Midlands and Lancashire
Commissioning Support Unit

# Criteria Based Clinical Treatments

## Amended September 2023

**Provided by:**
NHS Halton CCG
NHS Liverpool CCG
NHS Southport and Formby CCG
NHS South Sefton CCG
NHS Warrington CCG

## Version control

| | |
|---|---|
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| **Purpose** | This document is part of a suite of policies that the Clinical Commissioning Group (CCG) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite. |
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| **Author (inc Job Title):** | Midlands and Lancashire Commissioning support Unit – Policy Development Programme |
| **Ratified by:**<br><br>**(Name of responsible Committee)** | Produced in collaboration and ratified by the following CCG Governing Bodies (May 2019)<br>• NHS Halton CCG<br>• NHS Liverpool CCG<br>• NHS Southport and Formby CCG<br>• NHS South Sefton CCG<br>• NHS St Helens CCG<br>• NHS Warrington CCG |
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| 1.7 | Amendments to overall policy to include policies issued in May 2018 under the Clarification document. This covers the updated policies for<br>A2.2 Surgical Treatments for Minor Skin Lesions<br>A2.3 Policy for Surgical removal of Lipoma<br>A7.1 Policy for Hemorrhoidectomy. Rectal surgery and removal of haemorrhoidal and anal skin tags<br>A14.2 Augmentation Mammoplasty - Breast Enlargement | MLCSU Policy Development Team | 19/12/2018 |
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| | Dilatation & curettage for heavy menstrual bleeding in women<br>Knee arthroscopy for patients with osteoarthritis<br>Injection for nonspecific low back pain without sciatica<br>Breast reduction<br>Removal of benign skin lesions<br>Grommets for glue ear in children<br>Tonsillectomy for recurrent tonsillitis<br>Haemorrhoid surgery<br>Hysterectomy for heavy menstrual bleeding<br>Chalazia removal<br>Arthroscopic shoulder decompression for subacromial shoulder pain<br>Carpal tunnel syndrome release<br>Dupuytren's contracture release in adults<br>Ganglion excision<br>Trigger finger release in adults<br>Varicose vein interventions | | |
| 1.9 | Update to A14.6 Male Breast Reduction Surgery for Gynaecomastia. Policy now refers back to A14.1 Breast reduction | MLCSU Policy Development Team | 02/04/2019 |
| 1.10 | Remove all reference to '*Removal of Lipoma policy'* as now covered by EBI *'Removal of Benign Skin Lesions policy'*. | MLCSU Policy Development Team | 24/05/2019 |
| 1.11 | Policy amended and re-formatted to illustrate policy positions superseded by Cheshire and Merseyside ICB policies 01/04/2023 as | MLCSU Policy Development Team | 01/04/2023 |

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| **Version** | **Amendment** | **By who** | **Date amendment made** |
| | referenced and as listed in Appendix 1.<br>Readers should note the following standalone CCG commissioning policies are documented separately, outside of this document, these will be subject to review and update as part of the ICB's policy harmonisation programme of work:<br>• Gluten Free<br>• Pinnaplasty<br>• Subfertility | | |
| 1.12 | Policy document amended to include hyperlinks to ICB policies. | MLCSU Policy Development Team | 09/2023 |

# Table of Contents

# INTRODUCTION

## Purpose and Scope

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

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

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

## Context

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

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

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

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

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

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

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

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

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

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

## Background

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

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

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

## Principles

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

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

- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

## Core eligibility criteria

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

These core clinical eligibility criteria are as follows:

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

## Policy Categories

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

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

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

## Diagnostic Procedures

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

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

## Psychological factors

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

Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image, but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR .

## Lifestyle and surgery

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

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

## CBCT Referral/Treatment Listing Processes

### Primary Care

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

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

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

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

### Secondary Care

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

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

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

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

# IFR APPLICATIONS/CLINICAL EXCEPTIONALITY

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

In this scenario, should a patient not fulfil the clinical criteria, but the referring clinician is willing to support the application as clinically exceptional, the case can be referred to the IFR Panel for consideration. The person who fills in the IFR can be a consultant or a GP.

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

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

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

The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

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

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

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

Email addresses for Individual Funding Request teams at CCGs:

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

NHS

Midlands and Lancashire Commissioning Support Unit

| Key |
| --- |
| Further consideration |
| Exit point - FUND |
| Exit point – DO NOT FUND |
| Decision point |
| Exit point – service development |

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

# Application to consider a new Individual Funding Request

## SCREENING (DESKTOP REVIEW)

Is there a policy?

No

Yes

Is it a service development?

Yes

Funding Declined CCG Advised

No

Does the patient satisfy the policy?
(The procedure or treatment being requested could be either criteria based or not routinely commissioned)

Yes

Funding Approved CCG Advised

Is there a case for exceptionality?

No

Funding Declined CCG advised

Uncertain

## PANEL REVIEW

Yes

Panel

Funding Declined CCG Advised

Funding Approved CCG Advised

## Medicines

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

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

## Clinical Trials

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

## Photographic evidence

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

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

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

## Personal data

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

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

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

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

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

## Copies of this policy

Electronic copies of this policy can be found on the websites of the respective CCGs. Alternatively; you may contact the CCG and ask for a copy of the Criteria Based Clinical Treatments 2019-20 policy document.

## Monitoring and review

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

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

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

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

## Evidence

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

# GLOSSARY

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

| Term | Meaning |
|---|---|
| **Multi-disciplinary** | Involving several professional specialisms for example in a multi-disciplinary team (MDT). |
| **NICE guidance** | The guidance published by the National Institute for Health and Care Excellence. |
| **Not routinely funded (a procedure)** | This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **NSAIDS** | Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation. |
| **Paediatric(ian)** | Medical care concerning infants, children and adolescents usually under 18. |
| **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. |

# POLICY POSITIONS

A = Last reviewed 2019/21
B = Last reviewed 2014/15

## 1. Complementary Therapies

| B1.1 Complementary Therapies | |
|---|---|
| **Eligibility Criteria** | Not routinely commissioned<br>unless recommended by NICE guidance. |
| **Evidence** | *Complementary and alternative medicine*<br>– NHS Choices 2012.<br>http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/ |
| **Comments** | Individual CCG addendums apply. |

## 2. Dermatology

| B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels) | |
|---|---|
| **Eligibility Criteria** | Only be commissioned in the following circumstances:<br><br>Severe scarring following:<br><br>Acne once the active disease is controlled.<br><br>Chicken pox.<br>OR<br>Trauma (including post-surgical).<br>Procedures will only be performed on the head and neck area.<br>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br>Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. |
| **Evidence** | Modernisation Agency's Action on Plastic Surgery 2005.<br><br>Haedersdal, 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.<br><br>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 |

| B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels) | |
|---|---|
| | outcomes for PDT.<br><br>www.evidence.nhs.uk<br><br>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.<br><br>NHS England Interim protocol NHS England (2013)<br>Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. |

| A2.2 Policy for the Removal of Benign Skin Lesions |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin005 – Benign skin lesions, removal v1 01/04/2023 |

| B2.4 Treatments for Skin Pigment Disorders |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin009 – Camouflage Treatment for Skin Pigmentation and other disorders v1 01/04/2023 |

| B2.5 Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers | |
|---|---|
| **Eligibility Criteria** | Will be commissioned in any of the following circumstances:<br><br>Severe pain substantially interfering with functional abilities.<br>Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.<br>Extensive warts (particularly in the immune-suppressed patient).<br>Facial warts.<br>Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist. |
| **Evidence** | Modernisation Agency's Action on Plastic Surgery 2005.<br><br>Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>patient.co.uk/doctor/viral-warts-excluding-verrucae<br><br>http://www.patient.co.uk/doctor/verrucae |
| **Comments** | Most viral warts will clear spontaneously or following application of topical treatments. |

| B2.5 | Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers |
|---|---|
| | 65% are likely to disappear spontaneously within 2 years.<br><br>There are numerous OTC preparations available.<br><br>Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care. |

## 3. Diabetes

| B3.1 | Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus |
|---|---|
| See CCG separate standalone policy | |

## 4. ENT

| A4.1 | Policy for Adenoidectomy |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin002 – Adenoidectomy v1 01/04/2023 | |

| A4.2 | Policy for Pinnaplasty |
|---|---|
| See separate standalone policy | |

| A4.3a | Policy for Grommets for Glue Ear (Children) |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin023 – Grommets for glue ear in children v1 1/04/2023 | |

| B4.3b | Insertion of Grommets for Glue Ear (Adults) |
|---|---|
| **Eligibility Criteria** | Grommets in adults with OME will be funded only in the following circumstances:<br>• Significant negative middle ear pressure measured on two sequential appointments.<br>AND<br>• Significant ongoing associated pain.<br>OR<br>Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy. |

| B4.3b Insertion of Grommets for Glue Ear (Adults) | |
|---|---|
| **Evidence** | http://www.rcseng.ac.uk/healthcarebodies/docs/published-guides/ome<br>Royal College of Surgeons (2013).<br>http://www.england.nhs.uk/wpcontent/uploads/2013/11/N-SC015.pdf |

| A4.4 Policy for Tonsillectomy for Recurrent Tonsillitis |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin046 – Tonsillectomy v1 1/04/2023 |

| B4.5 Surgical Remodelling of External Ear Lobe |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin45 – Split (cleft) Earlobe, surgical repair v1 1/04/2023 |

| B4.6 Use of Sinus X-ray |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin44 – Sinus X-Ray v1 1/04/2023 |

| A4.7 Policy for Rhinoplasty | |
|---|---|
| **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. |
| **Policy Statement** | **Restricted**<br>a) Rhinoplasty is not routinely commissioned for cosmetic reasons.<br><br>b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. a septoplasty. |
| **Eligibility Criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• Documented medical breathing problems caused by obstruction of the nasal airway **OR**<br>• Correction of complex congenital conditions e.g. Cleft lip and palate<br>This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Rationale** | This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Rhinoplasty Guide<br>Weblink:<br>https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/ |

| B4.8 Surgery of Laser Treatment of Rhinophyma |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin41 - Rhinophyma, surgical management v1 1/04/2023 |

## 5. Equipment

| B5.1 Use of Lycra Suits | |
|---|---|
| **Eligibility Criteria** | Lycra Suits are not normally commissioned for postural management of cerebral palsy.<br><br>Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. |
| **Evidence** | What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy?<br><br>Health Improvement Scotland, May 2013.<br><br>For further references please refer to Public Health Lycra Suits Paper. |
| **Comments** | Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames.<br>Public Health Recommendation:<br>Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.<br>Lycra suit orthoses for cerebral palsy should be assigned low priority.<br>Individual CCG addendums apply.<br><br>PH Lycra Suits Paper.pdf |

## 6. Fertility/Assisted Conception

| B6.1 Infertility Treatment for Subfertility 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. General Surgery

| A7.1 Policy for Haemorrhoid Surgery |
|---|

This policy has been superseded by ICB Policy CMICB_Clin024 – Haemorrhoids, surgical management v1 01/04/2023

| A7.2 | Policy for Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and Surgical correction of Diastasis of the Recti |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin014 – Diastasis (divarication) of the Recti Repair v1 1/04/2023 | |

| A7.3 | Policy for Surgery for Asymptomatic Gallstones |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin021 – Gallstones (Asymptomatic), Surgical Management v1 1/04/2023 | |

| B7.4 | Lithotripsy for Gallstones |
|---|---|
| **Eligibility Criteria** | Lithotripsy not routinely commissioned. |
| **Evidence** | |
| **Comments** | Lithotripsy rarely performed as rate recurrence high. |

## 8. Gynaecology

| A8.1 | Policy for Hysterectomy for Heavy Menstrual Bleeding |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy v1 01/04/2023 | |

| A8.2 | Policy for Dilatation and Curettage (D&C) for Heavy Menstrual Bleeding in Women |
|---|---|
| This policy has been superseded by ICB Policy CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage v1 1/04/2023 | |

## 9. Mental Health

| B9.1 | Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) |
|---|---|
| **Eligibility Criteria** | Inpatient care for chronic fatigue syndrome is not routinely commissioned.<br><br>If inpatient treatment is recommended an IFR referral will be required. |

| B9.1 Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS) | |
|---|---|
| **Evidence** | *Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53.<br><br>*Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008.<br>*Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137.<br><br>*Cost-effectiveness of counselling, graded- exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care*<br>- BMC Health Services Research 2012, 12:264. |
| **Comments** | Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.<br><br>NICE section 1.915 states:<br><br>Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital |

| B9.3 Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services) | |
|---|---|
| **Eligibility Criteria** | This is not routinely commissioned. |
| **Evidence** | Interventions to reduce substance misuse among vulnerable young people –<br><br>NICE Public Health Guidance 4 (2007)<br><br>Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007).<br><br>Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence –<br><br>NICE Clinical Guideline 115 (2011). |

| A9.4 Policy for Private Mental Health Care | |
|---|---|
| **Summary of intervention** | Private Mental Health Care is not routinely commissioned because most mental health conditions can be managed in the community with input from Community Mental Health teams.<br><br>NHS England Specialist Commissioning provides NHS specialist services for various conditions including PTSD, eating disorders and severe OCD.<br><br>There is also a specialist NHS Mental Health service provided for affective disorders. |
| **Policy Statement** | Not Routinely Commissioned |

## 10. Neurology

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

| B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy | |
|---|---|
| **Eligibility Criteria** | Not routinely commissioned. |
| **Evidence** | Physical therapy for Bell's palsy (idiopathic facial paralysis).<br>Cochrane Database of Systematic Reviews.<br>Issue 12 (2011). |

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

## 11. Ophthalmology

| B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid | |
|---|---|
| **Eligibility Criteria** | Only commissioned in the following circumstances:<br>Eyelid function interferes with visual field. |
| **Evidence** | Eyelid Surgery<br>*The British Association of Aesthetic Plastic Surgeons 2011.*<br><br>Modernisation Agency's Action on Plastic Surgery 2005.<br>Procedures of Limited Clinical Effectiveness<br>Phase 1 - Consolidation and repository of the |

| B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid | |
|---|---|
| | existing evidence-base<br>London Health Observatory 2010. |
| **Comments** | Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.<br><br>Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment.<br>Impairment to visual field to be documented. |

| B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid | |
|---|---|
| **Eligibility Criteria** | Only commissioned in any of the following circumstances:<br>• Correction of ectropion or entropion which threatens the health of the affected eye.<br>• Removal of lesions of eyelid skin or lid margin.<br>• Rehabilitative surgery for patients with thyroid eye disease. |
| **Evidence** | *Eyelid Surgery*<br>The British Association of Aesthetic Plastic Surgeons 2011.<br>Local PCT consensus – review conducted 2007.<br>Modernisation Agency's Action on Plastic Surgery 2005.<br>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. |
| **Comments** | 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. |

| B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) | |
|---|---|
| **Eligibility Criteria** | Only commissioned for Larger legions which satisfy all of the following:<br>• Not responded to treatment for underlying familial lipoprotein lipase deficiency.<br>• Failed topical treatment.<br>• Causing significant disfigurement.<br>• Causing functional impairment.<br>Topical treatments may be available in a primary care or community setting. |
| **Evidence** | Local PCT consensus – review conducted 2007.<br>DermNet NZ information resources<br>updated Jan 2013.<br>Commissioning Criteria – Plastic Surgery<br>Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br>Health Commission Wales (2008). |

| B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) | |
|---|---|
| | http://www.patient.co.uk/doctor/xanthelasma |
| **Comments** | The following treatments should be considered for patients with xanthelasma:<br>Topical trichloroacetic acid (TCA) or cryotherapy.<br>Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist.<br>Lesions are harmless. |

| B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia) |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment v1 01/04/2023 |

| A11.5 Policy for Cataract Surgery | |
|---|---|
| **Summary of intervention** | A cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).<br><br>The Royal College of Ophthalmologists' National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to:<br>• 6/6 Snellen (3% of cataract surgery patients)<br>• 6/9 Snellen (5% of cataract surgery patients)<br>• 6/12 Snellen (36% of cataract surgery patients)<br><br>So eyes with visual acuities of 6/9 or better, accounted for only about 10% of cataract surgery. |
| **Policy Statement** | The presence of a cataract in itself does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risks and benefits of surgery. This assessment will usually be undertaken by an accredited community optometrist prior to referral.<br>Where both eyes are affected by cataract, the first eye referred for cataract surgery is usually expected to be the eye where cataract has caused the greatest reduction in visual acuity.<br>This policy does not extend to cataract removal incidental to the management of other eye conditions. |
| **Eligibility Criteria** | Referral of patients to ophthalmologists for cataract surgery should be based on the following indications:<br>1. The patient has sufficient cataract to account for visual symptoms. |

| A11.5 Policy for Cataract Surgery | |
|---|---|
| | It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired.<br><br>A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any of the following factors, although this is not an exhaustive list:<br>a. the patient is at significant risk of falls<br>b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving<br>c. the impact of symptoms is compromising the patient's independence<br>d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities<br>e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces.<br>f. the patient is experiencing disabling glare.<br>**AND**<br>2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/<br>3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery<br>**Guidance for second eye surgery in patients with bilateral cataracts**<br><br>**The second eye criteria is**<br>As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon |
| **Evidence for inclusion and threshold** | **Guidance/evidence**<br>Atlas of Variation *Tacking Unwarranted Variation in Healthcare across the NHS* Public Health England, NHS Right Care and NHS England September 2015<br>*Evidence Review Cataract Surgery* –ChaMPs May 2014<br>Royal College of Ophthalmologists *Commissioning Guide for Cataract Surgery* February 2015<br>NHS Choices<br>NHS Patient Decision Aids – Cataract |

## B11.6 Coloured (irlens) Filters for Treatment of Dyslexia

This policy has been superseded by ICB Policy CMICB_Clin017 - Dyslexia Treatment using Coloured (Irlen) Filters v1 01/04/2023

## B11.7 Intra Ocular Telescope for Advanced Age-Related Macular Degeneration

This policy has been superseded by ICB Policy CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT) v1 01/04/2023

### A11.8 Policy for Chalazia Removal

This policy has been superseded by ICB Policy CMICB_Clin011 - Chalazia (meibomian cysts), removal v1 01/04/2023

## 12. Oral Surgery

### B12.1 Surgical Replacement of the Temporo- Mandibular Joint, Temporo-Mandibular Joint Dysfunction syndrome & Joint Replacement

| | |
|---|---|
| **Eligibility Criteria** | Only commissioned in the following circumstances:<br><br>Any or a combination of the following symptoms are present:<br><br>• Restricted mouth opening <35mm).<br>• Dietary score of< 5/10 (liquid scores 0, full diet scores 10).<br>• Occlusal collapse (anterior open bite or retrusion).<br>• Excessive condylar resorption and loss of height of vertical ramus.<br>• Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms).<br>• Other significant quality of life issues. AND<br>Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms. |
| **Evidence** | Surgical Replacement of the Temporo- mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.<br><br>  <br>TMJ Replacement Guidance .pdf<br><br>Total prosthetic replacement of the Temporomandibular joint (IPG329)<br><br>NICE 2009<br>http://www.patient.co.uk/doctor/temporomandib ular-joint-dysfunction-and-pain-syndromes |

## 13. Paediatrics

### B13.1 Cranial Banding for Positional Plagiocephaly

This policy has been superseded by ICB Policy CMICB_Clin039 - Positional Plagiocephaly/brachycephaly in children, helmet therapy v1 1/04/2023

# 14. Plastic Surgery

## A14.1 Policy for Breast Reduction

This policy has been superseded by ICB Policy CMICB_Clin007 – Breast Reduction v1 1/04/2023

## A14.2 Policy for Augmentation Mammoplasty - Breast Enlargement

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|---|---|
| **Summary of intervention** | **Breast Enlargement**<br>Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape.<br><br>Weblink:<br>http://www.nhs.uk/conditions/Cosmeticsurgery/Pages/Introduction.aspx and<br>http://www.nhs.uk/Conditions/Cosmeticsurgery/Pages/Procedures.aspx |
| **Eligibility Criteria** | Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria:<br>• There is congenital absence of breast tissue unilaterally ***(affecting one breast only)*** of three or more cup size difference as measured by a specialist.<br>AND<br>• The patient's BMI is under 25 and has been stable for at least 12 months<br>AND<br>Aged over 18 years old. |
| **Evidence for inclusion and threshold** | NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009).<br>Weblink:<br>https://www.nice.org.uk/guidance/cg80<br><br>NICE Quality Standard 12 – Breast Cancer (2016)<br>Weblink:<br>https://www.nice.org.uk/guidance/qs12<br><br>British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012)<br>Weblink:<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0<br><br>Breast Cancer Care – Breast Reconstruction<br>Weblink:<br>https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction<br><br>Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 |

| A14.2 Policy for Augmentation Mammoplasty - Breast Enlargement | |
|---|---|
| | Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46.<br><br>Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45.<br><br>Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64.<br><br>North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf<br><br>Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050.<br><br>*Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* |

| A14.3 Policy for Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation | |
|---|---|
| **Summary of intervention** | **COSMETIC SURGERY**<br>Cosmetic surgery is often carried out to change a person's appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner.<br>1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.<br>2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment<br>3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.<br>4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment<br>5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community<br>6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance<br>7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.<br><br>A good summary of Cosmetic Surgery is provided by NHS Choices. |

| A14.3 Policy for Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation | |
|---|---|
| | Weblink:<br>http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and<br>http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx |
| **Eligibility Criteria** | Removal and/or replacement of silicone implants is not routinely commissioned.<br><br>The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:<br><br>Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only but will **not** replace them. |
| **Evidence for inclusion and threshold** | Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).<br><br>NHS Choices: PIP breast implants<br>http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx<br><br>NHS Choices: Breast Enlargement<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

| A14.4 Policy for Mastopexy - Breast Lift |
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| This policy has been superseded by ICB Policy CMICB_Clin030 – Mastopexy (breast lift) v1 1/04/2023 |

| A14.5 Policy for Surgical Correction of Nipple Inversion |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin035 – Nipple inversion, surgical correction v1 1/04/2023 |

| A14.6 Policy for Male Breast Reduction Surgery for Gynaecomastia | |
|---|---|
| **Summary of intervention** | **Gynaecomastia**<br>Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of >2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological.<br><br>Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter. |

| A14.6 Policy for Male Breast Reduction Surgery for Gynaecomastia | |
|---|---|
| | http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx |
| **Policy Statement** | See breast reduction policy. |

| A14.7 Policy for Policy for Hair Removal Treatments | |
|---|---|
| **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.<br><br>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.<br><br>A range of treatment options are available:<br>• 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.<br>• 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. |
| **Eligibility Criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR**<br>• Is undergoing treatment for pilonidal sinuses to reduce recurrence<br><br>This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - hirsuitism patient information leaflet<br>Weblink:<br>http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document<br><br>NHS Choices – Laser Hair Removal<br>Weblink:<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx<br><br>Pan Mersey APC Guidance for Eflornithine:<br>http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=306706356201612211113329 |

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

This policy has been superseded by ICB Policy CMICB_Clin038 – Pectus Deformity, surgical treatment v1 01/04/2023

## A14.9 Policy for Surgical Revision of Scars

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| **Summary of intervention** | The different types of scars include:<br>• **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.<br>• **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years.<br>• **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.<br>• **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance.<br>• **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.<br><br>**Treating scars**<br>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:<br>• pressure dressings<br>• corticosteroid injections<br>• cosmetic camouflage (make-up)<br>• surgery<br><br>It is often the case that a combination of treatments can be used. |
| **Eligibility Criteria** | The CCG will fund this treatment if the patient meets the following criteria:<br>• For severe post burn cases or severe traumatic scarring<br>**OR**<br>• Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function<br><br>This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. |
| **Evidence for inclusion and threshold** | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>NHS Choices – Scars - Treatment<br>http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx |

| A14.10 Policy for Laser Tattoo Removal | |
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| **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.<br>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.<br><br>A good summary of Cosmetic Surgery is provided by NHS Choices.<br>Weblink:<br><br>http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx |
| **Eligibility Criteria** | Removal of Tattoos is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>Modernisation Agency's Action on Plastic Surgery 2005.<br>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>NHS Choices – The NHS Guide to cosmetic procedures<br>Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx |

| A14.11 Abdominoplasty/Apronectomy (sometimes called 'tummy tuck') | |
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| **Summary of intervention** | Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.<br><br>A good summary of Cosmetic Surgery is provided by NHS Choices.<br>Weblink:<br>http://www.nhs.uk/conditions/Cosmeticsurgery/Pages/Introduction.aspx<br>and http://www.nhs.uk/Conditions/Cosmeticsurgery/Pages/Procedures.aspx |
| **Eligibility Criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).<br><br>Royal College of Surgeons - Cosmetic Surgery Categorisation |

| A14.11 Abdominoplasty/Apronectomy (sometimes called 'tummy tuck') | |
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| | Weblink: https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file<br><br>Royal College of Surgeons – Abdominplasty Guide<br>Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/<br><br>NHS Choices: Tummy Tuck (abdominoplasty<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

| A14.12 Policy for Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat |
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| This policy has been superseded by ICB Policy CMICB_Clin006 – Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty) v1 01/04/2023 |

| A14.13 Policy for Surgical Treatments for hair Loss | |
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| **Summary of intervention** | **Alopecia**<br>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.<br>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:<br>• Alopecia totalis (no scalp hair)<br>• Alopecia universalis (no hair on scalp or body)<br><br>Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It's more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome.<br><br>It's also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.<br><br>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.<br><br>Further information can be found at following link: |

| A14.13 Policy for Surgical Treatments for hair Loss | |
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| | http://www.alopeciaonline.org.uk/treatments-and-wigs.asp<br><br>**Hair transplantation**<br>A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. ,It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant isn't normally available on the NHS, as it is regarded as cosmetic surgery.<br><br>**Male Pattern Baldness**<br>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.<br><br>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.<br><br>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 |
| **Eligibility Criteria** | Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned.<br><br>The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients. |
| **Evidence for inclusion and threshold** | British Association of Dermatologists - alopecia areata patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document<br><br>Interventions for alopecia areata – Cochrane Library 2008.<br><br>http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf<br>Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment.<br><br>No evidence of effective treatments for alopecia – Cochrane Pearls 2008.<br><br>NICE Clinical Knowledge Summaries 2014.<br>https://cks.nice.org.uk/alopecia-areata |

| A14.13 Policy for Surgical Treatments for hair Loss | |
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| | Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service<br><br>Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>NHS Choices – Guide to Hair Loss Treatment<br>Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx<br><br>**Hair transplantation**<br>*A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697.<br><br>Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 |

| A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy | |
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| **Summary of intervention** | **Labiaplasty**<br>A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening.<br><br>**Vaginoplasty**<br>Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex.<br><br>**Hyenorrhaphy**<br>hymenorrhaphy or hymen reconstruction surgery, is a cosmetic procedure.<br><br>Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx |
| **Eligibility Criteria** | These procedures are not routinely commissioned. |
| **Evidence for inclusion and threshold** | rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf<br>(RCOG Statement 6). |

| A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy | |
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| | http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf<br><br>NHS Choices – Guide to Labiaplasty<br>Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx<br><br>Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10.<br><br>Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature.<br><br>Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159*<br><br>Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499.<br><br>Department for Education and Skills. (2004). *Local Authority Social Services Letter*. *LASSAL (2004)4,* London, DfES. |

| A14.17 Policy for Liposuction | |
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| **Summary of intervention** | Liposuction (also known as liposculpture) is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.<br><br>A good summary of Cosmetic Surgery is provided by NHS Choices.<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx |
| **Eligibility Criteria** | Liposuction is not routinely commissioned. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Liposuction: Weblink<br>https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/<br><br>NHS Choices: Liposuction<br>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx<br><br>Liposuction for chronic lymphoedema<br>NICE 2008.<br><br>Modernisation Agency's Action on Plastic Surgery 2005. |

| A14.17 Policy for Liposuction | |
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| | http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2<br><br>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service |

| A14.18 Policy for Rhytidectomy - Face or Brow Lift |
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| This policy has been superseded by ICB Policy CMICB_Clin042 – Rhytidectomy v1 01/04/2023 |

## 15. Respiratory

| A15.1 Intervention for Snoring (not OSA) |
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| This policy has been superseded by ICB Policy CMICB_Clin043 – Simple snoring, surgical management v1 1/04/2023 |

## 16. Trauma and Orthopaedics

| A16.1 Policy for non-invasive interventions for low Back pain and sciatica | |
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| **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.<br><br>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.<br><br>For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that's the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery. |

| A16.1 Policy for non-invasive interventions for low Back pain and sciatica | |
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| | 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.<br><br>You should seek early advice from your GP if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor. |
| **Policy Statement** | Restricted |
| **Eligibility Criteria** | **<u>Acupuncture</u>**<br>Acupuncture for low back pain and sciatica is **not routinely commissioned**<br><br>**<u>Manual Therapy</u>**<br>The following procedures are **not routinely commissioned**:<br>• Lumbar traction<br>• Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)<br>• Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation.<br><br>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.<br><br>**<u>Orthotics</u>**<br>The following are **not routinely commissioned**:<br>• Foot orthotics<br>• Rocker shoes<br>• Belts and corsets<br><br>**<u>Electrotherapy</u>**<br>The following are **not routinely commissioned:**<br>• Transcutaneous electrical nerve stimulation (TENS)<br>• Percutaneous electrical nerve stimulation (PENS)<br>• Ultrasound<br>• Interferential<br>• Laser therapy<br><br>**<u>Pharmacological interventions</u>**<br>The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain:<br>• Paracetamol used alone<br>• Selective serotonin re-uptake inhibitors (**SSRIs**)<br>• Serotonin– norepinephrine reuptake inhibitors<br>• Tricyclic antidepressants |

| A16.1 Policy for non-invasive interventions for low Back pain and sciatica | |
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| | • Anti-convulsants<br>• Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)<br><br>Patients with neuropathic pain should be managed in line with NICE CG 173:<br>• Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)<br><br>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.<br><br>1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).<br><br>1.1.11 Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.<br><br>***Treatments that should not be used***<br>1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:<br>• cannabis sativa extract<br>• capsaicin patch<br>• lacosamide<br>• lamotrigine<br>• levetiracetam<br>• morphine<br>• oxcarbazepine<br>• topiramate<br>• tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use)<br>venlafaxine. |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>Osteoarthritis: the care and management of osteoarthritis in adults<br>https://www.nice.org.uk/guidance/cg59<br><br>The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012)<br>http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf |

| A16.1 Policy for non-invasive interventions for low Back pain and sciatica | |
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| | Final_TAMARS_report[1].pdf |

| A16.2 Policy for Imaging for Patients Presenting with Low Back Pain | |
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| **Summary of intervention** | Imaging does not often change the initial management and outcomes of someone with back pain. This is because the reported imaging findings are usually common and not necessarily related to the person's symptoms. Many of the imaging findings (for example, disc and joint degeneration) are frequently found in asymptomatic people. Requests for imaging by non-specialist clinicians, where there is no suspicion of serious underlying pathology, can cause unnecessary distress and lead to further referrals for findings that are not clinically relevant. |
| **Policy Statement** | Restricted |
| **Eligibility Criteria** | X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings.<br><br>For patients with non-urgent presentations consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery.<br><br>Imaging is only commissioned where patients present with red flags(see below) or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management.<br><br>Emergency Spinal Referral<br>Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms)<br>Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit)<br>Major motor radiculopathy<br>Suspected Spinal Infection<br>Priority Spine imaging (Protocol led MRI whole spine unless contraindicated)<br>Past history of cancer *(new onset spinal pain)<br>Recent unexplained weight loss<br>Objectively unwell with spinal pain<br>Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice)<br>Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids).<br>Prolonged steroid use *<br>Known osteoporosis, with new severe spinal pain<br>Age <15, or >60 years new onset axial back pain<br>*Statistically significant red flags. Although the others listed may not be |

| A16.2 Policy for Imaging for Patients Presenting with Low Back Pain | |
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| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging<br>https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referrals-for-imaging<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 |

| A16.3 Policy for Injections for nonspecific low back pain without sciatica | |
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| **Summary of intervention** | NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work - https://www.nice.org.uk/guidance/ng59 |
| **Policy Statement** | Restricted |
| **Eligibility Criteria** | Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.<br><br>Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.<br><br>For people with non-specific low back pain the following injections should not be offered:<br>facet joint injections<br>therapeutic medial branch blocks<br>intradiscal therapy<br>prolotherapy<br>Trigger point injections with any agent, including botulinum toxin<br>Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis<br>Any other spinal injections not specifically covered above<br><br>Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.<br><br>Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral. |

| A16.3 Policy for Injections for nonspecific low back pain without sciatica | |
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| | Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.<br><br>For further information, please see:<br>https://www.nice.org.uk/guidance/ng59<br>NICE guidelines recommend that spinal injections should not be offered for non-specific low back pain.<br><br>Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.<br><br>Exclusion criteria for the NICE (NG59) include: Conditions of a non-mechanical nature, including;<br>Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)<br>Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)<br>Neurological disorders (including cauda equina syndrome or mononeuritis)<br>Adolescent scoliosis<br>Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)<br>Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.<br><br>NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s<br><br>Spinal injections<br>1.3.1 Do not offer spinal injections for managing nonspecific low back pain.<br><br>Radiofrequency denervation<br>1.3.2 Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when:<br>non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.<br>1.3.3 Only perform radiofrequency denervation in people with non-specific low back pain after a positive response to a diagnostic medial branch block.<br>1.3.4 Do not offer imaging for people with non-specific low back pain with specific facet join pain as a prerequisite for radiofrequency denervation. |

| A16.3 Policy for Injections for nonspecific low back pain without sciatica | |
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| **Evidence for inclusion and threshold** | References<br>NICE guidance: https://www.nice.org.uk/guidance/ng59,<br>United Kingdom Spine Societies Board: https://www.ukssb.com/improving-spinal-care-project<br>Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al.The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul- Aug;15(4):E363-404<br>Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53.<br>Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May-Jun;38(3):175-200.<br>Royal College of Anaesthetists: https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk |

| A16.4 Policy for Spinal Fusion | |
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| **Summary of intervention** | Spinal fusion is used to join two or more vertebrae together by placing an additional section of bone in the space between them.<br><br>This helps to prevent excessive movements between two adjacent vertebrae, lowering the risk of further irritation or compression of the nearby nerves and reducing pain and related symptoms.<br><br>The additional section of bone can be taken from somewhere else in your body (usually the hip) or from a donated bone. More recently, synthetic (man-made) bone substitutes have been used.<br><br>To improve the chance of fusion being successful, some surgeons may use screws and connecting rods to secure the bones.<br><br>Afterwards, the surgeon will close the incision with stitches or surgical staples.<br><br>http://www.nhs.uk/Conditions/Lumbardecompressivesurgery/Pages/surgery.aspx |
| **Eligibility Criteria** | The following procedures are not routinely commissioned:<br>Fusion<br>Non-rigid stabilisation techniques<br>Lateral body fusion in the lumbar spine<br>Transaxial interbody lumbrosacral fusion<br>Anterior lumbar interbody fusion (ALIF)<br>Posterior lumbar interbody fusion (PLIF)<br>Or any other combination of approach where surgical fixation is performed |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017 |

| A16.4 Policy for Spinal Fusion | |
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| | http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br><br>IPG 387: https://www.nice.org.uk/guidance/ipg387<br>Transaxial interbody lumbosacral fusion |

| A16.5 Disc and Decompression procedures | |
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| **Summary of intervention** | **Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.**<br><br>It's only recommended when non-surgical treatments haven't helped.<br><br>The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.<br><br>Lumbar decompression surgery is often used to treat:<br>•spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside<br>•a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve<br>•spinal injuries – such as a fracture or the swelling of tissue<br>•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 |
| **Policy Statement** | Restricted |
| **Eligibility Criteria** | Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:<br><br>Patient presents with severe and acute sciatica<br>AND<br>have failed to respond to conservative intervention<br>AND<br>have imaging findings concordant with clinical presentation<br>Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network.<br><br>The following procedures are NOT routinely commissioned:<br>Endoscopic Laser Foraminoplasty<br>Endoscopic Lumbar Decompression<br>Percutaneous Disc Decompression using Coblation for Lower Back Pain<br>Percutaneous Intradiscal Laser Ablation in the Lumbar Spine<br>Automated Percutaneous Mechanical Lumbar Discectomy |

| A16.5 Disc and Decompression procedures | |
|---|---|
| | Prosthetic Intervertebral Disc Replacement in the Lumbar Spine<br>Intradiscal Electro Thermal Annuloplasty (IDET)<br>Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) |
| **Evidence for inclusion and threshold** | Low back pain and sciatica in over 16s: assessment and management (November 2016)<br>https://www.nice.org.uk/guidance/ng59<br><br>National Low Back and Radicular Pain Pathway 2017<br>http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf<br><br>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173<br><br>IPG31 Endoscopic laser foraminoplasty: guidance<br>NICE 2003 (confirmed 2009)<br>Reviewed October 2011 – Decision taken that this policy does not require update.<br><br>IPG570: https://www.nice.org.uk/guidance/ipg570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016)<br><br>IPG543: https://www.nice.org.uk/guidance/ipg543<br>Percutaneous coblation of the intervertebral disc for low back pain and sciatica<br><br>IPG:357 https://www.nice.org.uk/guidance/ipg357<br>Percutaneous intradiscal laser ablation in the lumbar spine<br><br>IPG141: https://www.nice.org.uk/guidance/ipg141<br>Automated percutaneous mechanical lumbar discectomy<br><br>IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine<br>NICE 2009. |

| A16.6 Policy for Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain |
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| This policy has been superseded by ICB Policy CMICB_Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation v1 01/04/2023 |

| A16.7 Policy for Therapeutic endoscopic Division of epidural adhesions |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division v1 01/04/2023 |

| B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha | |
|---|---|
| **Eligibility Criteria** | Dibotermin alfa is commissioned in the following situation:<br>• The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation.<br>• Eptotermin alfa is commissioned in line with its licensed indication: Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible. |
| **Evidence** | Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review<br><br>Health Technology Assessment NHS R&D HTA Programme, 2007.<br>Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI<br>Annals of Internal Medicine \| Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data<br>June 2013<br>BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16 |

| A16.18 Policy for Trigger Finger Release |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin048 – Trigger Finger release in adults v1 01/04/2023 |

| A16.19 Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin036 – Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid) v1 01/04/2023 |

| B16.20 Secondary Care Administered Steroid Joint Injections |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin037 – Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids v1 01/04/2023 |

| A16.21 Policy for Dupuytren's Contracture Release |
|---|
| This policy has been superseded by ICB Policy CMICB_Clin016 – Dupuytren's Contracture release in adults v1 01/04/2023 |

| A16.23a Policy for Hip Replacement Surgery | |
|---|---|
| **Summary of intervention** | A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.<br><br>The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.<br>Some common reasons why a hip joint can become damaged include:<br>osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other<br>rheumatoid arthritis – this is caused by the immune system (the body's defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness<br>hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it<br><br>Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.<br>The purpose of a new hip joint is to:<br>relieve pain<br>improve the function of your hip<br>improve your ability to move around<br>improve your quality of life<br><br>Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms-<br>Pain<br>Stiffness<br>reduced function<br><br>Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time. |
| **Eligibility Criteria** | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.<br><br>**Referral criteria for <u>Total Hip Replacements (THR)</u>** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria; |

| A16.23a Policy for Hip Replacement Surgery | |
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| | Patient complains of severe joint pain.<br>AND<br>Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.<br>OR<br>Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.<br><br>The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44). |
| **Evidence for inclusion and threshold** | Royal College of Surgeons – Painful Hip Commissioning Guide<br>https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/<br><br>NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)<br>Weblink:<br>https://www.nice.org.uk/guidance/cg177<br><br>NHS Choices – Hip replacement<br>Weblink:<br>http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx |

| A16.23b Policy for Knee Replacement Surgery | |
|---|---|
| **Summary of intervention** | Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old.<br><br>For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain.<br><br>There are two main types of surgery, depending on the condition of the knee:<br>total knee replacement (TKR) – both sides of your knee joint are replaced<br>partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period<br><br>The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:<br>rheumatoid arthritis<br>haemophilia<br>gout |

| A16.23b Policy for Knee Replacement Surgery | |
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| | knee injury<br><br>A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven't helped reduce pain or improve mobility.<br>You may be offered knee replacement surgery if:<br>You have severe pain, swelling and stiffness in your knee joint and your mobility is reduced<br>your knee pain is so severe that it interferes with your quality of life and sleep<br>everyday tasks, such as shopping or getting out of the bath, are difficult or impossible<br>you cannot work or have a normal social life<br><br>Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms;<br>Pain<br>Stiffness<br>Reduced function |
| **Eligibility Criteria** | Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.<br><br>**Funding for <u>total or partial knee replacement</u> <u>surgery</u> is available if the following criteria are met**<br><br>. Patients with BMI <40.<br>AND<br>. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.<br>AND<br>. Has radiological features of severe disease.<br>OR<br>. Has radiological features of moderate disease with limited mobility or instability of the knee joint. |
| **Evidence for inclusion and threshold** | Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017)<br>Weblink:<br>https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en<br><br>NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014)<br>Weblink:<br>https://www.nice.org.uk/guidance/cg177<br><br>Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review |

| A16.23b Policy for Knee Replacement Surgery | |
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| | Saif Salih* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25) Weblink: (http://www.biomedcentral.com/2052-1847/5/25)<br><br>NHS Choices – Knee replacement<br>Weblink:<br>http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx |

| B16.24 Diagnostic Arthroscopy for Arthritis of the Knee |
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| This policy has been superseded by ICB Policy CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears v1 01/04/2023 |

| A16.25 Policy for Knee Arthroscopy with Osteoarthritis |
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| This policy has been superseded by ICB Policy CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023 |

| B16.26 Patient Specific Unicompartmental Knee Replacement | |
|---|---|
| **Eligibility Criteria** | This is not commissioned. |
| **Evidence** | IPG317 Individually magnetic resonance imaging- designedunicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009 |
| **Comments** | Referral should be made to specialist centres only. |

| B16.27 Patient Specific Total Knee Replacement |
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| This policy has been superseded by ICB Policy CMICB_Clin047 – Total Knee Arthroplasty, patient specific instrumentation/implants v1 01/04/2023 |

| A16.28 Policy for Carpal tunnel Syndrome Release |
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| This policy has been superseded by ICB Policy CMICB_Clin010 – Carpal Tunnel interventions and surgery v1 01/04/2023 |

| B16.29 Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) |
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This policy has been superseded by ICB Policy CMICB_Clin033 – Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal v1 01/04/2023

## A16.30 Policy for Surgical Removal of Ganglions

This policy has been superseded by ICB Policy CMICB_Clin022 – Ganglia, surgical removal and general management v2 01/04/2023

## B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement

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| **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 of the following criteria:<br>• A definite diagnosis of hip impingement syndrome/femoro- acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.<br>• An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.<br>• The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.<br>The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy. |
| **Evidence** | IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011.<br><br>http://www.hullccg.nhs.uk/uploads/policy/file/22/ hip-arthroscopy-hull-ccg.pdf<br><br>NHS Hull Clinical Commissioning Group 2012.<br>Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68.<br><br>Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).<br><br>Ng V Y et al.. Efficacy of Surgery for Femoro- acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345.<br><br>Commissioning Guide: Painful osteoarthritis of the hip<br><br>Royal College of Surgeons (2013).<br><br>IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011 |
| **Comments** | 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. |

| B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement | |
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| | 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. |

| B16.32 Surgical Removal of Bunions/Surgery for Lesser Toe Deformity |
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| This policy has been superseded by ICB Policy CMICB_Clin008 – Bunions, surgical removal v1 01/04/2023 |

| B16.33 Surgical Treatment of Morton's Neuroma |
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| This policy has been superseded by ICB Policy CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023 |

| B16.34 Surgical Treatment of Plantar Fasciitis | |
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| **Eligibility Criteria** | Surgical Treatment is not routinely commissioned unless the following pathway has been followed:<br><br>• Patient has documented evidence that they are not responding to conservative treatments<br>• Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following:<br>• Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss<br>• Been referred to a podiatrist or physiotherapist<br>Not responded to corticosteroid injections |
| **Evidence** | Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.<br><br>Plantar fasciitis<br><br>NICE Clinical Knowledge Summaries (2009). Plantar fasciitis<br>BMJ 2012;345:e6603. |

| B16.35 Treatment of Tendinopathies (Extracorporeal Shock Wave Therapy; Autologous Blood or Platelet Injection) |
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| This policy has been superseded by ICB Policy CMICB_Clin001 - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections v1 01/04/2023 |

| A16.36 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain | |
|---|---|
| **Summary of intervention** | Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases.<br>Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery. Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf<br>In order to facilitate non-operative treatment in primary and intermediate care, BESS and Getting It Right First Time programme have produced patient exercise rehab videos and booklets for GPs and patients to use. http://www.bess.org.uk/index.php/public-area/shpi-videos |
| **Policy Statement** | Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically. |
| **Eligibility Criteria** | Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.<br><br>For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention |
| **Rationale** | Number of CCG interventions in 2017/18 – 13,930<br><br>Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function[1]. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery.<br><br>On the other hand, a more recent prospective randomised trial comparing the long-term outcome (10 year follow up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment[3]<br><br>Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non- |

| A16.36 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain | |
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| | operative management fails.[4,5] There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.[6]<br><br>A review of the literature identified one further systematic review that looked at the effectiveness of surgery.[2] The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options.<br><br>Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.7<br>Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic. |
| **Evidence for inclusion and threshold** | <u>References</u><br>Beard DJ, Rees JL, Cook JA, Rombach I, Cooper C, Merritt N, Shirkey BA, Donovan JL, Gwilym S, Savulescu J, Moser J, Gray A, Jepson M, Tracey I, Judge A, Wartolowska K, Carr AJ; CSAW Study Group. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial. Lancet. 2018 Jan 27;391(10118):329-338. doi: 10.1016/S0140-6736(17)32457-1. Epub 2017 Nov 20. PubMed PMID: 29169668; PubMed Central PMCID: PMC5803129.<br>Dorrestijn O, Stevens M, Winters JC, van der Meer K, Diercks RL. Conservative or surgical treatment for subacromial impingement syndrome? A systematic review. J Shoulder Elbow Surg 2009; 18: 652–60.<br>Farfaras S, Sernert N, Rostgard Christensen L, Hallström EK, Kartus JT. Subacromial Decompression Yields a Better Clinical Outcome Than Therapy Alone: A Prospective Randomized Study of Patients With a Minimum 10-Year Follow-up. Am J Sports Med. 2018 May;46(6):1397-1407<br>Holmgren T, Björnsson Hallgren H, Öberg B, Adolfsson L, Johansson K. Effect of specific exercise strategy on need for surgery in patients with subacromial impingement syndrome: randomised controlled study. BMJ. 2012 Feb 20;344:e787. doi: 10.1136/bmj.e787<br>Magaji SA, Singh HP, Pandey RK. Arthroscopic subacromial decompression is effective in selected patients with shoulder impingement syndrome. J Bone Joint Surg Br. 2012 Aug;94(8):1086-9<br>Jacobsen JR, Jensen CM, Deutch SR. Acromioplasty in patients selected for operation by national guidelines. J Shoulder Elbow Surg. 2017 Oct;26(10):1854-1861.<br>https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf |

## 17. Urology

| A17.1 Policy for Circumcision for medical reasons only | |
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| **Summary of intervention** | Male circumcision is the surgical removal of the foreskin.<br>The foreskin is the retractable fold of skin that covers the end of the penis. It's a continuation of the skin that covers the whole penis.<br><br>Further information can be found at:<br>http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx |
| **Eligibility Criteria** | **Circumcision will be funded in the following medical circumstances**:<br>• Balantis xerotica obliterans.<br>• Traumatic foreskin injury/scarring where it cannot be salvaged.<br>• 3 or more episodes of balanitis/balanoposthitis.<br>• Pathological phimosis.<br>• Irreducible paraphimosis.<br>• Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract.<br>• Tight foreskin causing pain on arousal/ interfering with sexual function<br><br>This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk.<br><br>This procedure is not offered for social, cultural or religious reasons. |
| **Evidence for inclusion and threshold** | 2008 UK National Guideline on the Management of Balanoposthitis –<br>Clinical Effectiveness Group British Association for Sexual Health and HIV (2008).<br><br>Balanitis<br>NICE Clinical Knowledge Summaries 2015<br><br>I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes<br>Sexually Transmitted Infections 2012;88:A55-A56.<br><br>Balanitis<br>Patient.co.uk.<br><br>https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions--commissioning-guide.pdf<br>Foreskin Conditions: Royal College of Surgeons guidance (2013).<br><br>NHS Choices – Circumcision<br>Weblink:<br>http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx<br><br>Male Circumcision: Guidance for Healthcare Practitioners<br>Royal College of Surgeons, 2000<br>https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/ |

| B17.3 Reversal of Male Sterilisation |
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| This policy has been superseded by ICB Policy CMICB_Clin040 – Reversal of Male Sterilisation v1 01/04/2023 |

| B17.4 ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome | |
|---|---|
| **Eligibility Criteria** | This is not commissioned as there is limited clinical evidence of effectiveness. |
| **Evidence** | Guidelines on chronic pelvic pain<br>European Association of Urology (2012).<br>https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf |

| B17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome | |
|---|---|
| **Eligibility Criteria** | This is not commissioned as there is limited evidence of effectiveness. |

| B17.6 Surgery for Prostatism | |
|---|---|
| **Eligibility Criteria** | Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances:<br>• International prostate symptom score >7; dysuria;<br>• Post voided residual volume >150ml;<br>• Recurrent proven Urinary Tract Infections (UTI);<br>• Deranged renal function;<br>Prostate-specific antigen (PSA) > age adjusted normal values. |
| **Evidence** | CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men<br>NICE 2010.<br>LUTS in men, age-related (prostatism)<br>NICE Clinical Knowledge Summaries (2010).<br>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts<br>Royal College of Surgeons (2013). |
| **Comments** | No references to treatment thresholds found. |

## 18. Vascular Surgery

| B18.1 Surgery for Extreme Sweating (Hyperhydrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy) |
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| This policy has been superseded by ICB Policy CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management v1 01/04/2023 |

| B18.2 Chelation Therapy for Vascular Occlusions |
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| This policy has been superseded by ICB Policy CMICB_Clin015 – Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction v1 01/04/2023 |

| A18.3 Policy for Varicose Veins Interventions |
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| This policy has been superseded by ICB Policy CMICB_Clin049 – Varicose Veins v1 01/04/2023 |

## 19. Other

| B19.1 Botulinum Toxin A & B | |
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| **Eligibility Criteria** | Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane.<br><br>The use of botulinum toxin type A is commissioned in the following indications:<br><br>• Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections.<br>• Blepharospasm and hemifacial spasm.<br>• Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8<br>• Focal dystonia, where other measures are inappropriate or ineffective.<br>• Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective.<br>• Idiopathic cervical dystonia (spasmodic torticollis).<br>• Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260<br>• Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms.<br>• Sialorrhoea (excessive salivary drooling), when all other treatments have failed.<br><br>Botulinum toxin type A is not routinely commissioned in the following |

| B19.1 Botulinum Toxin A & B | |
|---|---|
| | indications:<br><br>• Canthal lines (crow's feet) and glabellar (frown) lines.<br>• Hyperhidrosis.<br>• Any other indication that is not listed above<br><br>The use of Botulinum Type B is not routinely commissioned.<br><br>Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications.<br><br>For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside.<br>Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes.<br>If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated. |
| **Evidence** | NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260<br><br>Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections.<br><br>Diagnosis and management of hyperhidrosis British Medical Journal. |

# 20. Appendix 1 - List of Clinical Commissioning Group policies superseded by Cheshire and Merseyside Integrated Care Board (ICB)

| Merseyside CCG Ref | ICB Policy Ref | ICB Version Number | ICB Date Published | ICB Policy Title |
|---|---|---|---|---|
| B16.35 | CMICB_Clin001 | 1 | 01/04/2023 | Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections |
| A4.1 | CMICB_Clin002 | 1 | 01/04/2023 | Adenoidectomy |
| B11.7 | CMICB_Clin003 | 1 | 01/04/2023 | Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT) |
| B16.24 | CMICB_Clin004 | 1 | 01/04/2023 | Arthroscopic Surgery of the Knee for Meniscal Tears |
| A2.2 | CMICB_Clin005 | 1 | 01/04/2023 | Benign skin lesions, removal |
| A14.12 | CMICB_Clin006 | 1 | 01/04/2023 | Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty) |
| A14.1/A14.6 | CMICB_Clin007 | 1 | 01/04/2023 | Breast Reduction |
| B16.32 | CMICB_Clin008 | 1 | 01/04/2023 | Bunions, surgical removal |
| B2.4 | CMICB_Clin009 | 1 | 01/04/2023 | Camouflage Treatment for Skin Pigmentation and other disorders |
| A16.28 | CMICB_Clin010 | 1 | 01/04/2023 | Carpal Tunnel interventions and surgery |
| A11.8 | CMICB_Clin011 | 1 | 01/04/2023 | Chalazia (meibomian cysts), removal |
| A16.6 | CMICB_Clin012 | 1 | 01/04/2023 | Chronic Low Back Pain, Peripheral Nerve Field Stimulation |
| A7.2 | CMICB_Clin014 | 1 | 01/04/2023 | Diastasis (divarication) of the Recti Repair |
| B18.2 | CMICB_Clin015 | 1 | 01/04/2023 | Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction |
| A16.21 | CMICB_Clin016 | 1 | 01/04/2023 | Dupuytren's Contracture release in adults |

| Merseyside CCG Ref | ICB Policy Ref | ICB Version Number | ICB Date Published | ICB Policy Title |
|---|---|---|---|---|
| B11.6 | CMICB_Clin017 | 1 | 01/04/2023 | Dyslexia Treatment using Coloured (Irlen) Filters |
| A16.5 | CMICB_Clin018 | 1 | 01/04/2023 | Endoscopic Laser Foraminoplasty |
| A16.7 | CMICB_Clin019 | 1 | 01/04/2023 | Epidural Adhesions, Therapeutic Endoscopic Division |
| N/A | CMICB_Clin020 | 1 | 01/04/2023 | Erectile dysfunction, penile prosthesis surgery |
| A7.3/B7.4 | CMICB_Clin021 | 1 | 01/04/2023 | Gallstones (Asymptomatic), Surgical Management |
| A16.30 | CMICB_Clin022 | 2 | 01/09/2023 | Ganglia, surgical removal and general management |
| A4.3a/B4.3b | CMICB_Clin023 | 1 | 01/04/2023 | Grommets for glue ear in children |
| A7.1 | CMICB_Clin024 | 1 | 01/04/2023 | Haemorrhoids, surgical management |
| A8.2 | CMICB_Clin025 | 1 | 01/04/2023 | Heavy Menstrual Bleeding, Dilatation and Curettage |
| A8.1 | CMICB_Clin026 | 1 | 01/04/2023 | Heavy Menstrual Bleeding, Hysterectomy |
| B18.1 | CMICB_Clin027 | 1 | 01/04/2023 | Hyperhidrosis (excessive sweating), Surgical Management |
| A16.25 | CMICB_Clin028 | 1 | 01/04/2023 | Knee Osteoarthritis, Arthroscopic Lavage and Debridement |
| A16.5 | CMICB_Clin029 | 1 | 01/04/2023 | Low back pain, disc replacement |
| A14.4 | CMICB_Clin030 | 1 | 01/04/2023 | Mastopexy (breast lift) |
| B16.33 | CMICB_Clin032 | 1 | 01/04/2023 | Morton's Neuroma, surgical treatment |
| B16.29 | CMICB_Clin033 | 1 | 01/04/2023 | Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal |
| B11.4 | CMICB_Clin034 | 1 | 01/04/2023 | Myopia, Hyperopia and Astigmatism, Laser Treatment |
| A14.5 | CMICB_Clin035 | 1 | 01/04/2023 | Nipple inversion, surgical correction |
| A16.19 | CMICB_Clin036 | 1 | 01/04/2023 | Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid) |

| Merseyside CCG Ref | ICB Policy Ref | ICB Version Number | ICB Date Published | ICB Policy Title |
|---|---|---|---|---|
| B16.20 | CMICB_Clin037 | 1 | 01/04/2023 | Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids |
| A14.8 | CMICB_Clin038 | 1 | 01/04/2023 | Pectus Deformity, surgical treatment |
| B13.1 | CMICB_Clin039 | 1 | 01/04/2023 | Positional Plagiocephaly/brachycephaly in children, helmet therapy |
| B17.3 | CMICB_Clin040 | 1 | 01/04/2023 | Reversal of Male Sterilisation |
| B4.8 | CMICB_Clin041 | 1 | 01/04/2023 | Rhinophyma, surgical management |
| 14.18 | CMICB_Clin042 | 1 | 01/04/2023 | Rhytidectomy |
| A15.1 | CMICB_Clin043 | 1 | 01/04/2023 | Simple Snoring, surgical management |
| B4.6 | CMICB_Clin044 | 1 | 01/04/2023 | Sinus X-Ray |
| B4.5 | CMICB_Clin045 | 1 | 01/04/2023 | Split (cleft) Earlobe, surgical repair |
| A4.4 | CMICB_Clin046 | 1 | 01/04/2023 | Tonsillectomy |
| B16.27 | CMICB_Clin047 | 1 | 01/04/2023 | Total Knee Arthroplasty, patient specific instrumentation/implants |
| A16.18 | CMICB_Clin048 | 1 | 01/04/2023 | Trigger Finger release in adults |
| A18.3 | CMICB_Clin049 | 1 | 01/04/2023 | Varicose Veins |