 2 IEFR Process



11. Appendix 3 IFER Panel Contact Details

Telephone: 01244 650 305

Email:

CCG	Email Address
Wirral CCG	Wirralccg.IFR@nhs.net

12. 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