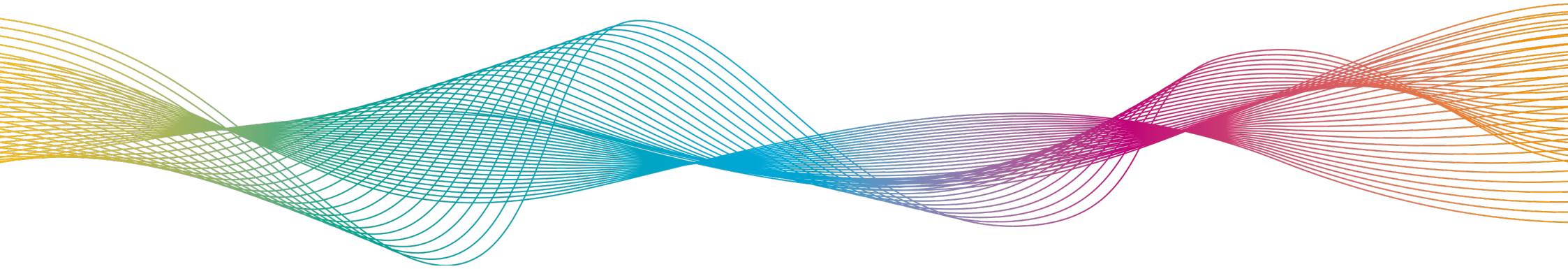
NHS
St Helens
Clinical Commissioning Group

Criteria Based Clinical Treatments

Version 7 – 18 March 2024



Document Description

Organisation	NHS St Helens Clinical Commissioning Group (CCG)
Document Name	Criteria Based Clinical Treatments (CBCT) : A collaboration of policies for: NHS Halton CCG; NHS Liverpool CCG; NHS Southport and Formby CCG; NHS South Sefton CCG; NHS St Helens CCG; NHS Warrington CCG;
Version	Version 7 – 18 March 2024
Document Status	Final
Document Development	Version 7 – 18 March 2024 has been produced by the Midlands and Lancashire Commissioning Support Unit to support the transition from individual Clinical Commissioning Group (CCG) policies to a single suite of Cheshire and Merseyside Integrated Care Board (ICB) policies. This policy is amended to reflect the ICB policy position as individual ICB policies are completed and published.
Document Editor(s)	Midlands and Lancashire Commissioning Support Unit, Policy Development Service
Publication Date	18 March 2024
Document Purpose	To publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed.
Target Audience	This document is intended for patients, clinicians, and other referrers in primary and secondary care. It sets out the eligibility criteria under which the CCG will commission specific treatments or interventions.
Superseded Document	Criteria Based Clinical Treatments (CBCT) - Version September 2023
Contact Details (For Further Information)	Tony.McLeod@sthelensccg.nhs.uk
Approved By	Governing Body / Quality Committee
Ratified By	Governing Body
Date Ratified	18 March 2024
Date of Issue via Internet/Intranet	18 March 2024
Date of Review	This policy will be subject to continued monitoring and review with subsequent updates being issued as individual policies are reviewed.
Lead Officer (CCG)	Tony.McLeod@sthelensccg.nhs.uk

Contents

1. Purpose and Scope

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

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

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

2. Context

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

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

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

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

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

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

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

2.7 The CCG recognises there may be exceptional clinical circumstances where it may be clinically effective to fund the procedures listed in this policy for individual patients. Either where:

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

To be clear, this means clinical features which make that patient different to the rest of the cohort of patients with that condition. It does not refer to social circumstances.

2.8 In accordance with the CCG's Individual Funding Request (IFR) process, the patient's clinical situation and relevant history should be evidenced in an application made by the patient's clinician will be considered on a case-by-case basis. This position is supported by each CCG's Ethical Framework.

3. Principles

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

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- CCG Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- CCG Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

3.2 This policy aims to improve consistency by bringing together a common set of criteria for treatments and procedures across the region. CCGs across Merseyside and Warrington have collaborated to develop a harmonised core set of commissioning criteria where agreed. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for patients.

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

4. Core eligibility criteria

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

4.2 These core clinical eligibility criteria are as follows:

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

5. Referral/Treatment Listing Processes (CBCT Listed Procedures)

Primary Care

5.1 Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.

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

5.3 Any referral letter should include specific information regarding the patient's potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.

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

Secondary Care

5.5 The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not. The consultant may also request additional information before seeing the patient.

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

5.7 Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient's notes should clearly reflect exactly how the criteria were fulfilled including prior approval authorisation where relevant. This will allow for case note audit to support contract management.

5.8 Should the patient not meet the eligibility criteria this should be recorded in the patient's notes and the consultant should return the referral back to the General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

6. Individual Funding Request (Exceptional Case) Approval (IFR) Application

6.1 An Individual Funding Request (Exceptional Case) application is used to demonstrate an individual patient's clinical exceptional circumstances with the purpose of obtaining approval to proceed with a specific clinical treatment or intervention.

6.2 An IFR (Exceptional Case) application is generally completed on behalf of a patient when a patient does not meet all the criteria outlined for a procedure or treatment restricted by this policy; the procedure or treatment is not routinely commissioned in accordance with this policy; or, the procedure or treatment is new/rare and a commissioning position has not yet been determined.

6.3 For example, should a patient not fulfil the 'minimum clinical eligibility' criteria, but the referring clinician believes there are clinically exceptional circumstances; and as the patient's responsible clinician they are willing to support the application as clinically exceptional; their request once submitted will follow the IFR assessment and decision-making processes. The patient's responsible clinician, completing the IFR application, can be a patient's consultant or GP. Often the patient's consultant will be best placed to demonstrate clinical exceptionality given their specialist subject knowledge, and their understanding about the standard cohort of patients for which the treatment or intervention is commissioned.

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

- The patient has a clinical picture that is significantly different to the general population of patients with that condition;

AND as a result of that difference

- The patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

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

6.6 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.

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

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

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

Personal data

6.9 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.

6.10 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 and 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.

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

Photographic evidence

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

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

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

7. Cosmetic Surgery

7.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

7.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

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

8. Diagnostic Procedures

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

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

9. Psychological factors

9.1 Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases, ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

9.2 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.

10. Lifestyle Factors and Surgery

10.1 Lifestyle factors can have an impact on the functional results of some elective surgery, e.g. smoking affects healing, especially bone-healing, and good nutrition is essential to healing in general. The rates of postoperative complication and length of stay are higher in patients who are overweight or who smoke. Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to secondary care, should be able to access CCG and Local Authority Public Health commissioned smoking cessation and weight reduction management services prior to surgery.

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

11. Medicines

11.1 Prior approval or advice about the appropriate funding route for treatment, may need to be sought from the responsible Medicine Management Team or the CCG directly 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

12. Clinical Trials

12.1 The CCG does not expect to provide funding for patients to continue treatment commenced as part of a clinical trial unless arrangements have been agreed with the CCG prior to initiation. 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.

13. Equality Analysis

13.1 An Equality Impact Analysis has been undertaken for each policy at the time of its review. For more information please contact Andy.woods3@nhs.net

14. Monitoring and review

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

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

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

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

14.4 For more detailed information about the development/review of each individual policy within this document please contact communications.ccg@sthelensccg.nhs.uk

15. Copies of this document

15.1 Electronic copies of this policy can be found on the CCG website.

16. Contact details

16.1 Enquiries relating to this document and the policies within should be sent to communications.ccg@sthelensccg.nhs.uk

17. Policy Categories

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

1. **Category 1 - Not routinely commissioned (NRC)** – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an Individual Funding Request (IFR) Exceptional Case application in line with the CCG's IFR process, demonstrates clinical exceptionality.

    - **Individual Funding Request (Exceptional Case) Approval (IFR) – Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances must be demonstrated.

2. **Category 2 - Restricted** – This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality:

    - **Monitored Approval (MA) – Prior Approval Not Required** – **Only applies if the patient meets the policy criteria –** The specific treatment may be undertaken in line with agreed policy criteria/routine commissioning arrangements provided the policy criteria is met, clinicians can refer patients without seeking approval. If the patient does not meet the policy criteria clinicians should apply for Individual Funding Request (Exceptional Case) Approval. Audits may be undertaken to ensure adherence with agreed commissioning arrangements.

    - **Prior Approval (PA) – Prior Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances do not always have to be demonstrated.

    - **Individual Funding Request (Exceptional Case) Approval (IFR) – Prior Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances must be demonstrated.

18. Policies

Funding Approval Category		Approval Required	Notes
1	**Individual Funding Request (Exceptional Case) Approval (IFR)**	**Yes**	A decision has been taken not to commission a specific treatment. Funding will only be approved if there is evidence of clinical exceptional circumstances.
2	**Prior Approval (PA)**	**Yes**	The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without funding approval from commissioners. Exceptional circumstances do not always have to be demonstrated.
3	**Monitored Approval (MA)** ***NOTE: Only applies if the patient meets the policy criteria.***	**No**	The specific treatment may be undertaken in line with agreed EUR policy criteria/routine commissioning arrangements provided the policy criteria is met, clinicians can refer patients without seeking approval. If the patient does not meet the policy criteria clinicians should apply for Individual Funding Request (Exceptional Case) Approval. Audits may be undertaken to ensure adherence with agreed commissioning arrangements

Guidance for Clinicians:
Refer to Section 4 'core eligibility criterion' before applying policy specific criteria. An IFR (Exceptional Case) application should only be submitted if the patient's circumstances are deemed clinically exceptional when compared to the general cohort of patients to which the policy applies; OR the treatment or intervention required is considered new/rare.

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
1	Complementary Therapies	1.1		Complementary and Alternate Treatments e.g. Acupuncture, Homeopathy, Aromatherapy, Meditation, Colonic Irrigation. Osteopathy, Herbal Medicines etc.	22	3	Monitored Approval	18/03/2024
2	Dermatology	2.1		Skin Resurfacing: Laser Dermabrasion and Chemical Peels	22	3	Monitored Approval	2014/2015
		2.2		Benign Skin Lesions: Surgical Removal (NHS England Evidence Based Intervention)	23	3	Monitored Approval	09/2023
		2.4		Skin Pigment Disorder: Biopsy or Camouflage	23	3	Monitored Approval	09/2023
		2.5		Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers	23	3	Monitored Approval	2014/2015
3	Diabetes	3.1	a	Continuous Glucose Monitors (Adults): Type 1 Diabetes	24	3	Monitored Approval	27/10/2022
		3.1	b	Continuous Glucose Monitors (Children and Young People): Type 1 Diabetes	24	3	Monitored Approval	27/10/2022

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		3.2		Insulin Pump Therapy (Continuous Sub-Cutaneous Insulin Infusion (CSII) Therapy: Type 1 Diabetes (including Cystic Fibrosis Related Diabetes)	24	3	Monitored Approval	27/10/2022
4	ENT	4.1		Adenoidectomy	24	3	Monitored Approval	09/2023
		4.2		Pinnaplasty/Otoplasty: Prominent Ears	25	3	Monitored Approval	14/07/2020
		4.3	a	Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear (NHS England Evidence Based Intervention)	27	3	Monitored Approval	09/2023
			b	Grommets Insertion (Adults): Otitis Media with Effusion/Glue Ear	28	3	Monitored Approval	2014/2015
		4.4		Tonsillectomy: Recurrent Tonsillitis (NHS England Evidence Based Intervention)	28	3	Monitored Approval	09/2023
		4.5		External Ear Lobe Surgical Remodelling	28	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		4.6		Sinus X-Ray: Rhinosinusitis or Sinusitis	29	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		4.7	a	Rhinoplasty/Septoplasty: Nose Reconstruction for Non-Cosmetic/Other Reasons	29	3	Monitored Approval	20/02/2018
			b	Rhinoplasty/Septoplasty: Nose Reconstruction for Cosmetic Reasons	30	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		4.8		Rhinophyma Surgery or Laser Treatment	30	1	Individual Funding Request (Exceptional Case) Approval	09/2023
5	Equipment	5.1		Lycra Suits: Cerebral Palsy Posture Management	30	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
6	Fertility	6.1		Infertility Treatment e.g. Medicines, Surgical Procedures and Assisted Conception. This Also Includes Reversal of Vasectomy or Female Sterilisation	31	3	Monitored Approval	2014/2015
7	Gastroenterology	7.1		Haemorrhoids Surgical Removal (NHS England Evidence Based Intervention)	31	3	Monitored Approval	09/2023
		7.2	a	Hernias - Incisional and Ventral (Asymptomatic) Surgical Treatment	31	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
			b	Diastasis of the Recti Surgical Correction	31	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		7.3		Gallstones (Asymptomatic) Surgical Treatment	31	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		7.4		Gallstones Lithotripsy	32	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		7.5		Transanal Irrigation	32	3	Monitored Approval	11/03/2020
8	Gynaecology	8.1	a	Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology (NHS England Evidence Based Intervention)	34	3	Monitored Approval	09/2023
			b	Hysterectomy: Heavy Menstrual Bleeding – Fibroids ³3cm In Diameter (NHS England Evidence Based Intervention)	34	3	Monitored Approval	09/2023
			c	Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids (NHS England Evidence Based Intervention)	34	3	Monitored Approval	09/2023
		8.2		Dilatation and Curettage (D&C): Heavy Menstrual Bleeding (NHS England Evidence Based Intervention)	34	1	Individual Funding Request (Exceptional Case) Approval	09/2023
9	Mental Health	9.1		Chronic Fatigue Syndrome (CFS) Inpatient Care and Treatment	34	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		9.3		Drug and Alcohol Rehabilitation: Non-NHS Commissioned Services	35	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		9.4		Private Mental Health Care	35	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
10	Neurology	10.1		Bobath Therapy: Neurological Conditions	35	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		10.2		Trophic Electrical Stimulation: Idiopathic Facial/Bell's Palsy	35	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		10.3	a	Functional Electrical Stimulation (FES): Foot Drop of Central Neurological Origin e.g. Stroke, MS, Spinal Cord Injury	35	3	Monitored Approval	18/03/2024
			b	Functional Electrical Stimulation (FES): Lower Motor Neurone Lesions	35	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
11	Ophthalmology	11.1		Blepharoplasty: Upper Eyelid Correction	36	3	Monitored Approval	2014/2015

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		11.2		Blepharoplasty: Lower Eyelid Correction	36	3	Monitored Approval	2014/2015
		11.4		Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction Surgery or Laser Treatment	37	3	Monitored Approval	09/2023
		11.5		Cataract Surgery	37	3	Monitored Approval	18/03/2024
		11.6		Coloured Filters: Irlens Syndrome/Dyslexia	37	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		11.7		Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration	37	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		11.8		Chalazia (Meibomian Cyst) Surgical Removal (NHS England Evidence Based Intervention)	38	3	Monitored Approval	09/2023
12	Oral Surgery	12.1		Temporo-Mandibular Joint Dysfunction Syndrome Surgical Replacement	38	3	Monitored Approval	18/03/2024
13	Paediatrics	13.1		Cranial Banding: Positional Plagiocephaly	38	1	Individual Funding Request (Exceptional Case) Approval	09/2023
14	Plastic Surgery	14.1	a	Bilateral Breast Reduction Surgery: Breast Macromastia (NHS England Evidence Based Intervention)	38	3	Monitored Approval	09/2023
			b	Unilateral Breast Reduction Surgery: Breast Asymmetry (NHS England Evidence Based Intervention)	39	3	Monitored Approval	09/2023
			c	Breast Reduction Surgery: Gynaecomastia (NHS England Evidence Based Intervention)	39	3	Monitored Approval	20/02/2018
		14.2		Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia	39	3	Monitored Approval	20/02/2018
		14.3	a	Breast Implant Removal Surgery: Silicone Breast Reconstruction	40	3	Monitored Approval	20/02/2018
			b	Breast Implant Replacement Surgery (Cosmetic or Non-Cosmetic Purposes): Silicone Breast Reconstruction	41	3	Monitored Approval	20/02/2018
		14.4		Mastopexy: Breast Lift Surgery	41	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		14.5		Nipple Inversion Surgical Correction	41	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		14.7		Electrolysis/Laser Therapy: Hair Removal	42	3	Monitored Approval	20/02/2018

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		14.8		Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction	43	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		14.9		Scar Revision Surgery	43	3	Monitored Approval	20/02/2018
		14.10		Tattoo Laser Removal	44	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.11		Abdominoplasty/Apronectomy: Surgical Excision of Redundant Skin or Fat	45	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		14.12		Thigh, Buttock or Arm Lift: Surgical Excision of Redundant Skin or Fat	45	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		14.13		Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)	45	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.16		Labiaplasty, Vaginoplasty and Hymenorrhaphy	47	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		14.17		Liposuction: Removal of Excess/Unwanted Fat	47	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		14.18		Rhytidectomy: Face or Brow Lift	47		Monitored Approval	09/2023
15	Respiratory	15.1		Snoring in the Absence of OSA Surgery (Adult) (NHS England Evidence Based Intervention)	47	1	Individual Funding Request (Exceptional Case) Approval	09/2023
16	Trauma and Orthopaedics	16.1	a	Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica	48	3	Monitored Approval	20/02/2018
			b	Opioids (Including Tramadol and Capasicin Cream): Low Back Pain Management	51	3	Monitored Approval	20/02/2018
			c	Capsaicin Cream, Cannabis Sativa Extract, Capsaicin Patch, Lacosamind, Lamotrigine, Levetiracetam, Morphine, Oxcarbazepine, Topiramate, Tramadol (For Long-Term Use), Venlafaxine: Lower Back Neuropathic Pain Treatment	51	3	Monitored Approval	20/02/2018
			d	TENS, PENS, Ultrasound, Interferential and Laser Therapy: Low Back Pain and Sciatica	52	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
			e	Paracetamol (Used Alone), SSRIS, Serotonin, Tricyclic Antidepressants, Anti-Convulsants: Back Pain without Neuropathic Pain	52	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.2	a	Spinal Imaging Emergency Referral: Low Back Pain	53	3	Monitored Approval	18/03/2024

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
			b	Spinal Priority Imaging (Protocol Led MRI Whole Spine Unless Contraindicated): Low Back Pain	53	3	Monitored Approval	18/03/2024
		16.3	a	Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)	53	3	Monitored Approval	18/03/2024
			b	Radiofrequency Denervation: Low Back Pain Without Sciatica (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)	53	3	Monitored Approval	18/03/2024
			c	Spinal Injections (NHS England Evidence Based Intervention)	53	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		16.4		Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain	54	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		16.5		Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain	54	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		16.6		Spinal Fusion; Non-Rigid Stabilisation Techniques; Lateral Body Fusion in the Lumbar Spine; Trans axial Interbody Lumbosacral Fusion; Anterior Lumbar Interbody Fusion (ALIF); Posterior Lumbar Interbody Fusion (PLIF); or Any Other Combination of Approach where Surgical Fixation is Performed: Spinal Fixation	54	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		16.7		Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression	54	3	Monitored Approval	20/02/2018
		16.8		Bone Morphogenetic Protein (Dibotermin Alfa and Eptotermin Alfa): Non-Healing Fractures	56	3	Monitored Approval	2014/2015
		16.9		Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain	56	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		16.10		Steroid Joint Injections (Secondary Care Administered): Joint Pain	56	3	Monitored Approval	09/2023
		16.11	a	Hip Replacement Surgery	57	3	Monitored Approval	18/03/2024
			b	Hip Resurfacing	57	3	Monitored Approval	18/03/2024
		16.12		Hip Arthroscopy: Hip Impingement Syndrome/Femoro–Acetabular Impingement	57	3	Monitored Approval	2014/2015
		16.13		Knee Arthroplasty: Knee Replacement	58	3	Monitored Approval	18/03/2024
		16.14	a	Diagnostic Knee Arthroscopy: Knee Arthritis (Without Osteoarthritis)	58	3	Monitored Approval	09/2023

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
			b	Diagnostic Knee Arthroscopy: Knee Arthritis (With Osteoarthritis)	58	3	Monitored Approval	09/2023
		16.15		Knee Arthroscopy: Knee Osteoarthritis (NHS England Evidence Based Intervention)	58	3	Monitored Approval	09/2023
		16.16		Uni-compartmental Knee Replacement (Patient Specific): Knee Osteoarthritis	58	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		16.17		Total Knee Replacement (Patient Specific)	58	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		16.18		Trigger Finger/Thumb Surgical Release (NHS England Evidence Based Intervention)	59	3	Monitored Approval	09/2023
		16.19	a	Collagenase Injection: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)	59	3	Monitored Approval	09/2023
			b	Needle Fasciotomy, Fasciectomy and Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)	59	3	Monitored Approval	09/2023
		16.20		Carpal Tunnel Syndrome Surgical Release (NHS England Evidence Based Intervention)	59	3	Monitored Approval	09/2023
		16.21		Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal	59	3	Monitored Approval	09/2023
		16.22		Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts) (NHS England Evidence Based Intervention)	60	3	Monitored Approval	09/2023
		16.23		Bunion or Lesser Toe Deformity Surgery	60	3	Monitored Approval	09/2023
		16.24		Morton's Neuroma Surgical Treatment	60	3	Monitored Approval	09/2023
		16.25		Plantar Fasciitis Surgical Treatment	60	3	Monitored Approval	2014/2015
		16.26		Extracorporeal Shock Wave Therapy or Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow	61	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		16.27		Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement (NHS England Evidence Based Intervention)	61	3	Monitored Approval	18/03/2024
17	Urology	17.1	a	Circumcision for Medical Reasons	61	3	Monitored Approval	18/03/2024

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
			b	Circumcision for Social, Cultural, or Religious Reasons	61	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		17.3		Male Sterilisation Reversal: Infertility	62	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		17.4		Extracorporeal Shockwave Therapy (ESWT): Prostadynia or Pelvic Floor Syndrome	62	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		17.5		Hyperthermia Treatment: Prostadynia or Pelvic Floor Syndrome	62	1	Individual Funding Request (Exceptional Case) Approval	18/03/2024
		17.6	a	Prostatism/Lower Urinary Tract Specialist Assessment Referral	62	3	Monitored Approval	11/03/2020
			b	Prostatism Surgery	64	3	Monitored Approval	11/03/202
18	Vascular Surgery	18.1		Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating)	64	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		18.2		Chelation Therapy: Vascular Occlusions	64	1	Individual Funding Request (Exceptional Case) Approval	09/2023
		18.3	a	Vascular Service Referrals: Varicose Veins (Legs Only) (NHS England Evidence Based Intervention)	64	3	Monitored Approval	09/2023
			b	Compression Hosiery Treatment: Varicose Veins (NHS England Evidence Based Intervention)	65	3	Monitored Approval	09/2023
19	Other	19.1	a	Botulinum Toxin A	65	3	Monitored Approval	11/03/2020
			b	Botulinum Toxin B	69	1	Individual Funding Request (Exceptional Case) Approval	11/03/2020

1. Complementary Therapies

1.1 Complementary and Alternate Treatments e.g. Acupuncture, Homeopathy, Aromatherapy, Meditation, Colonic Irrigation. Osteopathy, Herbal Medicines etc.

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin067 – Complementary and alternative therapies

2. Dermatology

2.1 Skin Resurfacing: Laser Dermabrasion and Chemical Peels

CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has severe scarring on their head or neck as a result of acne, and the active disease is controlled. ☐ The patient has severe scarring on their head or neck as a result of chicken pox. ☐ The patient has severe scarring on their head or neck caused by trauma (including post-surgical). **PLEASE NOTE:** This intervention is only routinely commissioned for the patient's head and/or neck area. If treatment is required for other areas of the body an Individual Funding Request must be completed. If the treatment is requested as a non-core procedure for a patient with gender dysphoria the Gender Identity Clinic should apply to the CCG for funding for the treatment.	**Policy Statement** Skin resurfacing techniques including laser dermabrasion and chemical peels are restricted in accordance with the minimum eligibility criteria. **Minimum eligibility criteria** Procedures will only be performed on the head and neck area in cases of Severe scarring following: • Acne once the active disease is controlled. **OR** • Chicken pox. **OR** • Trauma (including post-surgical). 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.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS only (Procedure driven): S103, S113, S601, S602*

Evidence for inclusion and threshold

1. Modernisation Agency's Action on Plastic Surgery 2005.
2. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78.

2.1 Skin Resurfacing: Laser Dermabrasion and Chemical Peels

3. 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.
4. www.evidence.nhs.uk
5. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) - Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.
6. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.

2.2 Benign Skin Lesions: Surgical Removal

Including: benign moles (excluding large congenital naevi); solar comedones; corn/callous; dermatofibroma; lipomas; milia; molluscum contagiosum (non-genital); epidermoid and pilar cysts (sometimes incorrectly called sebaceous cysts); seborrhoeic keratoses (basal cell papillomata); skin tags (fibroepithelial polyps) including anal tags; spider naevi (telangiectasia); non-genital viral warts in immunocompetent patients; xanthelasmata; neurofibromata.
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin005 – Benign skin lesions

2.4 Skin Pigment Disorder: Biopsy or Camouflage

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin009 – Camouflage Treatment for Skin Pigmentation and other disorders

2.5 Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following the following statements:

- ☐ The patient is experiencing severe pain which is substantially interfering with functional abilities.
- ☐ The patient's warts have persisted for at least 2 years and they are spreading and have been refractive to at least 3 months of primary care or community treatment.
- ☐ The patient has extensive warts.

Policy Statement
Surgical/laser therapy for viral warts (excluding genital warts) from secondary care providers, are restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria

- Severe pain substantially interfering with functional abilities.
- Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.
- Extensive warts (particularly in the immune-suppressed patient).
- Facial warts.
- Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.

Version: *2014/2015*

Clinical Coding:
ICD-10 Only (Diagnosis driven):
B07X

2.5 Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers		
☐ The patient has facial warts. **PLEASE NOTE:** Community treatments such as cryosurgery, curettage and prescription only topical treatments should be considered before referral to secondary care for surgical treatment. A referral to a Dermatologist for assessment should be considered for patients who are immuno-suppressed who have severe pain and/or persistent or extensive warts.	**Rationale** Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.	
Evidence for inclusion and threshold		
1. Modernisation Agency's Action on Plastic Surgery 2005. 2. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. 3. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service 4. patient.co.uk/doctor/viral-warts-excluding-verrucae 5. http://www.patient.co.uk/doctor/verrucae		

3. Diabetes

3.1a Continuous Glucose Monitors (Adults): Type 1 Diabetes

3.1b Continuous Glucose Monitors (Children and Young People): Type 1 Diabetes

3.2 Insulin Pump Therapy (Continuous Sub-Cutaneous Insulin Infusion (CSII)) Therapy: Type 1 Diabetes (Including Cystic Fibrosis Related Diabetes):

These policies have been superseded as follows:
At the NHS Cheshire & Merseyside ICB Board Meeting held on 27 October 2022, it was agreed that the former CCG commissioning polices in respect of CGMs and Insulin Pump Therapy be retired, and the recommendations within NICE guidance NG17, NG18 and NG28 be adopted.

4. ENT

4.1 Adenoidectomy

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin002 – Adenoidectomy

4.2 Pinnaplasty / Otoplasty: Prominent Ears

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient is age ≥ 7 years to ≤ 18 years
- ☐ The patient has prominent ear, upper 3rd mastoid – helical distance is ≥21.5 mm
- ☐ The patient is suffering from significant psychological distress due to their prominent ears as determined by a consultant surgeon (confirmed by documentary evidence if available), **OR** is experiencing significant functional difficulties such as inability to keep a hearing aid in place or ears folding over when asleep causing pain.
- ☐ The child and parent understand the risks, likely outcome and are motivated to proceed with surgery.

Policy Statement
Pinnaplasty is restricted in accordance with the Minimum Eligibility Criteria.

Summary of intervention

Ear correction surgery is cosmetic surgery to alter the size or shape of the ears or pin them back if they stick out/protrude.
Protruding ears can be distressing to the individual who has them. This procedure aims to improve the appearance of the ear without cutting into the skin. A hollow needle is used to divide the ear cartilage, and stitches buried under the skin are used to remould the ear.
Pinning back the ears is known as an otoplasty, or pinnaplasty. It is usually carried out on children and young teenagers, although adults may wish to have it done, too.
An otoplasty is not suitable for children younger than five as their ears will still be growing and developing.
Most people are happy with the results of an otoplasty, and generally it is a safe procedure. But it can be expensive and there are risks that need considering.
Weblink:
http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Minimum Eligibility Criteria

Children with prominent ears should be offered Pinnaplasty/Otoplasty according to the following criteria:

- Age ≥ 7 years to ≤ 18 years

AND

- Prominent ear, upper 3rd mastoid – helical distance is ≥21.5 mm

AND

- During the clinical assessment, a consultant surgeon is able to verify that the child is suffering from significant psychological distress due to their prominent ears (provision of documented evidence, e.g. from the child's school will complement this assessment but is not essential)

AND

- The child and parent understand the risks, likely outcome and are motivated to proceed with surgery.

Version: *09/12/2020*

Clinical Coding:
OPCS only (Procedure driven): D033

4.2 Pinnaplasty / Otoplasty: Prominent Ears

	With the exception of functional reasons e.g. to keep a hearing aid in place or ears folding over when asleep causing pain, all other cases of pinnaplasty will not be commissioned. **Rationale for restriction** Pinnaplasty is generally regarded as a cosmetic procedure in the majority of cases. This is particularly so in adults. Even in children, not all patients with prominent ear will benefit from surgery. Therefore, this policy is restricted to those children most likely to benefit i.e. those suffering significant psychological distress due to their prominent ears. These criteria were developed following a critical appraisal of the literature (Sept 2020) and in conjunction with local surgeons. The principal entrance criterion, a prominent ear, upper 3rd mastoid – helical distance of ≥21.5 mm), is based on a literature definition of a "normal" ear and this was confirmed as clinically appropriate by local surgeons. The upper age limit of 18 years is consistent with Royal College of Surgeons' guidance for this procedure. However, the lower age limit of 7 years in this policy has also been specified by local surgeons on grounds of a local audit which demonstrated a greater number of complications in the younger age group.	

Evidence for inclusion and threshold

1. Driessen JP, Borgstein JA, Vuyk HD. Defining the protruding ear. The Journal of craniofacial surgery 2011;22(6):2102-08. doi: 10.1097/SCS.0b013e3182326dfb
2. Nazarian R, Eshraghi AA. Otoplasty for the protruded ear. Seminars in plastic surgery 2011;25(4):288-94. doi: 10.1055/s-0031-1288921
3. Ahmad Z, Ahmad F. Pinnaplasty - A dwindling art in today's modern NHS. Journal of Plastic, Reconstructive and Aesthetic Surgery 2009;62(2):159-60. doi: 10.1016/j.bjps.2008.11.036
4. Pawar SS, Koch CA, Murakami C. Treatment of Prominent Ears and Otoplasty: A Contemporary Review. JAMA facial plastic surgery 2015;17(6):449-54. doi: 10.1001/jamafacial.2015.0783
5. Hope N, Smith CP, Cullen JR, et al. A retrospective study of patient outcomes and satisfaction following pinnaplasty. Patient related outcome measures 2016;7:49-53. doi: 10.2147/PROM.S99622
6. Fioramonti P, Serratore F, Tarallo M, et al. Otoplasty for prominent ears deformity. European review for medical and pharmacological sciences 2014;18(21):3156-65.
7. Walker FDL, Kubba H, Clement WA. Use of facial proportions in pinnaplasty assessment. Journal of plastic, reconstructive & aesthetic surgery : JPRAS 2011;64(8):1110-13. doi: 10.1016/j.bjps.2011.03.007
8. Yugueros P, Friedland JA. Otoplasty: the experience of 100 consecutive patients. Plastic and reconstructive surgery 2001;108(4):1045.
9. Petersson RS, Friedman O. Current trends in otoplasty. Current opinion in otolaryngology & head and neck surgery 2008;16(4):352-58. doi: 10.1097/MOO.0b013e328304b40d
10. Stewart KJ, Lancerotto L. Surgical Otoplasty: An Evidence-Based Approach to Prominent Ears Correction. Facial plastic surgery clinics of North America 2018;26(1):9-18. doi: 10.1016/j.fsc.2017.09.002
11. Songu M, Kutlu A. Long-term psychosocial impact of otoplasty performed on children with prominent ears. The Journal of laryngology and otology 2014;128(9):768-71. doi: 10.1017/S0022215114001662
12. Janis JE, Rohrich RJ, Gutowski KA. Otoplasty. Plastic and reconstructive surgery 2005;115(4):60e.
13. Incisionless otoplasty. Interventional procedures guidance. London: National Institute for health and care excellence, 2012.
14. Bradbury ET, Hewison J, Timmons MJ. Psychological and social outcome of prominent ear correction in children. British journal of plastic surgery 1992;45(2):97-100. [published Online First: 1992/02/01]

4.2 Pinnaplasty / Otoplasty: Prominent Ears

15. Horlock N, Vogelin E, Bradbury ET, et al. Psychosocial outcome of patients after ear reconstruction: a retrospective study of 62 patients. Ann Plast Surg 2005;54(5):517-24. [published Online First: 2005/04/20]
16. Gasques JAL, Pereira de Godoy JM, Cruz EMTN. Psychosocial effects of otoplasty in children with prominent ears. Aesthetic plastic surgery 2008;32(6):910-14. doi: 10.1007/s00266-008-9179-x
17. Cooper-Hobson G, Jaffe W. The benefits of otoplasty for children: further evidence to satisfy the modern NHS. Journal of plastic, reconstructive & aesthetic surgery : JPRAS 2009;62(2):190-94.
18. Braun T, Hainzinger T, Stelter K, et al. Health-related quality of life, patient benefit, and clinical outcome after otoplasty using suture techniques in 62 children and adults. Plastic and reconstructive surgery 2010;126(6):2115-24. doi: 10.1097/PRS.0b013e3181f449c7
19. Bermueller C, Kirsche H, Sebert A, et al. Quality of life and patients' satisfaction after otoplasty. European archives of oto-rhino-laryngology : official journal of the European Federation of Oto-Rhino-Laryngological Societies (EUFOS) : affiliated with the German Society for Oto-Rhino-Laryngology - Head and Neck Surgery 2012;269(11):2423-31. doi: 10.1007/s00405-012-2060-1
20. Hao W, Chorney JM, Bezuhly M, et al. Analysis of health-related quality-of-life outcomes and their predictive factors in pediatric patients who undergo otoplasty. Plastic and reconstructive surgery 2013;132(5):811e. doi: 10.1097/PRS.0b013e3182a3c133
21. Dias-Vaz M, Estevao-Costa J, Morgado H, et al. Measuring otoplasty outcome: Expanding the validity to caregivers' perspective and to Portuguese-speaking children. Clinical Otolaryngology 2018;43(6):1513-21. doi: 10.1111/coa.13198
22. Limandjaja GC, Breugem CC, Mink van der Molen AB, et al. Complications of otoplasty: a literature review. Journal of plastic, reconstructive & aesthetic surgery : JPRAS 2009;62(1):19-27. doi: 10.1016/j.bjps.2008.06.043
23. Sadhra SS, Motahariasl S, Hardwicke JT. Complications after prominent ear correction: A systematic review of the literature. J Plast Reconstr Aesthet Surg 2017;70(8):1083-90. doi: 10.1016/j.bjps.2017.05.033 [published Online First: 2017/06/13]
24. MacIsaac ZM, Zammerilla L, Grunwaldt LJ. Treatment of the Prominent Ear: A Standardized Approach Without Intraoperative Measurements. The Journal of craniofacial surgery 2019;30(1):228-30. doi: 10.1097/SCS.0000000000004868
25. Schlegel-Wagner C, Pabst G, Müller W, et al. Otoplasty using a modified anterior scoring technique: standardized measurements of long-term results. Archives of facial plastic surgery 2010;12(3):143-48. doi: 10.1001/archfacial.2010.34
26. Henderson J. The plastic surgery postcode lottery in England. International journal of surgery (London, England) 2009;7(6):550-58. doi: 10.1016/j.ijsu.2009.09.004
27. Shelton F, Biggs T, Henderson A, et al. Procedures of limited clinical value in ENT: What effect has there been on operating numbers? International Journal of Surgery 2014;12
28. Commissioning guide: Pinnaplasty. 35-32 LIncoln's Inn Fields, London: The Royal College of surgeons of England, 2013:9.

4.3a Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin023 – Grommets for glue ear in children

4.3b Grommets Insertion (Adults): Otitis Media with Effusion/Glue Ear

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient is an adult with significant negative middle ear pressure measured on two sequential appointments and has significant ongoing associated pain.
- ☐ The patient is an adult and has unilateral middle ear effusion where a post-nasal space biopsy is required to exclude an underlying malignancy.

PLEASE NOTE: It is not necessary to obtain authorisation to insert grommets for patients with recurrent acute otitis media or atrophic tympanic membranes, or in order to access the middle ear for transtympanic instillation of medication, or to investigate unilateral glue ear in adults.

Policy Statement

Insertion of grommets for glue ear (otitis media with effusion) in adults is restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria

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

AND

- Significant ongoing associated pain.

OR

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

Version: *2014/2015*

Clinical Codes:
*ICD-10 inclusion: H652, H653, H66**
Age qualifier: >=18
OPCS with ICD Inclusions (Procedure driven), requires additional age qualifier:
OPCS4: D151, D289

Evidence for inclusion and threshold

1. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome - Royal College of Surgeons (2013).
2. http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf

4.4 Tonsillectomy: Recurrent Tonsillitis

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin046 – Tonsillectomy

4.5 External Ear Lobe: Surgical remodelling

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin45 – Split (cleft) Earlobe, surgical repair

4.6 Sinus X-ray: Rhinosinusitis or Sinusitis

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin44 – Sinus X-Ray

4.7a Rhinoplasty / Septoplasty: Nose Reconstruction for Non-Cosmetic/Other Reasons

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has documented medical breathing problems caused by obstruction of the nasal airway.
- ☐ The surgery is being undertaken to correct a complex congenital conditions e.g. cleft lip and palate.

Policy Statement
Rhinoplasty/Septoplasty for non-cosmetic/other reasons is restricted in accordance with the Minimum Eligibility Criteria.

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

Minimum eligibility criteria
The CCG will fund this treatment if the patient meets the following criteria:

- Documented medical breathing problems caused by obstruction of the nasal airway

OR

- Correction of complex congenital conditions e.g. Cleft lip and palate

This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

Rationale
This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe.
Cosmetic surgery is often carried out to change a person's appearance in order to achieve what a person perceives to be a more desirable look.
Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

Version: *20/02/2018*

Clinical Coding:
OPCS with both ICD Inclusions and Exclusions.
OPCS4: E023, E024, E025, E026, E028, E073, E022, E027, E029, E036, E037, E071, E072, E078, E079
ICD-10 exclusions: Z411,
ICD-10 inclusions: Q351, Q353, Q355, Q357, Q359, Q360, Q361, Q369, Q370, Q371, Q372, Q373, Q374, Q375, Q378, Q379, J348, S022, S099, J342, M950

Evidence for inclusion and threshold

1. Royal College of Surgeons – Rhinoplasty Guide - Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/

4.7b Rhinoplasty / Septoplasty: Nose Reconstruction for Cosmetic Reasons

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 4.7a Rhinoplasty/Septoplasty for cosmetic reasons is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with both ICD Inclusions & Exclusions.* *OPCS4: E023, E024, E025, E026, E028, E073, E022, E027, E029, E036, E037, E071, E072, E078, E079* *ICD-10 inclusions: Z411, J342, M950* *ICD-10 exclusions: Q351, Q353, Q355, Q357, Q359, Q360, Q361, Q369, Q370, Q371, Q372, Q373, Q374, Q375, Q378, Q379, J348, S022, S099*

Evidence for inclusion and threshold

Please refer to 4.7a

4.8 Rhinophyma Surgery or Laser Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin41 - Rhinophyma, surgical management

5. Equipment

5.1 Lycra Suits: Cerebral Palsy Posture Management

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin071 – Lycra™ Suits and Orthotics (Dynamic Elastomeric Fabric Orthoses)

6. Fertility

6.1 Infertility Treatment

e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation

See separate standalone CCG document - Assisted Conception / Subfertility Policy.

7. Gastroenterology

7.1 Haemorrhoids Surgical Removal

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin024 – Haemorrhoids, surgical management

7.2a Hernias Incisional and Ventral (Asymptomatic) Surgical Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin083 – Minimally symptomatic inguinal hernia repair

7.2b Diastasis of the Recti Surgical Correction

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin014 – Diastasis (divarication) of the Recti Repair

7.3 Gallstones (Asymptomatic) Surgical Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin021 – Gallstones (Asymptomatic), Surgical Management

7.4 Gallstones Lithotripsy

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement**	***Version:*** *2014/2015*

7.4 Gallstones Lithotripsy		
	Lithotripsy for gallstones is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Rationale** Lithotripsy rarely performed as rate of recurrence high.	***Clinical Coding:*** *OPCS only (Procedure driven): J261*

7.5 Transanal Irrigation		
CATEGORY 2 – Restricted **Monitored Approval** The CCG will only fund this treatment in **ALL** the following circumstances: ☐ The patient suffers with one of the following conditions: • Neurogenic bowel dysfunction; • Post anterior resection syndrome; • Congenital bowel malformations; • Slow transit bowel; • Obstructive defaecation; • Faecal incontinence. ☐ The patient has undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy and although these have been maximised they proved unsuccessful. ☐ The patient has tried all appropriate laxatives at adequate doses and for several months at a time. ☐ The patient has undergone all appropriate investigations, including sigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies. ☐ The treatment has been prescribed initially by a consultant-led multidisciplinary specialist service which will: -commit to using the most cost-effective system	**Policy Statement** Transanal irrigation is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Transanal irrigation systems are a highly specialist management option and should not be initiated by GPs in primary care, without specialist management. Comprehensive training for the individual plus on-going structured support is essential for safe and efficient long-term use of rectal irrigation[1]. Rectal irrigation should only be used after medication has been tried (oral drugs, suppositories and enemas), changes to the diet have been made and various physiotherapy and retraining sessions have taken place. Patients must be motivated and determined to succeed with rectal irrigation. The evidence is weak[2]. The best evidence comes from a trial of 87 patients with neurogenic bowel dysfunction as a result of spinal cord injury[3] but even this is limited as the outcome measures are reported by the patients. The NICE costing model is based on adults with neurogenic bowel dysfunction from the trial above and NICE admits there is considerable uncertainty in the costing. The estimated savings are £2,867 per patient over 37 years, based on it being used every other day. The savings are based on fewer hospital visits, fewer healthcare professional visits, less carer time, reduced faecal incontinence leading to fewer incontinence pads and fewer urinary tract infections. **Minimum Eligibility Criteria** Transanal irrigation is commissioned for adults and children with neurogenic bowel dysfunction, post anterior resection syndrome, congenital bowel malformations, slow transit bowel, obstructive defaecation and a limited number of patients with faecal incontinence. All patients should meet the eligibility criteria below. ALL the following criteria must be met and apply to all patients whether referred to the specialist service by the GP or by another secondary care specialty: Only commissioned for adults and children who have already undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy and these have been maximised but proved unsuccessful.	***Version: 11/03/2020*** ***Clinical Coding:***

7.5 Transanal Irrigation

-use a balloon pump rather than an electric pump for all patients, with the exception of those with very poor dexterity -establish patients on alternate day use and gain agreement from the patient to use the irrigation system regularly and -re-evaluate the treatment at 8-12 weeks should a reliable and effective routine not be established -Make arrangements for ongoing structured patient and Primary Care clinician support, including: • Patient, carers and NHS staff specialist training in the use of the irrigation system. • Written information for both the patient, their carer and the Primary Care clinician, advising of risk awareness and action to take including relevant and appropriate specialist service contact telephone numbers for advice and guidance. • Primary Care clinician support material to enable monitoring of compliance and effectiveness and ongoing prescribing and supervision.	• All appropriate laxatives should have been tried at adequate doses and for several months at a time. See Pan Mersey Constipation Guidelines . • All appropriate investigations should have been carried out, including sigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies. • Prescribing should be initiated by a consultant-led multidisciplinary specialist service and the most cost-effective system should be used. • The patient, carers and NHS staff supporting the patient should receive specialist training in the use of the irrigation system. • Ongoing structured patient support including written information, risk-awareness and action to take and contact telephone numbers must be established before the specialist requests a transfer of prescribing to primary care. • The patient's Primary Care Clinician must be supplied with enough written supporting material to monitor compliance and effectiveness and to be able to provide ongoing prescribing and supervision, plus a contact telephone number. GPs do not have to take over prescribing if they do not feel confident and competent to do so. • The specialist service should be available for advice and support for both patients and Primary Care Clinicians. • A balloon pump should be used if possible. Electric pumps should only be used for patients that meet all the other criteria but have very poor dexterity e.g. as a result of spinal injury, MS or CVA and are unable to use a balloon pump. The patient should be established on alternate day use by the specialist service and the irrigation system should be stopped if the patient does not use it regularly or does not want to continue with it. There should be a demonstrable improvement in validated measures of bowel function such as the Cleveland Clinic constipation scoring system, St Mark's faecal incontinence score or neurogenic bowel dysfunction score It may take 4-12 weeks to establish a reliable and effective routine. If success has not been achieved by 8-12 weeks, a re-evaluation needs to be undertaken. The specialist service should retain prescribing until the training and support criteria have been met.	

Evidence for inclusion and threshold

1. PrescQIPP Bulletin 171 February 2017. Rectal Irrigation (DROP-List)
2. NICE Medical Technology Guidance February 2018. Peristeen transanal irrigation system for managing bowel dysfunction.
3. Christenson P et al. A randomized, controlled trial of transanal irrigation versus conservative bowel management in spinal cord-injured patients. Gastroenterology 2006;131:738-747

8. Gynaecology

8.1a Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy

8.1b Hysterectomy: Heavy Menstrual Bleeding – Fibroids ≥3cm in Diameter
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy

8.1c Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy

8.2 Dilatation and Curettage (D&C): Heavy Menstrual Bleeding
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage

9. Mental Health

9.1 Chronic Fatigue Syndrome (CFS) Inpatient Care and Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin066 – Chronic fatigue syndrome/Myalgic Encephalomyelitis (CFS/ME): Inpatient Management

9.3	Drug and Alcohol Rehabilitation: Non-NHS Commissioned Services

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin072 – Private Drug and Alcohol Rehabilitation

9.4	Private Mental Health Care

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin073 – Mental health disorders, specialist, general and non-NHS services

10.	Neurology

10.1	Bobath Therapy: Neurological conditions

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin063 – Bobath Therapy

10.2	Trophic Electrical Stimulation: Idiopathic Facial/Bell's Palsy

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin062 – Idiopathic Facial Paralysis (Bell's Palsy) -Trophic Electrical Stimulation

10.3a	Functional Electrical Stimulation (FES): Foot Drop of Central Neurological Origin e.g. Stroke, MS, Spinal Cord Injury

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin064 – Foot Drop, Functional Electrical Stimulation (FES)

10.3b	Functional Electrical Stimulation (FES): Lower Motor Neurone Lesions

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:

10.3b Functional Electrical Stimulation (FES): Lower Motor Neurone Lesions

CMICB_Clin064 – Foot Drop, Functional Electrical Stimulation (FES)

11. Ophthalmology

11.1 Blepharoplasty: Upper Eyelid Correction

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient has excess skin in the upper eyelid.
- ☐ The excess skin is interfering with the patient's visual field.
- ☐ The requirement for surgical correction has been confirmed by an appropriate specialist.

Policy Statement
Upper Eyelid Blepharoplasty is restricted in accordance with the minimum eligibility criteria.

Summary of Intervention
Excess skin in the upper eyelids can accumulate due to ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment.

Minimum Eligibility Criteria
Only commissioned in the following circumstances:
- Eyelid function interferes with visual field.*

*Impairment to visual field to be documented.

Version: *2014/2015*

Clinical Coding
OPCS with ICD exclusions (Procedure driven):
OPCS4: C132
ICD exclusions: H534

Evidence for inclusion and threshold

1. Eyelid Surgery
2. The British Association of Aesthetic Plastic Surgeons 2011.
3. Modernisation Agency's Action on Plastic Surgery 2005.
4. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base
5. London Health Observatory 2010.

11.2 Lower Eyelid Correction: Blepharoplasty

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The surgery is required to treat the patient's ectropion or entropion, which is threatening the health of the affected eye.

Policy Statement
Lower Eyelid Blepharopasty is restricted in accordance with the minimum eligibility criteria.

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

Version: *2014/2015*

Clinical Coding
OPCS with ICD exclusions (Procedure driven):
OPCS4: C131, C133, C134, C138, C139
ICD exclusions: H020, H021, H023, H024, H025, H026, H027, H028, H029, H010, Q100, H534

11.2 Lower Eyelid Correction: Blepharoplasty		
☐ The surgery is required to remove a lesion on the patient's eyelid or eyelid margin. ☐ The treatment is required as rehabilitative surgery for thyroid eye disease.	**Rationale** Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.	
Evidence for inclusion and threshold		
1. *Eyelid Surgery* 2. The British Association of Aesthetic Plastic Surgeons 2011. 3. Local PCT consensus – review conducted 2007. 4. Modernisation Agency's Action on Plastic Surgery 2005. 5. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.		

11.4 Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction: Surgery or Laser Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment

11.5 Cataract Surgery

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin097 – Cataract Surgery

11.6 Coloured filters: Irlens Syndrome/Dyslexia

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin017 - Dyslexia Treatment using Coloured (Irlen) Filters

11.7 Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT)

11.8 Chalazia (Meibomian Cyst) Surgical Removal
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin011 - Chalazia (meibomian cysts), removal

12. Oral Surgery

12.1 Temporo-Mandibular Joint Dysfunction Syndrome Surgical Replacement

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin093 – Temporomandibular joint, surgical replacement

13. Paediatrics

13.1 Cranial Banding: Positional Plagiocephaly

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin039 - Positional Plagiocephaly/brachycephaly in children, helmet therapy

14. Plastic Surgery

14.1a Bilateral Breast Reduction Surgery: Breast Macromastia
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin007 – Breast Reduction

14.1b Unilateral Breast Reduction Surgery: Breast Asymmetry

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin007 – Breast Reduction

14.1c Breast Reduction Surgery: Gynaecomastia

(NHS England Evidence Based Intervention)

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient is male and has >2cm of palpable, firm, subareolar gland and ductal breast tissue (gynaecomastia). ☐ The patient's gynaecomastia has been caused by medication prescribed or treatment undertaken for a diagnosed medical condition e.g. prostate cancer.	**Policy Statement** Male breast reduction surgery (gynaecomastia) is restricted in accordance with the minimum eligibility criteria. Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.	***Version:*** *18/02/2019* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: B275, B311* *ICD inclusions: N62X* *Codes as per 14.1a with an additional qualifier needed to denote sex (sex=1)*

Evidence for inclusion and threshold

Please refer to 14.1a

14.2 Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient has a congenital absence of breast tissue unilaterally (affecting one breast only) of three or more cup size difference as measured by a specialist. ☐ The patient's BMI is under 25 and has been stable for at least 12 months. ☐ The patient is at least 18 years old.	**Policy Statement** Breast enlargement surgery (augmentation mammoplasty) is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx **Minimum eligibility criteria**	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions and inclusions (Procedure driven):* *OPCS4: B301, B312, B375, B301, B302, B303, B304, B308, B309* *ICD exclusions: C500, C501, C502, C503, C504, C505, C506, C508, C509, Z803, Z853, T857, T814* *ICD inclusions: Z411*

14.2 Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia

	Augmentation Mammoplasty will be funded if the patient meets ALL the following criteria: • There is congenital absence of breast tissue unilaterally ***(affecting one breast only)*** of three or more cup size difference as measured by a specialist. **AND** • The patient's BMI is under 25 and has been stable for at least 12 months **AND** • Aged over 18 years old.	

Evidence for inclusion and threshold

1. NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80
2. NICE Quality Standard 12 – Breast Cancer (2016) - Weblink: https://www.nice.org.uk/guidance/qs12
3. British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) - Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0
4. Breast Cancer Care – Breast Reconstruction - Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction
5. Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800
6. Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46.
7. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45.
8. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64.
9. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf
10. Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050.
11. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service*

14.3a Silicone Breast Implant Removal Surgery: Breast Reconstruction

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was carried out by the NHS. ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was	**Policy Statement** Silicone breast implant removal is restricted in accordance with the minimum eligibility criteria. **Minimum eligibility criteria** The removal of **ruptured** silicone implants will only be commissioned in the following circumstances: • Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only but will **not** replace them.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: B303* *ICD exclusions: T854*

14.3a Silicone Breast Implant Removal Surgery: Breast Reconstruction		
undertaken at a private clinic/hospital which no longer exists. ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was undertaken at a private clinic/hospital who have refused a request to remove the implants.	Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.	
Evidence for inclusion and threshold		
1. Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group - Department of Health (June 2012). 2. NHS Choices: PIP breast implants - http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx 3. NHS Choices: Breast Enlargement - http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx 4. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service		

14.3b Breast Reconstruction Surgery: Silicone Breast Implant Replacement (Cosmetic or Non-Cosmetic Purposes)		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 14.3a Silicone breast implant replacement for cosmetic or non-cosmetic purposes is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: B302, B303, B304* *ICD exclusions: T854*
Evidence for inclusion and threshold		
Please refer to 14.3a		

14.4 Mastopexy: Breast Lift Surgery

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin030 – Mastopexy (breast lift)

14.5 Nipple Inversion Surgical Correction

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin035 – Nipple inversion, surgical correction

14.7 Electrolysis/Laser Therapy: Hair Removal

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has undergone reconstructive surgery leading to abnormally located hair-bearing skin.
- ☐ The patient is undergoing treatment for pilonidal sinuses, to reduce recurrence.

Policy Statement
Hair removal using electrolysis/laser therapy is restricted in accordance with the minimum eligibility criteria.

Summary of Intervention
Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.
Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or middle eastern descent.

Minimum eligibility criteria
The CCG will fund this treatment if the patient meets the following criteria:

- Has undergone reconstructive surgery leading to abnormally located hair-bearing skin

OR

- Is undergoing treatment for pilonidal sinuses to reduce recurrence

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
A range of treatment options are available:

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

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD inclusions (Diagnosis driven):
OPCS4: S606, S607
ICD inclusions: L680, L681, L682, L683, L688, L689

Evidence for inclusion and threshold

1. British Association of Dermatologists - hirsuitism patient information leaflet - Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document
2. NHS Choices – Laser Hair Removal - Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx
3. Pan Mersey APC Guidance for Eflornithine: http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=3067063562016122111329

14.8 Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin038 – Pectus Deformity, surgical treatment

14.9 Scar Revision Surgery

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has severe post-burn scarring.
- ☐ The patient has severe traumatic scarring.
- ☐ The patient requires revision surgery for scars following complications of surgery.
- ☐ The patient requires revision surgery for keloid formation or other hypertrophic scar formation as the scarring is causing significant functional disability.
- ☐ The patient requires revision surgery for keloid formation or other hypertrophic scars to restore normal function.

Policy Statement
Surgical revision of scars is restricted in accordance with the minimum eligibility criteria.

Summary of Intervention
The different types of scars include:

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

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

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

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

Minimum eligibility criteria
The CCG will fund this treatment if the patient meets the following criteria:

- For severe post burn cases or severe traumatic scarring

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD inclusions (Diagnosis driven):
OPCS4: S604
ICD inclusions: L905, L910

14.9 Scar Revision Surgery		
	OR • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	
Evidence for inclusion and threshold		
1. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service 2. NHS Choices – Scars – Treatment - http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx		

14.10 Tattoo Laser Removal		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Laser tattoo removal is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Summary of Intervention** Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks. The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all. **Rationale** Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. A good summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmeticsurgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: S091, S092* *ICD inclusions: L818*

14.10 Tattoo Laser Removal

Evidence for inclusion and threshold

1. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
2. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
3. NHS Choices – The NHS Guide to cosmetic procedures - Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx

14.11 Abdominoplasty/Apronectomy: Tummy Tuck

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin099 – Abdominoplasty or Apronectomy (tummy tuck)

14.12 Thigh, Buttock or Arm Lift Surgery: Excision of Redundant Skin or Fat

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin006 – Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty)

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)

CATEGORY 1 – NOT ROUTINELY COMMISSIONED
Individual Funding Request (Exceptional Case) Approval

Policy Statement
Surgical treatments for alopecia and male pattern baldness, including hair transplantation and hair intralace systems, are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.

The NHS has a policy for Wigs which may be an alternative option for patients:
http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx
The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.

Alopecia
Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.
In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour.
Some people go on to develop a more severe form of hair loss, such as:

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: S211, S212, S331, S332, S333, S338, S339, S218, S219
ICD exclusions: Z410, L630, L631, L632, L638, L639, L640, L648, L649, L650, L651, L652, L658, L659

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)		
	• Alopecia totalis (no scalp hair) • Alopecia universalis (no hair on scalp or body) Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It is more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome. It is also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition. Alopecia areata can occur at any age, although it's more common in people aged 15-29. It affects one or two people in every 1,000 in the UK. Further information can be found at following link: http://www.alopeciaonline.org.uk/treatments-and-wigs.asp **Hair transplantation** A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant is not normally available on the NHS, as it is regarded as cosmetic surgery. **Male Pattern Baldness** Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties. It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon. Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.	
Evidence for inclusion and threshold		
1. British Association of Dermatologists - alopecia areata patient information leaflet - Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document 2. Interventions for alopecia areata – Cochrane Library 2008. 3. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf		

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)

4. 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.
5. No evidence of effective treatments for alopecia – Cochrane Pearls 2008.
6. NICE Clinical Knowledge Summaries 2014. https://cks.nice.org.uk/alopecia-areata
7. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
8. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
9. NHS Choices – Guide to Hair Loss Treatment - Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx
10. **Hair transplantation** - *A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697.
11. Modernisation Agency's Action on Plastic Surgery 2005.
12. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin077 – Labiaplasty, vaginoplasty and hymenorrhaphy

14.17 Liposuction: Excess/Unwanted Fat Removal

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin0100 – Liposuction

14.18 Rhytidectomy: Face or Brow Lift

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin042 – Rhytidectomy

15. Respiratory

15.1 Snoring in the Absence of OSA Surgery (Adult)

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin043 – Simple snoring, surgical management

16. Trauma and Orthopaedics

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient has low back pain (with or without sciatica).
- ☐ The treatment is being requested as part of a treatment package which includes exercise (with or without psychological therapy).

Policy Statement
Spinal mobilisation, manipulation, soft tissue techniques and massage for back pain with or without sciatica is restricted in accordance with the Minimum Eligibility Criteria.

Summary of Intervention
Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer. Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous.
Most people will tend to suffer from back pain at some point in their lives and indeed it may recur.
Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities.
For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that is the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery.
If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help.
Early advice from your GP should be sought if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor.

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD inclusions (Diagnosis driven):
*OPCS4: A706, V501, V509, X613 with secondary coding for levels of spine V55**
ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, M544, M5440, M5445, M5446, M5447, M5448, M5449, M5416

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica

Minimum Eligibility Criteria

Acupuncture

Acupuncture for low back pain and sciatica is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.

Manual Therapy

The following procedures are **not routinely commissioned**:

- Lumbar traction
- Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)
- Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation.

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

Orthotics

The following are **not routinely commissioned**:

- Foot orthotics
- Rocker shoes
- Belts and corsets

Electrotherapy

The following are **not routinely commissioned:**

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

Pharmacological interventions

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

- Paracetamol used alone
- Selective serotonin re-uptake inhibitors (**SSRIs**)
- Serotonin– norepinephrine reuptake inhibitors

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica		
	• Tricyclic antidepressants • Anti-convulsants • Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol) Patients with neuropathic pain should be managed in line with NICE CG 173: Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia) 1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. 1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use). 1.1.11 Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. ***Treatments that should not be used*** 1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.	

Evidence for inclusion and threshold

1. Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59
2. National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf
3. Osteoarthritis: the care and management of osteoarthritis in adults https://www.nice.org.uk/guidance/cg59
4. The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012) - http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf
5. Final_TAMARS_report[1].pdf

16.1b Opioids (including Tramadol): Low Back Pain Management:

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet ONE of the following statements: ☐ Weak opioids are being requested as the patient has acute back pain and NSAIDS are contraindicated, ineffective or cannot be tolerated. ☐ The patient requires tramadol for acute rescue therapy only.	**Policy Statement** Please refer to 16.1a Opioids for management of low back pain including tramadol is restricted in accordance with the minimum eligibility criteria.	***Version:*** *20/02/2018* ***Clinical Coding:*** *Medication – no codes applicable.*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.1c Capsaicin Cream, Cannabis Sativa Extract, Capsaicin Patch, Lacosamind, Lamotrigine, Levetiracetam, Morphine, Oxcarbazepine, Topiramate, Tramadol (for Long-Term Use), Venlafaxine: Lower Back Neuropathic Pain Treatment

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The requested treatment is capsaicin cream (only), and the patient has localised neuropathic pain and wishes to avoid or cannot tolerate oral treatments. ☐ The treatment requested is cannabis sativa extract, capsaicin patch, lacosamind, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, tramadol (for long-term use) or venlafaxine AND the treatment has been initiated or advised for this patient by a secondary or tertiary care specialist.	**Policy Statement** Please refer to 16.1a Capsaicin cream, cannabis sativa extract, capsaicin patch, lacosamind, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, tramadol (for long-term use), venlafaxine as treatments for neuropathic pain is restricted in accordance with the minimum eligibility criteria.	***Version:*** *20/02/2018* ***Clinical Coding:*** *Medication – no codes applicable.*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.1d TENS, PENS, Ultrasound, Interferential and Laser Therapy: Low Back Pain and Sciatica		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 16.1a TENS, PENS, Ultrasound, Interferential and Laser therapy for low back pain and sciatica are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions and inclusions (Diagnosis driven):* *OPCS4: A704, A707 with secondary coding for levels of spine V55** *A704 (Insertion of neurostimulator electrodes into peripheral nerve)* *A707 (Application of transcutaneous electrical nerve stimulator)* *ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, M544, M5440, M5445, M5446, M5447, M5448, M5449, M5416*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.1e Paracetamol (Used Alone), SSRIS, Serotonin, Tricyclic Antidepressants, Anti-Convulsants: Back Pain without Neuropathic Pain		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 16.1a Paracetamol (used alone), SSRIs, Serotonin, tricyclic antidepressants, anti-convulsants as treatments for back pain without neuropathic pain are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.	***Version:*** *20/02/2018* ***Clinical Coding:*** *Medication – no codes applicable.*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.2a Spinal Imaging Emergency Referral: Low Back Pain
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin086 – Low Back Pain Imaging

16.2b Spinal Priority Imaging (Protocol Led MRI Whole Spine Unless Contraindicated): Low Back Pain
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin086 – Low Back Pain Imaging

16.3a Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin060 – Spinal Injections for Low Back Pain

16.3b Radiofrequency Denervation: Low Back Pain without Sciatica (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin089 – Chronic Low Back Pain, Radiofrequency Denervation

16.3c Spinal Injections including Facet Joint Injections, Therapeutic Medial Branch Blocks (i.e. Not Diagnostic), Intradiscal Therapy, Prolotherapy and Trigger Point Injections (excluding Epidurals): Low Back Pain (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin060 – Spinal Injections for Low Back Pain

16.4 Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation

16.5 Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division

16.6 Spinal Fusion; Non-Rigid Stabilisation Techniques; Lateral Body Fusion in the Lumbar Spine; Transaxial Interbody Lumbrosacral Fusion; Anterior Lumbar Interbody Fusion (ALIF); Posterior Lumbar Interbody Fusion (PLIF); or Any Other Combination of Approach where Surgical Fixation is Performed: Spinal Fixation:

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain
CMICB_Clin090 – Non-rigid stabilisation techniques for degenerative disease of the lumbar spine

16.7 Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient presents with severe and acute sciatica.
- ☐ The patient has failed to respond to conservative intervention.
- ☐ Imaging findings are concordant with clinical presentation.
- ☐ The treatment being requested is NOT one of the following: endoscopic laser foraminoplasty; endoscopic lumbar decompression; percutaneous disc decompression using coblation for lower back pain;

Policy Statement
Spinal decompression i.e. laminectomy, discectomy, facetectomy and foraminotomy are restricted in accordance with the minimum eligibility criteria.

Summary of Intervention
Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.
It is only recommended when non-surgical treatments have not helped.
The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.
Lumbar decompression surgery is often used to treat:

- spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside
- a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: V25, V528 (with secondary qualifier of Y261), V563, V603, V623*
ICD exclusions: G551, M511, M512

16.7 Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression		
percutaneous intradiscal laser ablation in the lumbar spine; automated percutaneous mechanical lumbar discectomy; prosthetic interverterbal disc replacement in the lumbar spine; intradiscal electro thermal annuloplasty; or percutaneous intradiscal radiofrequency thermocoagulation.	• spinal injuries – such as a fracture or the swelling of tissue • metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves. **Minimum eligibility criteria** Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where: • Patient presents with severe and acute sciatica **AND** • have failed to respond to conservative intervention **AND** • have imaging findings concordant with clinical presentation Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network. The following procedures are NOT routinely commissioned: • Endoscopic Laser Foraminoplasty • Endoscopic Lumbar Decompression • Percutaneous Disc Decompression using Coblation for Lower Back Pain • Percutaneous Intradiscal Laser Ablation in the Lumbar Spine • Automated Percutaneous Mechanical Lumbar Discectomy • Prosthetic Intervertebral Disc Replacement in the Lumbar Spine • Intradiscal Electro Thermal Annuloplasty (IDET) • Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)	

Evidence for inclusion and threshold

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

16.8 Bone Morphogenetic Protein (Dibotermin Alfa and Eptotermin Alfa): Non-Healing Fractures

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The requested treatment is Dibotermin Alfa, to be used as an adjunct to standard care of acute tibial fractures, including open fracture reduction and intramedullary unreamed nail fixation for a patient aged 18+ ☐ The requested treatment is Eptotermin Alfa to treat non-union of a fracture of the tibia which occurred secondary to trauma and has persisted for at least 9 months, where previous treatment with autograft has failed or is unfeasible and the patient is skeletally mature.	**Policy Statement** Dibotermin Alfa and Eptotermin Alfa (bone morphogenetic protein) for non-healing fractures are restricted in accordance with the minimum eligibility criteria.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: X923* *ICD inclusions: M8416, S822*

Evidence for inclusion and threshold

1. Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007.
2. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI
3. Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013
4. BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.

16.9 Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin036 – Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid)

16.10 Steroid Joint Injections (Secondary Care Administered): Joint Pain

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin037 – Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids

16.11a Hip Replacement Surgery: Hip Joint Damage

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin084 – Hip and knee replacement surgery

16.11b Hip Resurfacing: Hip Joint Damage

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin084 – Hip and knee replacement surgery

16.12 Hip Arthroscopy: Hip Impingement Syndrome/Femoro–Acetabular Impingement

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ An orthopaedic surgeon who specialises in young adult hip surgery has, in collaboration with a specialist musculoskeletal radiologist, diagnosed the patient as having femoro-acetabular impingement (hip impingement syndrome) having regard to appropriate investigations e.g. X-ray, MRI and CT scans.
- ☐ The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.
- ☐ The patient's symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.

Policy Statement
Hip arthroscopy for femoro-acetabular impingement is restricted in accordance with the minimum eligibility criteria.

Minimum Eligibility Criteria
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 the following criteria:

- A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.
- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.
- The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.
- The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.

Rationale
Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term.
With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.

Version: *2014/2015*

Clinical Coding:
OPCS with ICD inclusions (Procedure driven):
OPCS4: W84 with Z756*
ICD inclusions: M2585

16.13 Knee Arthroplasty

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin084 – Hip and knee replacement surgery

16.14a Diagnostic Knee Arthroscopy: Knee Arthritis without Osteoarthritis

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears

16.14b Diagnostic Knee Arthroscopy: Knee Arthritis with Osteoarthritis

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears

16.15 Knee Arthroscopy: Knee Osteoarthritis

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement

16.16 Uni-compartmental Knee Replacement (Patient Specific): Knee Osteoarthritis

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
ICB Policy CMICB_Clin094 – Patient-specific unicompartmental knee replacement

16.17 Total Knee Replacement (Patient Specific)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin047 – Total Knee Arthroplasty, patient specific instrumentation/implants

16.18 Trigger Finger/Thumb Surgical Release (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin048 – Trigger Finger release in adults

16.19a Collagenase Injection: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin016 – Dupuytren's Contracture release in adults

16.19b Needle Fasciotomy, Fasciectomy And Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults): (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin016 – Dupuytren's Contracture release in adults

16.20 Carpal Tunnel Syndrome Surgical Release (NHS England Evidence Based Intervention)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin010 – Carpal Tunnel interventions and surgery

16.21 Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin033 – Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal

16.22 Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts)
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin022 – Ganglia, surgical removal and general management

16.23 Bunion or Lesser Toe Deformity Surgery

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin008 – Bunions, surgical removal

16.24 Morton's Neuroma Surgical Treatment

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin032 – Morton's Neuroma, surgical treatment

16.25 Plantar Fasciitis Surgical Treatment

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient is experiencing significant pain or their symptoms are having a serious impact on their daily life.
- ☐ The patient has been referred to a podiatrist or physiotherapist.
- ☐ The patient has had 3 months of conservative treatments including footwear modification, stretching exercises, ice packs and weight loss (if patient is overweight) and has failed to respond to these treatments.
- ☐ The patient has not responded to corticosteroid injections.

Policy Statement
Surgical treatment of plantar fasciitis is restricted in accordance with the minimum eligibility criteria.

Minimum Eligibility Criteria
Surgical Treatment is not routinely commissioned unless the following pathway has been followed:

- Patient has documented evidence that they are not responding to conservative treatments
- Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following:
  - Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss
  - Been referred to a podiatrist or physiotherapist
  - Not responded to corticosteroid injections

Version: *2014/2015*

Clinical Coding:
OPCS with ICD inclusions (Diagnosis driven):
OPCS4: T542, T523
ICD inclusions: M722

16.25 Plantar Fasciitis Surgical Treatment

Evidence for inclusion and threshold

1. Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.
2. Plantar fasciitis - NICE Clinical Knowledge Summaries (2009).
3. Plantar fasciitis - BMJ 2012;345:e6603.

16.26 Extracorporeal Shock Wave Therapy / Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin001 - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections

16.27 Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin092 – Subacromial shoulder pain, arthroscopic shoulder decompression surgery

17. Urology

17.1a Circumcision for Medical Reasons

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin104 – Penile circumcision in children and young people under 16 years

17.1b Circumcision for Social, Cultural or Religious Reasons

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin104 – Penile circumcision in children and young people under 16 years

17.3 Male Sterilisation Reversal: Infertility

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
ICB Policy CMICB_Clin040 – Reversal of Male Sterilisation

17.4 Extracorporeal Shockwave Therapy (ESWT): Prostadynia or Pelvic Floor Syndrome

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin111 – Chronic Pelvic Pain Syndrome in Men, Hyperthermia, Extracorporeal Shockwave Therapy and Sacral Neuromodulation

17.5 Hyperthermia Treatment: Prostadynia or Pelvic Floor Syndrome

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin111 – Chronic Pelvic Pain Syndrome in Men, Hyperthermia, Extracorporeal Shockwave Therapy and Sacral Neuromodulation

17.6a Prostatism/Lower Urinary Tract Specialist Assessment Referral

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has lower urinary tract symptoms complicated by recurrent or persistent urinary tract infections.
- ☐ The patient has retention.
- ☐ The patient has renal impairment and lower urinary tract dysfunction is suspected.
- ☐ Urological cancer is suspected.
- ☐ The patient has stress urinary incontinence.
- ☐ The patient has failed a trial of appropriate drug therapies or conservative management options.

Policy Statement
Treatments for Prostatism or Lower Urinary Tract symptoms are restricted in accordance with the minimum eligibility criteria.

Summary of Intervention

Prostate problems are common, particularly in men aged over 50. The prostate is a small gland found only in men. It surrounds the tube that carries urine out of the body (urethra). The prostate gland produces a thick, white fluid that gets mixed with sperm to create semen.
The prostate gland is about the size and shape of a walnut but tends to get bigger as you get older. It can sometimes become swollen or enlarged by conditions such as:

- prostate enlargement
- prostatitis (inflammation of the prostate)
- prostate cancer

Minimum Eligibility Criteria

Version: *11/03/2020*

Clinical Coding:
No specific clinical coding

17.6a Prostatism/Lower Urinary Tract Specialist Assessment Referral

Refer patients for **specialist assessment** if they have one or more of the following symptoms:

- lower urinary tract symptoms complicated by recurrent or persistent urinary tract infections
- retention
- renal impairment you suspect is caused by lower urinary tract dysfunction
- suspected urological cancer
- stress urinary incontinence
- Failed a trial of the appropriate drug therapies or conservative management options.

Surgery for Prostatism will only be funded under the following circumstances:

- **For Voiding Symptoms** only if voiding symptoms are severe

AND

- conservative management options have failed or are not appropriate

For Storage Symptoms only if conservative management options have failed or are not appropriate

In both scenarios refer to https://pathways.nice.org.uk/pathways/lower-urinary-tract-symptoms-in-men#content=view-index&path=view%3A/pathways/lower-urinary-tract-symptoms-in-men/lower-urinary-tract-symptoms-in-men-overview.xml for guidance

Rationale

This is because LUTS are a major burden for the ageing male population. Age is an important risk factor for LUTS and the prevalence of LUTS increases as men get older. Bothersome LUTS can occur in up to 30% of men older than 65 years. This is a large group potentially requiring treatment.

Evidence for inclusion and threshold

1. NHS Choices – Prostate Problems - https://www.nhs.uk/conditions/prostate-problems/
2. Lower urinary tract symptoms in men: management Clinical guideline [CG97] Published date: May 2010 Last updated: June 2015 https://www.nice.org.uk/guidance/cg97/chapter/Introduction
3. See overview of NICE's recommendations for the treatment of lower urinary tract symptoms in men: https://pathways.nice.org.uk/pathways/lower-urinary-tract-symptoms-in-men

17.6b Prostatism Surgical Intervention

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The surgery is for severe voiding symptoms and conservative management options have failed or are not appropriate. ☐ The surgery is for storage symptoms and conservative management options have failed or are not appropriate.	**Policy Statement** Please refer to section 17.6a Prostatism Surgery is restricted in accordance with the minimum eligibility criteria.	***Version: 11/03/2020*** ***Clinical Coding:*** *No specific clinical coding*

Evidence for inclusion and threshold

Please refer to section 17.6a

18. Vascular Surgery

18.1 Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management

18.2 Chelation Therapy: Vascular Occlusions

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin015 – Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction

18.3a Vascular Service Referrals: Varicose Veins (Legs Only)

(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin049 – Varicose Veins

18.3b Varicose Veins: Compression Hosiery Treatment
(NHS England Evidence Based Intervention)

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin049 – Varicose Veins

19. Other

19.1a Botulinum Toxin A
Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The treatment is for anal fissure which have not healed in response to a minimum of eight weeks of topical management with lifestyle advice and topical pharmaceutical products and they have NOT already completed 2 courses of botulinum toxin A injections to treat their fissure(s).
- ☐ The treatment is for severe axillary hyperhidrosis which has not been adequately controlled by topical chloride or other extra-strength antiperspirants AND they do not have a social anxiety disorder. They have a baseline score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS), AND the patient has NOT already completed 2 courses of botulinum toxin A.
- ☐ Botulinum toxin type A will be prescribed and administered under the supervision of a specialist designation neurological centre for a patient diagnosed with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) who has not responded to at least three prior pharmacological

Policy Statement
Botulinum Toxin A is restricted in accordance with the minimum eligibility criteria.
Botulinum Toxin B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.

Botulinum toxin is a protein produced by clostridium botulinum bacteria and related species. When injected into the body it affects the nervous system and it can be used to treat a number of disorders that cause excessive or abnormal muscle movement. These include spasticity that results from a stroke or a spinal cord injury, and spasms in the head and neck, eyelid, vagina, limbs, jaw or vocal cords. Botox can also be used to relax clenched muscles (for example, when people grind their teeth in their sleep) and to correct eye alignment ("crossed eyes").

A number of botulinum toxin type A products are commercially available (including Botox®, Dysport®, Xeomin®). Other brands are available but are only licensed for cosmetic procedures (Allergan).

Minimum Eligibility Criteria

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

The use of Botulinum type A is commissioned for the following indications and provided the eligibility criteria are met:

Version: *01/10/2020*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: S532 with a secondary code of X851
ICD exclusions: G243, G245, G248, G35X, G43, G513, K117, K601, N328, Q438*
NB: coding is not medication specific.

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

prophylaxis therapies AND their condition is appropriately managed for medication overuse AND the treatment requested is in line with NICE TA260. ☐ The patient has a blepharospasm and hemifacial spasm. ☐ The patient has multiple sclerosis with probable contracture of joint and Botulinum Toxin A is to be used in line with NICE Clinical Guideline 186 i.e. where other measures are inappropriate or ineffective; AND in conjunction with prolonged stretching modalities. ☐ The patient has focal dystonia and other treatment measures are inappropriate or ineffective. ☐ The patient has focal spasticity with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries or other neurodegenerative disease, where other measures are inappropriate or ineffective. ☐ The patient has idiopathic cervical dystonia (spasmodic torticollis). ☐ The patient is a woman with urinary incontinence caused by refractory detrusor overactivity where conservative therapy and conventional drug treatment has failed to control symptoms AND the patient is able and willing to self-catheterise AND treatment will be in line with NICE Clinical Guideline 171. ☐ The patient is a man with urinary incontinence caused by refractory detrusor overactivity where conservative therapy and conventional drug treatment has failed to control symptoms AND the patient is able and willing to self-catheterise AND treatment will be in line with NICE Clinical Guideline 97.	**Anal fissures** *A maximum of two courses of Botulinum toxin type A is recommended as a treatment option in patients with chronic anal fissure that has not healed despite at least 8 weeks of topical management.* It has a similar mechanism of action to topical products. The preferred first line topical product is 0.4% glyceryl trinitrate (GTN) ointment, the only licensed non-surgical option available in the UK. Unlicensed topical 2% diltiazem oitment and unlicensed topical 0.2% GTN ointment are alternatives if there has been a partial response to topical 0.4% GTN but intolerance such as headache has necessitated discontinuation. For patients who proceed to treatment with botulinum toxin type A and whose fissure has not healed after one course of injections, alternative options for on-going management should be considered. However, where the specialist determines there has been a partial response to the first course, a second course may be considered particularly for patients where surgery is less suitable. To assist with healing and prevention of recurrence of fissures, patients should be encouraged to eat a high fibre diet and use laxatives if necessary. For the use of Botulinum toxin type A in treating Anal Fissures, refer also to the Pan Mersey Area Prescribing Committee Prescribing policy statement ***BOTULINUM TOXIN Type A injection for chronic anal fissure***: https://www.panmerseyapc.nhs.uk/media/1568/botulinum_anal.pdf **Hyperhidrosis** *A maximum of two courses of Botulinum toxin type A is recommended as a treatment option in patients with severe axillary hyperhidrosis that has not been adequately controlled by topical aluminium chloride or other extra-strength antiperspirants*. Severe axillary hyperhidrosis is indicated by a baseline score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS). The first line treatment for primary axillary hyperhidrosis is aluminium chloride hexahydrate 20% solution, the only licensed treatment that can be prescribed in primary care in the UK. Unlicensed or off label topical and oral treatments may be considered under specialist recommendation but there is weak evidence of their effectiveness. For patients who proceed to treatment with botulinum toxin type A and who do not have a clinical response after one treatment session, consider alternative options for on-going management. A clinical response is indicated by more than a 2-point improvement from baseline on the HDSS scale or more than a 4-point improvement from baseline on the Dermatology Life Quality Index (DLQI).	

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

☐ The patient has sialorrhoea (excessive salivary drooling) and all other treatments have failed. ☐ The patient is to be treated with Xeomin (botulinum neurotoxin type A) in line with NICE TA 605, AND is an adult with chronic sialorrhoea (excessive salivary drooling) caused by neurological condition AND all other treatments have failed.	Botulinum toxin type A should not be offered to treat hyperhidrosis in people with social anxiety disorder - NICE CG159 (May 2013). For the use of Botulinum toxin type A in treating Hyperhidrosis, refer also to the Pan Mersey Area Prescribing Committee Prescribing policy statement ***BOTULINUM TOXIN TYPE A injection for Severe Axillary Hyperhidrosis:*** https://www.panmerseyapc.nhs.uk/media/1067/botulinum_hyperhidrosis.pdf BOTULINUM TOXIN TYPE A is not routinely commissioned for non-axillary hyperhidrosis. **Migraine** Botulinum toxin type A is recommended as a treatment option for the prophylaxis of headaches in adults with migraine in accordance with NICE TA 260 (June 2012). NICE recommend Botulinum toxin type A as an option for the 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. Treatment with botulinum toxin type A should be stopped in people whose condition: • is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) OR • has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months. Botulinum toxin type A for the prophylaxis of migraine will be prescribed and administered under the supervision of a specialist designation neurological centre. **Botulinum Toxin A is also commissioned in the following indications:** Blepharospasm and hemifacial spasm Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities where other measures are inappropriate or ineffective (i.e. in line with NICE Clinical Guideline 186). https://www.nice.org.uk/guidance/cg186 Focal dystonia, where other measures are inappropriate or ineffective. Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. Idiopathic cervical dystonia (spasmodic torticollis).	

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

	Urinary incontinence due to refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 (updated November 2015) and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 (updated June 2015)where conservative therapy and conventional drug treatment has failed to control symptoms and the patient is able and willing to self-catheterise. Sialorrhoea (excessive salivary drooling), when other treatments have failed. In addition, Xeomin® (botulinum neurotoxin type A), is recommended as an option for treating chronic sialorrhoea caused by neurological conditions in adults. https://www.nice.org.uk/guidance/ta605 https://www.panmerseyapc.nhs.uk/media/2323/botulinum_sialorrhoea.pdf **Botulinum Type B** The use of Botulinum toxin type B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** Botulinum toxin can be used to treat various medical conditions and is an effective way to reduce pain and decrease muscle spasms. It is not commissioned for cosmetic reasons.	

Evidence for inclusion and threshold

1. NICE Technology Appraisal 159 relating to the treatment of hyperhidrosis in people with social anxiety disorder: https://www.nice.org.uk/guidance/cg159
2. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of severe axillary hyperhidrosis: https://www.panmerseyapc.nhs.uk/media/1067/botulinum_hyperhidrosis.pdf
3. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of Chronic anal fissure: https://www.panmerseyapc.nhs.uk/media/1568/botulinum_anal.pdf
4. NICE Technology Appraisal 260 relating to the treatment of migraines: https://www.nice.org.uk/guidance/ta260
5. Spasticity in under 19s: management (CG145 Updated November 2015) https://www.nice.org.uk/guidance/cg145/chapter/1-guidance
6. NHS Choices: Dystonia
7. http://www.nhs.uk/conditions/dystonia/Pages/Introduction.aspx
8. MHRA Report on Botox produced by Allergan (?)
9. http://www.mhra.gov.uk/home/groups/par/documents/websiteresources/con108643.pdf
10. Multiple sclerosis in adults: management, Clinical guideline [CG186] Published date: October 2014
11. https://www.nice.org.uk/guidance/cg186
12. Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 (updated November 2015) and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 (updated June 2015)
13. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of chronic sialorrhoea caused by neurological conditions in adults

19.1a Botulinum Toxin A Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.
14. https://www.panmerseyapc.nhs.uk/media/2323/botulinum_sialorrhoea.pdf 15. Xeomin (botulinum neurotoxin type A) for treating chronic sialorrhoea in line with NICE TA605 (October 2019) https://www.nice.org.uk/guidance/ta605

19.1b Botulinum Toxin B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 19.1a Botulinum Toxin B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *01/10/2020* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: S532 with a secondary code of X851* *ICD exclusions: G243, G245, G248, G35X, G43*, G513, K117, K601, N328, Q438* *NB: coding is not medication specific.*
Evidence for inclusion and threshold		
Please refer to 19.1a		

Appendix 1 – Glossary

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

Term	Meaning
Paediatric(ian)	Medical care concerning infants, children and adolescents usually under 18.
Pathology/pathological	The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing.
PCT	Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups).
PLCP	Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances.
Precipitates	Brings about/triggers.
Primary care	a patient's first point of interaction with NHS services e.g. a GP surgery.
Rationale	Explanation of the reason why.
Restricted (a procedure)	This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.
Secondary care	Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services.
Stakeholders	Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc.
Symptomatic	Something causing or exhibiting symptoms.

Appendix 2 – Document Version Control

Document version control			
Version	**Version**	**Version**	**Version**

2.0	• Format edited for clarity and ease of reference:
	  • Amalgamation and removal of Sections A and B so policies are aligned to specialties
	  • Creation of a quick reference table of policies
	  • Content Page Update
	  • NHS England Evidence Based Interventions highlighted
	  • Policy Titles format consistency where possible – Intervention : Condition
	  • Policy Statements
	  • Policy Category Clarification
	  • Policy Monitoring Criteria
	  • Addition of Cosmetic treatments policy position statement
	  • Move of IFR Process diagram to Appendix 1
	  • Move of Glossary to Appendix 2
	  • Move of Version history to Appendix 3
	  • Re-numbering of Section 16 – Trauma and Orthopaedics
	• Inclusion of suite 3 policy revisions:
	  3.1 Continuous Glucose Monitoring Systems
	  3.2 Insulin Pumps (NEW)
	  4.2 Pinnaplasty
	  16.10 Secondary Care administered steroid peripheral joint injections policy (previously 16.20)
	  17.2 Trans Anal Irrigation Policy (NEW)
	  17.6 Surgery for Prostatism
	  19.1 Botulinum Toxin A & B
	• Removal of Policy 11.3 Surgical treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) policy as included in Benign Skin Lesions Policy.
	• Removal of IFR Process Flowchart as it does not apply equally to all of the collaboration
		MLCSU Policy Development Team	01/10/2020

5.0	Produced by the Midlands and Lancashire Commissioning Support Unit in collaboration with Cheshire and Merseyside ICB sponsors to support the transition from individual Clinical Commissioning Group (CCG) policies to a single suite of Cheshire and Merseyside Integrated Care Board (ICB) policies. This policy is amended to reflect the ICB policy position as individual ICB policies are completed and published. This version involves the redaction of the following policies:	MLCSU Policy Development Team	01/04/2023

Document version control			
Version	**Version**	**Version**	**Version**
	2.2 Benign Skin Lesions: Surgical Removal 2.4 Skin Pigment Disorder: Biopsy or Camouflage 4.1 Adenoidectomy 4.3a Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear 4.4 Tonsillectomy: Recurrent Tonsillitis 4.5 External Ear Lobe: Surgical remodelling 4.6 Sinus X-ray: Rhinosinusitis or Sinusitis 4.8 Rhinophyma Surgery or Laser Treatment 7.1 Haemorrhoids Surgical Removal 7.2b Diastasis of the Recti Surgical Correction 7.3 Gallstones (Asymptomatic) Surgical Treatment 8.1a Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology 8.1b Hysterectomy: Heavy Menstrual Bleeding – Fibroids ≥3cm in Diameter 8.1c Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids 8.2 Dilatation and Curettage (D&C): Heavy Menstrual Bleeding 11.4 Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction: Surgery or Laser Treatment 11.6 Coloured filters: Irlens Syndrome/Dyslexia 11.7 Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration 11.8 Chalazia (Meibomian Cyst) Surgical Removal 13.1 Cranial Banding: Positional Plagiocephaly 14.1a Bilateral Breast Reduction Surgery: Breast Macromastia 14.1b Unilateral Breast Reduction Surgery: Breast Asymmetry 14.4 Mastopexy: Breast Lift Surgery 14.5 Nipple Inversion Surgical Correction 14.8 Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction 14.12 Thigh, Buttock or Arm Lift Surgery: Excision of Redundant Skin or Fat 14.18 Rhytidectomy: Face or Brow Lift 15.1 Snoring in the Absence of OSA Surgery (Adult) 16.4 Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain 16.5 Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain 16.9 Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain 16.10 Steroid Joint Injections (Secondary Care Administered): Joint Pain		

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Version	**Version**	**Version**	**Version**
	16.14a Diagnostic Knee Arthroscopy: Knee Arthritis without Osteoarthritis 16.14b Diagnostic Knee Arthroscopy: Knee Arthritis with Osteoarthritis 16.15 Knee Arthroscopy: Knee Osteoarthritis 16.17 Total Knee Replacement (Patient Specific) 16.18 Trigger Finger/Thumb Surgical Release 16.19a Collagenase Injection: Dupuytren's Contracture Release (Adults) 16.19b Needle Fasciotomy, Fasciectomy And Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults): 16.20 Carpal Tunnel Syndrome Surgical Release 16.21 Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal 16.22 Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts) 16.23 Bunion or Lesser Toe Deformity Surgery 16.24 Morton's Neuroma Surgical Treatment 16.26 Extracorporeal Shock Wave Therapy / Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow 17.3 Male Sterilisation Reversal: Infertility 18.1 Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating) 18.2 Chelation Therapy: Vascular Occlusions 18.3a Vascular Service Referrals: Varicose Veins (Legs Only) 18.3b Varicose Veins: Compression Hosiery Treatment		
6.0	Policy document amended to include hyperlinks to ICB policies. (Phase 1)	MLCSU Policy Development Team	09/2023
7.0	Policy document amended to include hyperlinks to ICB policies. (Phase 2)	MLCSU Policy Development Team	18/03/2024