Re: Freedom of Information Request

Further to your recent Freedom of Information request regarding Oculoplastic Surgery, please see below our response to your request.

Request:

As part of a project exploring service provision within oculoplastic surgery across the nation, I would be grateful if you could send me the following details on each of the procedures listed below:

- Are they routinely funded?
- If not routinely funded, how is this service accessed (e.g. criterion based access, individual funding request, other)
- If criterion based access, what are these criteria?
- Were any ophthalmologists/optometrists consulted when creating the policy for the procedure? If so, please provide us with their name and role.

Procedures: Blepharoplasty; ptosis repair; ectropion repair; entropion repair; brow lift; chalazion incision and curettage; benign skin lesion excision/surgical management; periorcular botulinum toxin injections; adult strabismus surgery; lacrimal surgery procedures (including dacrocystorhinostomy, punctoplasty, punctal plugs); any others you believe fall under the remit of oculoplastic surgery that have not been listed.

Response:

All details required in the questions above can be found in the attached policy; this policy was developed in 2014/15 by a predecessor organisation.

The PLCP policy is being reviewed in stages and phase 1 and phase 2 will shortly be implemented. The updated policy will be published to our corporate website once completed – scheduled for April 2018.

Within this policy:
- Blepharoplasty – As per criteria 11.1 and 11.2, this procedure is routinely funded if the patient meets the specified criteria.
- **Brow lift** - As per criteria 14.8, this procedure is routinely funded if the patient meets the specified criteria.
- **Chalazion incision and curettage** - As per criteria 2.2, this procedure is routinely funded if the patient meets the specified criteria.
- **Benign skin lesion excision/surgical management** - As per criteria 2.2, this procedure is routinely funded if the patient meets the specified criteria.
- **Periocular botulinum toxin injections** - As per criteria 19.1 this procedure is routinely funded if the patient meets the specified criteria.
- **Ectropion repair** - As per criteria 11.2, this procedure is routinely funded if the patient meets the specified criteria.

A full list of ophthalmology procedures under section 11, pages 26-29.

**For the following procedures please direct your query to the Trust directly:**
- Ptosis repair
- Adult strabismus surgery
- Lacrimal surgery procedures (including dacrocystorhinostomy, punctoplasty, punctal plugs)

Should you require any further information or clarification regarding this response or do not feel that your request has been answered as you would expect, please contact us to discuss.

We also wish to take this opportunity to inform you that a formal complaints and internal review process is available, which will be managed by a FOI Appeals Officer.

This can be formally requested and must be done within a reasonable period of time (3 calendar months) from the date this response was issued.

Where you are not satisfied with the response to a request for information that falls within the Environmental Information Regulations, you should make a representation for a review to FOI Appeals Officer, sthelensccg.foi@nhs.net within 40 days of receipt of the response.

If you are not satisfied with our review under the Freedom of Information Act or the Environmental Information Regulations, you may apply directly to the Information Commissioners Office (ICO) for a review of your appeal decision. Generally, the ICO cannot make a decision unless you have exhausted our complaints procedure.

The ICO can be contacted at:

ICO, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF
[www.ico.gov.uk](http://www.ico.gov.uk)

Should you need any further clarification or assistance, please do not hesitate to contact me quoting the above reference.

Yours sincerely,

Angela Delea
Associate Director – Corporate Governance
NHS St Helens Clinical Commissioning Group
CHESHIRE & MERSEYSIDE
Commissioning Policy

CRITERIA

2014/15

Proposed Review Date: September 2015
# Table of Contents

1. Introduction ......................................................................................................................... 8
2. Core Clinical Eligibility ......................................................................................................... 8
3. Referral & Approval Process ................................................................................................. 9
4. Exceptionality ....................................................................................................................... 10
5. Psychological Distress .......................................................................................................... 10
6. Personal Data (including photographs) .................................................................................. 11
7. Medicines Management ........................................................................................................ 11
8. Evidence ............................................................................................................................... 12
   1. Complementary Therapies ................................................................................................. 13
   2. Dermatology .................................................................................................................. 13
      Skin Resurfacing Techniques ........................................................................................... 13
      Surgical or Laser Therapy Treatments for Minor Skin Lesions e.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, comedones, molluscum contagiosum chalazion .............................................................. 13
      Surgical Treatment for Removal of Lipoma in Secondary Care ....................................... 14
      Treatments for Skin Pigment Disorders .......................................................................... 14
      Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers .............................................................................................................. 14
3. Diabetes .................................................................................................................................. 15
   Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus ............................................................................................. 15
4. ENT ...................................................................................................................................... 16
   Adenoidectomy .................................................................................................................... 16
   Pinnaplasty – for Correction of Prominent Ears ................................................................... 17
   Insertion of Grommets for Glue Ear .................................................................................... 17
   Tonsillectomy for Recurrent Tonsilitis (excluding peri-tonsillar abscess) Adults and Children ...................................................................................................................... 18
   Surgical Remodelling of External Ear Lobe ....................................................................... 19
   Use of Sinus X-ray ................................................................................................................. 19
   Rhinoplasty - Surgery to Reshape the Nose ...................................................................... 19
   Surgery of Laser Treatment of Rhinophyma ..................................................................... 20
5. Equipment ............................................................................................................................ 20
6. Fertility
   Infertility Treatment for Subfertility .......................................................... 21
7. General Surgery
   Haemorrhoidectomy - Rectal Surgery .......................................................... 21
   Removal of Haemorrhoidal Skin Tags ........................................................... 21
   Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias ......... 22
   Surgical correction of Diastasis of the Recti ............................................... 22
   Surgery for Asymptomatic Gallstones ......................................................... 22
   Lithotripsy for Gallstones ............................................................................. 22
8. Gynaecology ................................................................. 22
   Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding ....... 22
   Hysterectomy ............................................................................................... 22
   D&C (dilatation and curettage) ...................................................................... 22
9. Mental Health .............................................................. 23
   Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) .............. 23
   Treatment of Gender Dysphoria .................................................................... 24
   Non-NHS Drug and Alcohol Rehabilitation ................................................. 24
   Private Mental Health (MH) Care - Non-NHS Commissioned Services ....... 24
10. Neurology ........................................................................... 25
    Bobath Therapy .......................................................................................... 25
    Trophic Electrical Stimulation for Facial/Bells Palsy ................................ 25
    Functional Electrical Stimulation (FES) ....................................................... 26
11. Ophthalmology ..................................................................... 26
    Upper Lid Blepharoplasty - Surgery on the Upper Eyelid ......................... 26
    Lower Lid Blepharoplasty - Surgery on the Lower Eyelid ........................... 27
    Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) 27
    Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia) 28
    Cataract Surgery ......................................................................................... 28
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>Oral Surgery</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Surgical Replacement of the Temporo-Mandibular Joint</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Temporo-Mandibular Joint Dysfunction Syndrome &amp; Joint Replacement</td>
<td>29</td>
</tr>
<tr>
<td>13.</td>
<td>Paediatrics</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Cranial Banding for Positional Plagiocephaly</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Reduction Mammaplasty</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Augmentation Mammaplasty - Breast Enlargement</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Mastopexy - Breast Lift</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Surgical Correction of Nipple Inversion</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Male Breast Reduction Surgery for Gynaecomastia</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Hair Removal Treatments including Depilation</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Laser Treatment or Electrolysis – for Hirsutism</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Surgical Treatment for Pigeon Chest</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Surgical Revision of Scars</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Laser Tattoo Removal</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Apronectomy or Abdominoplasty</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Treatments to Correct Hair Loss for Alopecia</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Hair Transplantitation</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Treatments to Correct Male Pattern Baldness</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Labiaplasty, Vaginoplasty and Hymenorrhaphy</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Liposuction</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Rhytidectomy - Face or Brow Lift</td>
<td>40</td>
</tr>
<tr>
<td>15.</td>
<td>Respiratory</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Treatments for Snoring</td>
<td>41</td>
</tr>
</tbody>
</table>
16. Trauma & Orthopaedics ................................................. 42
Diagnostic, Interventions and Treatments for Early Management of Back Pain ................................................. 42
Radiofrequency Facet Joint Denervation ............................................................................................................. 42
Intra Discal Electro Thermal Annuloplasty (IDET) ............................................................................................... 42
Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) TAMARS (technology assisted micromobilisation and reflex stimulation) ................................................. 42
Fusion ..................................................................................................................................................................... 43
Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation ......................................... 43
Epidural Injection .................................................................................................................................................. 43
Endoscopic Laser Foraminoplasty .......................................................................................................................... 43
Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain ................................................................. 43
Endoscopic Lumbar Decompression ..................................................................................................................... 43
Percutaneous Disc Decompression using Coblation for Lower Back Pain ............................................................. 43
Non-Rigid Stabilisation Techniques .................................................................................................................... 44
Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine ........................................ 44
Percutaneous Intradiscal Laser Ablation in the Lumbar Spine .............................................................................. 44
Transaxial Interbody Lumbosacral Fusion ................................................................................................................ 44
Therapeutic Endoscopic Division of Epidural Adhesions ....................................................................................... 44
Automated Percutaneous Mechanical Lumbar Discectomy .................................................................................... 44
Prosthetic Intervertebral Disc Replacement in the Lumbar Spine ....................................................................... 44
Bone Morphogenetic Proteins ............................................................................................................................... 44
Dibotermin Alfa .................................................................................................................................................... 44
Eptotermin Alpha .................................................................................................................................................. 44
Surgery for Trigger Finger ...................................................................................................................................... 45
Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain ................................................................... 45
Secondary Care Administered Steroid Joint Injections .......................................................................................... 45
Palmar Fasciectomy/Needle Faciotomy for Dupuytren's Disease ......................................................................... 45
Radiotherapy ......................................................................................................................................................... 46
<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.</td>
</tr>
<tr>
<td>19.</td>
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<td>48.</td>
</tr>
</tbody>
</table>
1. **Introduction**

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

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

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

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

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

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

2. **Core Clinical Eligibility**

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

- All NICE Technology Appraisals will be implemented.

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

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

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

Any patient who needs urgent treatment will always be treated.

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

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

3. Referral & Approval Process

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

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

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

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

Have received prior approval by the CCG.

OR

Clearly state how the patient meets the criteria.

OR

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

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

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

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

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

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

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

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

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

Unless specifically stated otherwise in the policy, any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient’s psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.
6. Personal Data (including photographs)
In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

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

- Clearly label the envelope to a named individual i.e. first name & surname, and job title.
- Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.
- Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

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

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

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

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

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

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

8. Evidence
At the time of publication the evidence presented was the most current available. Where reference is made to publications over five years old, this still represents the most up to date view.
<table>
<thead>
<tr>
<th>Treatment/Procedure</th>
<th>Exceptionality - Prior Approval - Criteria</th>
<th>Evidence</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>1. Complementary Therapies</strong></td>
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<tr>
<td>1.1 Complementary Therapies</td>
<td>Not routinely commissioned unless recommended by NICE guidance.</td>
<td><a href="http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy/">Complementary and alternative medicine</a></td>
<td>Individual CCG addendums apply.</td>
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<td><strong>2. Dermatology</strong></td>
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<td>2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)</td>
<td>Only be commissioned in the following circumstances:  Severe scarring following:  • Acne once the active disease is controlled.  • Chicken pox.  OR  • Trauma (including post-surgical).  Procedures will only be performed on the head and neck area.  Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14.  Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.  Modernisation Agency’s Action on Plastic Surgery 2005.  Hædersdal, M., Togsverd-Bo, K., &amp; Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. <em>Journal of the European Academy of Dermatology and Venereology</em>, 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.  <a href="http://www.evidence.nhs.uk">www.evidence.nhs.uk</a>  Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14.  NHS England interim protocol  NHS England (2013)  Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
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<td>2.2 Surgical or Laser Therapy Treatments for Minor Skin Lesions e.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, corn/callous dermatofibromas, comedones, molluscum contagiosum chalazion</td>
<td>Will be commissioned in any of the following circumstances:  • Symptomatic e.g. ongoing pain or functional impairment.  • Risk of infection.  • Significant facial disfigurement.  • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins.  Uncomplicated benign skin lesions should NOT be referred.  Send suspected malignancy on appropriate pathway.  Consider if benefit outweighs risk associated with surgery.</td>
<td><a href="http://www.evidence.nhs.uk">Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base</a> - London Health Observatory 2010.  Modernisation Agency’s Action on Plastic Surgery 2005.  Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Surgical Treatment for Removal of Lipoma in Secondary Care.</td>
<td>Will only be commissioned where severely functionally disabling and/or subject to repeated trauma due to size and/or position. Lipomas that are under 5cms should be observed only unless the above applies.</td>
<td>Noninvasive lipoma size reduction using high-intensity focused ultrasound – Dermatologic Surgery 2013 Oct;39(10):1446-51.</td>
</tr>
<tr>
<td>2.4</td>
<td>Treatments for Skin Pigment Disorders</td>
<td>NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross. Non-core procedure Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
<td><a href="http://www.changingfaces.org.uk/Skin-Camouflage">http://www.changingfaces.org.uk/Skin-Camouflage</a> Interim Gender Dysphoria Protocol &amp; Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
</tr>
<tr>
<td>2.5</td>
<td>Surgical/Laser Therapy for Viral Warts (excluding)</td>
<td>Will be commissioned in any of the following circumstances:</td>
<td>Modernisation Agency’s Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management</td>
</tr>
</tbody>
</table>
| Genital Warts (from Secondary Care Providers) | • Severe pain substantially interfering with functional abilities.  
• Persistent and spreading after 2 years and refractory to at least 3 months of primary care or community treatment.  
• Extensive warts (particularly in the immune-suppressed patient).  
• Facial warts.  
• Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist. | Prescriber 2007 18(4) p33-44.  
patient.co.uk/doctor/viral-warts-excluding-verrucae  
http://www.patient.co.uk/doctor/verrucae  
following application of topical treatments.  
65% are likely to disappear spontaneously within 2 years.  
There are numerous OTC preparations available.  
Community treatments such as cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care. |

### 3. Diabetes

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

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

- Type 1 diabetes.  
- Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151.  
- HbA1c 69 mmol/l OR experiencing severe hypoglycaemic attacks which require intervention by a carer.  
- Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value.  

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


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


Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British
AND
- Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum).
AND
- Motivated to comply with the requirements.
- The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months.
- All cases will be subject to individual approval by the IFR Team.

Society for Paediatric Endocrinology and Diabetes, 2009.
For further references please refer to Public Health Continuous Glucose Monitors Paper.

<table>
<thead>
<tr>
<th>4. ENT</th>
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<tbody>
<tr>
<td>4.1 Adenoidectomy</td>
<td>Commissioned only in either of the following clinical situations.</td>
</tr>
<tr>
<td>In Children</td>
<td>For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy.</td>
</tr>
<tr>
<td>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 5.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adenoidectomy for recurrent or chronic nasal symptoms in children The Cochrane Library 2010.</td>
</tr>
<tr>
<td></td>
<td>Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract) Centre for Reviews and Dissemination 2013.</td>
</tr>
<tr>
<td></td>
<td>NICE “Do not do” recommendation: “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.”</td>
</tr>
</tbody>
</table>
### 4.2 Pinnaplasty – for Correction of Prominent Ears

May be commissioned in the following circumstances:

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

1. Referral only for children aged 5 to 18 years at the time of referral.
   AND
2. With very significant ear deformity or asymmetry.

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

Incisionless otoplasty is not commissioned.

**References**

- **Pinnaplasty**
  - Department of Health (2007).
  - Local PCT consensus - review conducted 2007.
  - IPG 422: [Incisionless otoplasty](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty)
  - NICE 2012.
  - [http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty)
  - Royal College of Surgeons (2013).

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

**CHILDREN**

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

- There is a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year.
  OR
- There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/audiologist/ENT surgeon).
  AND
- OME persists after three months.
  AND
- The child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse.

**References**

- [http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome)
- Royal College of Surgeons (2013).
- CG60 Surgical management of children with otitis media with effusion (OME) (February 2008).

The advice in the NICE guideline covers:

- The surgical management of OME in children younger than 12 years.

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

- Children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease).
confirmed over 3 months.
OR
Persistent bilateral OME with hearing loss less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child’s developmental, social or educational status.

Children with Downs Syndrome are normally fitted with Hearing Aids.

Management of children with cleft palate is under specialist supervision.

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

**ADULTS**

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

- Significant negative middle ear pressure measured on two sequential appointments.

AND

- Significant ongoing associated pain.

OR

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

-Children with multiple complex needs.

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


| 4.4 | Tonsillectomy for Recurrent Tonsillitis (excluding peritonsillar abscess) Adults and Children | Tonsillectomy will only be commissioned where:

- Seven or more well documented clinically significant adequately treated sore throats in the preceding year;

OR

- Five or more such episodes in each of the previous two years;

OR

- Three or more such episodes in each of the preceding three years.


Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis - Cochrane Ear, Nose and Throat Disorders Group (2008).


Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009.

Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.
| 4.5 | **Surgical Remodelling of External Ear Lobe** | This is not routinely commissioned. | Modernisation Agency’s Action on Plastic Surgery 2005. | Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. |
| 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:
  - Objective nasal deformity caused by trauma.
  - Problems caused by obstruction of nasal airway.
  - Correction of complex congenital conditions e.g. cleft lip and palate.

NHS England interim protocol | 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. |
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.

NHS England (2013)
Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

| 4.8 | Surgery of Laser Treatment of Rhinophyma | Not routinely commissioned. | Nuances in the management of rhinophyma
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. |

<table>
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<tr>
<th>5.</th>
<th>Equipment</th>
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<tbody>
<tr>
<td>5.1</td>
<td>Use of Lycra Suits</td>
<td>Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.</td>
<td>What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. For further references please refer to Public Health Lycra Suits Paper.</td>
<td>Any application for exceptional funding should include a comprehensive assessment of the child’s postural management needs with clear outcome goals and time frames. Public Health Recommendation: Current evidence does not support routine commissioning of Lycra suits in the management of</td>
</tr>
</tbody>
</table>
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 Cheshire & Merseyside Infertility Policy.


Contraception – sterilization – NICE Clinical Knowledge Summaries 2012

http://cks.nice.org.uk/contraception-sterilization#1scenario

Individual CCG addendums apply.

7. General Surgery

7.1 Haemorrhoidectomy - Rectal Surgery: & Removal of Haemorrhoidal Skin Tags

Surgery commissioned for symptomatic:
- Grade III and IV haemorrhoids.
- Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:-
  o Diet modification to relieve constipation.
  o Topical applications.
  o Stool softeners and laxatives.
  o Rubber band ligation.
  o Sclerosant injections.
  o Infrared coagulation.
- Surgical treatment options include:-
  o Surgical excision (haemorrhoidectomy).
  o Stapled haemorrhoidopexy.

Haemorrhoidal artery ligation
NICE 2010.

TAG128: Stapled haemorrhoidopexy for the treatment of haemorrhoids
NICE 2007.


Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008.


Individual CCG addendums apply.

There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure.

Short term efficacy and cost effectiveness is similar.
| 7.2 | Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias | Surgery: not commissioned if no symptoms, easily reducible (i.e. can be ‘pushed back in’) and not at significant risk of complications. | A systematic review on the outcomes of correction of diastasis of the recti
Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al. | Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect. |
| 7.3 | Surgery for Asymptomatic Gallstones | This procedure is not routinely commissioned. | http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones
Royal College of Surgeons (2013). | This procedure is considered a Low clinical priority for asymptomatic gallstones. Asymptomatic gallstones are 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. |

8. **Gynaecology**

| 8.1 | Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding |
| | Hysterectomy | Hysterectomy not commissioned unless all of the following requirements have been met: |
| | | • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has |
| | | Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US. |
| | | Management of haemorrhoids
| | | Haemorrhoids
NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab
http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding
Royal College of Surgeons (2013). | CG44 Heavy menstrual bleeding: full guideline
NICE 2007. |
| | | QS47 Heavy Menstrual Bleeding
NICE 2013. | |
made an informed choice not to use this treatment.

- The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance.
  - Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives.
  - Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens.
  - Endometrial ablation has been tried (unless patient has fibroids >3cm)

| 8.2 | D&C (dilatation and curettage) | Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure. |

9. **Mental Health**

| 9.1 | Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) | Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned.

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


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

NICE section 1.915 states:

Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family,
and be based on 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 either 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
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)

| 9.4 | Private Mental Health (MH) Care - Non-NHS Commissioned Services: including Psychotherapy. | This will not normally be funded.
Most mental health conditions can be managed in the community with input from Community Mental Health teams. | Veterans’ post traumatic stress disorder programme (Adult) Service Specification
Post-traumatic stress disorder (PTSD): The management of |
<table>
<thead>
<tr>
<th>10. Neurology</th>
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<tr>
<td><strong>10.1 Bobath Therapy</strong></td>
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<tr>
<td><strong>10.2 Trophic Electrical Stimulation for</strong></td>
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### 10.3 Facial/Bells Palsy

| Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities. Exclusion Criteria:  
- Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin.  
- Chronic oedema at site of stimulation.  
- Diagnosis of deep vein thrombosis.  
- Receptive dysphasia (unable to understand instructions).  
- Complete peripheral nerve damage.  
- Pacemaker in situ.  
- Pregnancy or intention to become pregnant.  
- Active cancer.  
- Uncontrolled epilepsy.  
- Metal in region of stimulation e.g.: pin and plate.  
- Ataxic and polio patients are generally poor responders although there are exceptions. |
| --- |


**Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation**, Clinical Rehabilitation. 2010 Nov; 24(11):963-78.

**Interventions for dysphagia and nutritional support in acute and subacute stroke**. Cochrane Database of Systematic Reviews 2012, Issue 10.

**Functional electrical stimulation for drop foot of central neurological origin**. NICE, 2009.

**Functional electrical stimulation for rehabilitation following spinal cord injury**. Centre for Reviews and Dissemination, NIHR, 2011.

### 11. Ophthalmology

11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid

| Only commissioned in the following circumstances:  
- Eyelid function interferes with visual field. |
| --- |

**Eyelid Surgery**

*The British Association of Aesthetic Plastic Surgeons 2011.*

*Modernisation Agency’s Action on Plastic Surgery 2005.*

**Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base**

*London Health Observatory 2010.*

Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Commissioned Conditions</th>
<th>Reference</th>
</tr>
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</table>
| 11.2 P | Lower Lid Blepharoplasty - Surgery on the Lower Eyelid. | Only commissioned in any of the following circumstances:  
1. Correction of ectropion or entropion which threatens the health of the affected eye.  
2. Removal of lesions of eyelid skin or lid margin.  
3. Rehabilitative surgery for patients with thyroid eye disease. | Eyelid Surgery  
The British Association of Aesthetic Plastic Surgeons 2011.  
Local PCT consensus – review conducted 2007.  
Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. |
| 11.3 P | Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) | Only commissioned for:  
1. Larger lesions which satisfy all of the following:  
   1. Not responded to treatment for underlying familial lipoprotein lipase deficiency.  
   3. Causing significant disfigurement.  
   Topical treatments may be available in a primary care or community setting. | Local PCT consensus – review conducted 2007.  
DermNet NZ information resources updated Jan 2013.  
Commissioning Criteria – Plastic Surgery  
http://www.patient.co.uk/doctor/xanthelasma |
<p>| 11.4 P | Surgery or Laser Treatment for Short Sightedness | Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned. | |</p>
<table>
<thead>
<tr>
<th>11.5</th>
<th>Cataract Surgery</th>
<th>See appendix 1 for details of Referral Guidance template. Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights. An example of a referral template for use by optometrists is given in appendix 1. There is good evidence that bilateral cataract replacement is beneficial.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.6</td>
<td>Coloured (irlens) Filters for Treatment of Dyslexia</td>
<td>There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.</td>
</tr>
<tr>
<td>11.7</td>
<td>Intra Ocular Telescope for Advanced Age-Related Macular Degeneration</td>
<td>This is not routinely commissioned as there is limited published evidence of effectiveness.</td>
</tr>
<tr>
<td>11.8</td>
<td>Surgical Removal of Chalazion or Meibomian Cysts</td>
<td>Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND</td>
</tr>
</tbody>
</table>
- Causes blurring or interference with vision.
- OR
- Has required treatment with antibiotics due to infection at least twice in the preceding six months.

In Children under 10 this is commissioned as visual development may be at risk.

### 12. Oral Surgery

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

Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement

- Only commissioned in the following circumstances:
  - Any or a combination of the following symptoms are present:
    - Restricted mouth opening <35mm).
    - Dietary score of< 5/10 (liquid scores 0, full diet scores 10).
    - Occlusal collapse (anterior open bite or retrusion).
    - Excessive condylar resorption and loss of height of vertical ramus.
    - Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms).
    - Other significant quality of life issues.
  - AND
  - Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.

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

![TMJ Replacement Guidance.pdf](image)

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

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 - Female Breast Reduction

Commissioned only if all of the following circumstances are met:
- Musculo-skeletal symptoms are not due to other causes.
- There is at least a two year history of attending the GP with the problem.
- Other approaches such as analgesia and physiotherapy have been tried.
- The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache).
- The wearing of a professionally fitted brassiere has not helped.
- Patients BMI is <25 and stable for at least twelve months.
- The patient’s breast is a cup size H or larger.
- There is a proposed reduction of at least a three cup sizes.
- Aged over 18 years old.
- It is envisaged there are no future planned pregnancies.

Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist.


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

**Commissioning Criteria – Plastic Surgery**
Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service


*An investigation into the relationship between breast size, bra size and mechanical back pain*
British School of Osteopathy (2010).

Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.
| 14.2 | Augmentation Mammoplasty - Breast Enlargement | Only commissioned in the following circumstance:
In all cases:
- The BMI is $<25$ and stable for at least twelve months.
AND
- There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist.
OR
- Congenital absence i.e. no obvious breast tissue.
In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.
All non-surgical options must have been explored e.g. padded bra.


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


Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. | Patients should be made aware that:
1 in 5 implants need replacing within 10 years regardless of make.
Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.

Not all patients demonstrate improvement in psychosocial outcome measures following breast intervention.
<table>
<thead>
<tr>
<th>14.3</th>
<th>Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation</th>
</tr>
</thead>
</table>
| **Revisional surgery** will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention.

If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.


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.

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<table>
<thead>
<tr>
<th>14.4</th>
<th>Mastopexy - Breast Lift</th>
</tr>
</thead>
</table>
| **Not routinely commissioned.**

May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.


Where the provision of “non-core” surgeries is... |

---

1 in 5 implants need replacing within 10 years regardless of make.

Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.
<table>
<thead>
<tr>
<th>14.5</th>
<th>Surgical Correction of Nipple Inversion</th>
<th>This is not routinely commissioned.</th>
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<tr>
<td></td>
<td>Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14.6</th>
<th>Male Breast Reduction Surgery for Gynaecomastia</th>
<th>Not routinely commissioned except on an exceptional basis where all of the following criteria are met:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• True gynaecomastia not just adipose tissue. AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Underlying endocrine or liver abnormality excluded. AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this. AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not due to prescribed drug use. AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Has not responded to medical management for at least three months e.g. tamoxifen. AND</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NHS England interim protocol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pages 13 &amp; 14 describe non-core NHS England &amp; CCG commissioning responsibilities.</td>
<td></td>
</tr>
</tbody>
</table>

|      | Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer. |

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. This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months.
• Post pubertal.
AND
• BMI <25kg/m² and stable for at least 12 months.
AND
• Patient experiences persistent pain.
AND
• Experiences significant functional impairment.
AND
• In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution.


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

14.7 Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism

Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence.

In other circumstances only commissioned if all of the following clinical circumstances are met:
• Abnormally located hair-bearing skin following reconstructive surgery located on face and neck.
• There is an existing endocrine medical condition and severe facial hirsutism.
  1. Ferryman Gallwey (A method of evaluating and quantifying hirsutism in women) Score 3 or more per area to be treated.
  2. Medical treatments have been tried for at least one year and failed.


cks.nice.org.uk/hirsutism#scenario - NICE: Clinical Knowledge Summaries 2010.
Laser and photoepilation for unwanted hair growth – Cochrane Library 2009.


The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.
3. Patients with a BMI of >30 should be in a weight reduction programme and should have lost at least 5% body weight.

All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist).

Photographs will also be required to allow the CCG’s to visibly assess the severity equitably.

Funded for 6 treatments only at an NHS commissioned premises.


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.


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

| 14.8 | Surgical Treatment for Pigeon Chest | This procedure is not routinely commissioned by the NHS on cosmetic grounds. | nice.org.uk/guidance/IPG310 NICE (2009). |
| 14.9 | Surgical Revision of Scars | Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |
| 14.10 | Laser Tattoo Removal | Only commissioned in any of the following circumstances:  
- Tattoo is result of trauma inflicted against the patient’s will.  
- The patient was a child and not responsible for his/her actions at the time of tattooing. | Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. |

| 14.11 Apronec
tomy or Abdomino
plasty (Tummy Tuck) | Not routinely commissioned other than if all of the following criteria are met:

- The flap hangs at or below the level of the symphysis pubis.
- 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).
- Bariatric surgery (if performed) was performed at least 3 years previously.
- AND any of the following:
  - Causes significant problems with activities of daily life (e.g. ambulatory restrictions).
  - Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.
  - Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made).

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

- Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.
- Health Commission Wales, 2008 Commissioning Criteria – Plastic Surgery, Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service

| Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced.
| Poor level of evidence of positive outcomes. |
| 14.12 | Other Skin Excisions/Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty) | Not routinely commissioned.  
If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered.  
Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).  
Bariatric surgery (if performed) was performed at least 3 years previously.  
AND any of the following:  
Causes significant problems with activities of daily life (e.g. ambulatory restrictions).  
Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.  
IFR information **must** contain the following information; | Health Commission Wales. *2008 Commissioning Criteria – Plastic Surgery, Procedures of Low Clinical Priority/Procedures not usually available on the National Health Service*  
[http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring](http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring)  
Royal College of Surgeons (2013).  
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.
- 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.


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.

NHS England interim protocol

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

14.13 Treatments to Correct Hair Loss for Alopecia

<table>
<thead>
<tr>
<th>14.13 Treatments to Correct Hair Loss for Alopecia</th>
<th>Only commissioned in either of the following circumstances:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Result of previous surgery.</td>
</tr>
<tr>
<td></td>
<td>- Result of trauma, including burns.</td>
</tr>
<tr>
<td>Hair Intralace System is not commissioned.</td>
<td>Dermatography is not commissioned.</td>
</tr>
<tr>
<td>NHS wigs will be available according to NHS policy.</td>
<td>British Association of Dermatologists’ guidelines for the management of alopecia areata 2012</td>
</tr>
<tr>
<td></td>
<td>Interventions for alopecia areata – Cochrane Library 2008.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>No evidence of effective treatments for alopecia – Cochrane Pearls 2008.</td>
</tr>
<tr>
<td>14.14</td>
<td>Hair Transplantation</td>
</tr>
<tr>
<td>14.15</td>
<td>Treatments to Correct Male Pattern Baldness</td>
</tr>
<tr>
<td>14.16</td>
<td>Labiaplasty, Vaginoplasty and Hymenorrhaphy</td>
</tr>
</tbody>
</table>

| 14.18 | Rhytidectomy - Face or Brow Lift | This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: | Modernisation Agency’s Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. | Changes to the face and brow result due to normal ageing; however, there are |
Congenital facial abnormalities.  
Facial palsy.

Treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis.  
- To correct consequences of trauma.  
- To correct deformity following surgery.


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.

NHS England interim protocol 

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

15. Respiratory

15.1 Treatments for Snoring  
Soft Palate Implants and Radiofrequency Ablation of the Soft Palate  
Sodium Tetradecyl Sulfate (STS) Injection or ‘snoreplasty’  
Uvulopalatoplasty and Uvulopalatopharyngoplasty

Not Routinely Commissioned.


Clinical Guideline 73: Management of obstructive sleep apnoea/hypopnoea syndrome in Adults 
SIGN (2003).

Surgery for obstructive sleep apnoea in adults  
Cochrane Database of Systematic Reviews (2005).


Effects and side-effects of surgery for snoring and obstructive sleep apnea: A systematic review – Sleep 2009 v.32(1) 27-36.

The British Snoring & Sleep Apnoea Association

NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient’s
Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as ‘Snoreplasty’ is not well recognised in the UK as an effective method of treating snoring.

16. **Trauma & Orthopaedics**

<table>
<thead>
<tr>
<th>16.1</th>
<th>Diagnostic, Interventions and Treatments for Early Management of Back Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent non-specific low back pain of duration 6 weeks to 12 months.</td>
<td></td>
</tr>
<tr>
<td>Excluding spinal pathology, radiculopathy, and children.</td>
<td></td>
</tr>
<tr>
<td>The following treatments should not be offered for the early management of persistent non-specific low back pain.</td>
<td></td>
</tr>
<tr>
<td>Selective serotonin re-uptake inhibitors (SSRIs) for treating pain.</td>
<td></td>
</tr>
<tr>
<td>Injections of therapeutic substances into the back.</td>
<td></td>
</tr>
<tr>
<td>Laser therapy.</td>
<td></td>
</tr>
<tr>
<td>Interferential therapy.</td>
<td></td>
</tr>
<tr>
<td>Therapeutic ultrasound.</td>
<td></td>
</tr>
<tr>
<td>Transcutaneous electrical nerve stimulation (TENS).</td>
<td></td>
</tr>
<tr>
<td>Lumbar supports.</td>
<td></td>
</tr>
<tr>
<td>Traction.</td>
<td></td>
</tr>
<tr>
<td>X Rays and MRI scans should not be offered unless in a context of referral for surgery.</td>
<td></td>
</tr>
<tr>
<td>Management should consist of a structured exercise programme, manual therapy or acupuncture.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16.2</th>
<th>Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following should not be offered for the early management of persistent non-specific low back pain.</td>
<td></td>
</tr>
<tr>
<td>Radiofrequency facet joint denervation.</td>
<td></td>
</tr>
<tr>
<td>Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency</td>
<td></td>
</tr>
<tr>
<td>16.3 Fusion</td>
<td>Not routinely commissioned. There is limited data on effectiveness and no data on superiority over other treatments. Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme. AND Still has severe non-specific low back pain for which they would consider surgery.</td>
</tr>
<tr>
<td>16.4 Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation</td>
<td>Non specific back pain over 12 months – Not routinely commissioned. May have a role as a diagnostic procedure when considering radio frequency ablation. This would require an individual funding request.</td>
</tr>
<tr>
<td>16.5 Epidural Injection</td>
<td>Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc &amp; spinal stenosis where surgery is not desirable.’ ‘Non Specific Back Pain – Not routinely commissioned’.</td>
</tr>
<tr>
<td>16.6 Endoscopic Laser Foraminoplasty</td>
<td>This procedure is NOT routinely commissioned.</td>
</tr>
<tr>
<td>16.7 Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain</td>
<td>This procedure is NOT routinely commissioned.</td>
</tr>
<tr>
<td>16.8 Endoscopic Lumbar Decompression</td>
<td>This procedure is NOT routinely commissioned.</td>
</tr>
<tr>
<td>16.9 Percutaneous Disc Decompression using Coblation for Lower</td>
<td>This procedure is NOT routinely commissioned.</td>
</tr>
<tr>
<td>16.10</td>
<td>Back Pain</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>16.11</td>
<td>Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine</td>
</tr>
<tr>
<td>16.12</td>
<td>Percutaneous Intradiscal Laser Ablation in the Lumbar Spine</td>
</tr>
<tr>
<td>16.13</td>
<td>Transaxial Interbody Lumbosacral Fusion</td>
</tr>
<tr>
<td>16.14</td>
<td>Therapeutic Endoscopic Division of Epidural Adhesions</td>
</tr>
<tr>
<td>16.15</td>
<td>Automated Percutaneous Mechanical Lumbar Discectomy</td>
</tr>
<tr>
<td>16.18</td>
<td>Surgery for Trigger Finger</td>
</tr>
<tr>
<td>16.20</td>
<td>Secondary Care Administered Steroid Joint Injections</td>
</tr>
<tr>
<td>16.21</td>
<td>Palmar Fasciectomy/Needle Faciotomy for Dupuytren’s Disease</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16.22</td>
<td>Radiotherapy Collagenase Injections for Dupuytren’s Disease</td>
</tr>
<tr>
<td></td>
<td><strong>Funding for total or partial knee replacement surgery is available if the following criteria are met</strong></td>
</tr>
<tr>
<td></td>
<td>AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.</td>
</tr>
<tr>
<td></td>
<td><strong>Referral criteria for Total Hip Replacements (THR)</strong> 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;</td>
</tr>
<tr>
<td></td>
<td>1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non-surgical treatments such as adequate doses</td>
</tr>
</tbody>
</table>
of NSAID analgesia, weight control treatments and physical therapies.

OR

3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.

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

<table>
<thead>
<tr>
<th>16.24</th>
<th>Diagnostic Arthroscopy for Arthritis of the Knee</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>However it is not routinely commissioned for any of the following indications:</td>
<td></td>
</tr>
<tr>
<td>• Investigation of knee pain.</td>
<td></td>
</tr>
<tr>
<td>• Treatment of Osteo-Arthritis including Arthroscopic washout.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.</td>
<td></td>
</tr>
</tbody>
</table>

CG59 Osteoarthritis. Section 3.1 NICE 2008

Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007.


http://guidance.nice.org.uk/CG177

CG177Osteoarthritis (NICE 2014)

<table>
<thead>
<tr>
<th>16.25</th>
<th>Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies).</td>
<td></td>
</tr>
<tr>
<td>16.26</td>
<td>Patient Specific Unicompartmental Knee Replacement</td>
</tr>
<tr>
<td>16.27</td>
<td>Patient Specific Total Knee Replacement</td>
</tr>
<tr>
<td>16.28</td>
<td>Surgical Treatment for Carpal Tunnel Syndrome</td>
</tr>
<tr>
<td>16.29</td>
<td>Surgical Removal of</td>
</tr>
</tbody>
</table>
| Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) | following circumstance:  
Failure of conservative treatments including watchful waiting.  
AND any of the following:  
- Nail growth disturbed.  
- Discharging, ulcerated or infected.  
- Size interferes with normal hand function. | Overview of condition – Medscape. |  


| Surgical Removal of Bunions/Surgery for Lesser Toe Deformity | Requests for the removal of bunions will only be considered where: | |  

| Hip Arthroscopy for Femoro-Acetabular Impingement | CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria:  
A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.  
An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.  
The patient has had severe FAI symptoms (restriction of movement, pain and ‘clicking’) or significantly compromised functioning for at least 6 months.  
NHS Hull Clinical Commissioning Group 2012.  
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. |
Conservative methods of management* have
failed.
AND
The patient suffers significant functional
impairment** as a result of the bunions.
AND
Radiographic evidence of joint damage (at point
of referral).

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

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

Treatment will not be commissioned for
cosmetic appearance only.

| 16.33 | Surgical Treatment of Morton's Neuroma | Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway.
- The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads.
- Been referred to an orthotist or podiatrist for an assessment.
- Had a trial of local corticosteroid injection. | IPG 332: Surgical correction of hallux valgus using minimal access techniques
NICE (2010)
Commissioning Guide: Painful deformed great toe in adults
Royal College of Surgeons (2013)

| 16.34 | Surgical Treatment of Heel pain—plantar fasciitis | Surgical Treatment is not routinely commissioned. | 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.
Morton's neuroma
NICE Clinical Knowledge Summaries (2010). |
<table>
<thead>
<tr>
<th>Plantar Fasciitis</th>
<th>commissioned unless the following pathway has been followed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient has documented evidence that they are not responding to conservative treatments</td>
<td></td>
</tr>
<tr>
<td>2. Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following.</td>
<td></td>
</tr>
<tr>
<td>3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss.</td>
<td></td>
</tr>
<tr>
<td>4. Been referred to a podiatrist or physiotherapist.</td>
<td></td>
</tr>
<tr>
<td>5. Not responded to corticosteroid injections.</td>
<td></td>
</tr>
</tbody>
</table>

**Plantar fasciitis**

*NICE Clinical Knowledge Summaries (2009).*

*Plantar fasciitis*  
*BMJ 2012;345:e6603.*

**16.35**  
**Treatment of Tendinopathies**  
**Extracorporeal Shock Wave Therapy**  
**Autologous Blood or Platelet Injection**

These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.

**IPG 311:** [Extracorporeal shockwave therapy for refractory plantar fasciitis](https://www.nice.org.uk/guidance/ipg311)  
*NICE 2009.*

**IPG 312:** [Extracorporeal shockwave therapy for refractory Achilles](https://www.nice.org.uk/guidance/ipg312)  
*NICE 2009.*

**IPG 313:** [Extracorporeal shockwave therapy for refractory tennis elbow](https://www.nice.org.uk/guidance/ipg313)  
*NICE 2009.*

**IPG 437:** [Autologous blood injection for plantar fasciitis](https://www.nice.org.uk/guidance/ipg437)  
*NICE 2013.*

**IPG 438:** [Autologous blood injection for tendinopathy](https://www.nice.org.uk/guidance/ipg438)  
*NICE 2013.*

<table>
<thead>
<tr>
<th>17. <strong>Urology</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>17.1 <strong>Circumcision</strong></th>
<th>This not offered for social, cultural or religious reasons.</th>
</tr>
</thead>
<tbody>
<tr>
<td>However certain CCGs may have individual policies.*</td>
<td></td>
</tr>
</tbody>
</table>
| Indicated for the following condition;  
  • Balanitis xerotica obliterans.  
  • Traumatic foreskin injury/scarring where it |
| **Male Circumcision: Guidance for Healthcare Practitioners**  
Royal College of Surgeons, 2002. |
| **2008 UK National Guideline on the Management of Balanoposthitis**  
Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). |
| **Balanitis** |

*Race/cultural implications*  
Individual CCG addendums apply.
### 17.2 Penile Implant: A Surgical Procedure to Implant a Device into the Penis


### 17.3 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

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

This is not commissioned as there is limited clinical evidence of effectiveness. Guidelines on chronic pelvic pain European Association of Urology (2012).

### 17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome

This is not commissioned as there is limited evidence of effectiveness. Guidelines on chronic pelvic pain European Association of Urology (2012). https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf

### 17.6 Surgery for Prostatism

Only commissioned where there are sound clinical reasons and after failure of conservative CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men No references to treatment
treatments and in any of the following circumstances:
- International prostate symptom score >7;
- Dysuria;
- Post voided residual volume >150ml;
- Recurrent proven Urinary Tract Infections (UTI);
- Deranged renal function;
- Prostate-specific antigen (PSA) > age adjusted normal values.

18. Vascular

18.1 Surgery for Extreme Sweating
Hyperhidrosis – all areas
Surgical Resection Endoscopic Thoracic Sympathectomy

Treatment is medical.

Treatment of hyperhidrosis with surgery is not routinely commissioned.

Risk of compensatory hyperhidrosis elsewhere is very high.

Hyperhidrosis Patient.co.uk.

18.2 Chelation Therapy for Vascular Occlusions

This is not commissioned.

Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006.

Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.

A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.

18.3 Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery.

Treatment of varicose veins is not commissioned except in the following circumstances:
- Ulcers/history of ulcers secondary to superficial venous disease.
- Liposclerosis.
- Varicose eczema.
- History of phlebitis.


Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.
| 19. Other | | | |
| --- | --- | --- | |
| Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine. | • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. | Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women [http://guidance.nice.org.uk(CG171](http://guidance.nice.org.uk/CG171) and only one course of injections. | |
| | • Blepharospasm and hemifacial spasm. | **Diagnosis and management of hyperhidrosis** [British Medical Journal](http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins) | |
| | • Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). | Royal College of Surgeons (2013) | |
- 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).

- Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women)
  [http://guidance.nice.org.uk/CG171](http://guidance.nice.org.uk/CG171) and Clinical Guideline 97 (men)
  [http://guidance.nice.org.uk/CG97](http://guidance.nice.org.uk/CG97) where conservative therapy and conventional drug treatment has failed to control symptoms.

- Sialorrhoea (excessive salivary drooling), when all other treatments have failed.

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

The use of Botulinum Type B is not routinely commissioned.

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

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

If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.
9. Appendix 1 Cataract Referral Guide

Referrals for cataract should only be made in the following context:

1) **ASSESSMENT OF VISION AND QUALITY OF LIFE**

<table>
<thead>
<tr>
<th>Questions</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  How well can patient see objects in the distance?</td>
<td>without difficulty</td>
<td>with slight difficulty</td>
<td>with great difficulty</td>
</tr>
<tr>
<td>2.  How well can patient read writing on the TV and/or road signs?</td>
<td>without difficulty</td>
<td>with slight difficulty</td>
<td>with great difficulty</td>
</tr>
<tr>
<td>3.  How well can patient recognise people on the street?</td>
<td>without difficulty</td>
<td>with slight difficulty</td>
<td>with great difficulty</td>
</tr>
<tr>
<td>4.  How well can patient read from newspapers/books?</td>
<td>without difficulty</td>
<td>with slight difficulty</td>
<td>with great difficulty</td>
</tr>
<tr>
<td>5.  How often does patient suffer from glare at night?</td>
<td>without difficulty</td>
<td>with slight difficulty</td>
<td>with great difficulty</td>
</tr>
</tbody>
</table>

**Interpretation**
- If answer to question 4 is b or c, this is often an indication of macular problems rather than cataract. If this is the only problem, referral for cataract surgery is inappropriate. However, referral for an opinion on maculopathy might be required.
- If answers to questions 1 to 3 are mainly (c), this is probably cataract-related and referral may be appropriate.
- If glare is the ONLY problem (question 5), the referrer (after discussion with the patient) will need to make a judgment as to the potential impact of cataract removal before deciding whether surgery is appropriate.

2) **FITNESS FOR SURGERY**

Is the patient medically fit for surgery?

3) **RISKS AND CONSENT**

Has the potential to benefit been explained?
Have details of the procedure and risks been explained to patient?
Is patient still willing to proceed?

The referrer should be satisfied that the criteria outlined in (1) to (3) have all been met before referring
10. Appendix 2 IFR Process
11. Appendix 3 IFR Panel Contact Details

Telephone: 01244 650 305
Email:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wirral CCG</td>
<td><a href="mailto:Wirralccg.IFR@nhs.net">Wirralccg.IFR@nhs.net</a></td>
</tr>
<tr>
<td>West Cheshire CCG</td>
<td><a href="mailto:Westcheshireccg.IFR@nhs.net">Westcheshireccg.IFR@nhs.net</a></td>
</tr>
<tr>
<td>Eastern Cheshire CCG</td>
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</tr>
<tr>
<td>South Cheshire CCG</td>
<td><a href="mailto:Southcheshireccg.IFR@nhs.net">Southcheshireccg.IFR@nhs.net</a></td>
</tr>
<tr>
<td>Vale Royal CCG</td>
<td><a href="mailto:Valeroyalccg.IFR@nhs.net">Valeroyalccg.IFR@nhs.net</a></td>
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