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Knowsley Clinical Commissioning Group Commissioning Policy

Updated September 2023

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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April 2023	1.11	Policy amended and re-formatted to illustrate removal of policy positions superseded by Cheshire and Merseyside ICB policies 01/04/2023 as referenced and as listed in Appendix 1. Readers should note the following standalone NHS Knowsley 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: <ul style="list-style-type: none"> • Continuous Glucose Monitoring • Gluten Free • Pinnaplasty • Subfertility
September 2023	1.12	Policy document amended to include hyperlinks to ICB policies.

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INTRODUCTION

1. Purpose and Scope

- 1.1 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 CCG 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 the CCG will commission stated treatments and procedures.
- 1.2 This Commissioning Policy describes the eligibility criteria under which the CCG will commission treatments or interventions classified as 'Criteria Based Clinical Treatments' (CBCT). The term Criteria Based Clinical Treatments refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP). The policy has been updated following the guidance 'Evidence-Based Interventions: Guidance for CCG's' published in January 2019.
- 1.3 In making these arrangements, the CCG has 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.

2. Context

- 2.1 CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of their population.
- 2.2 It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. As a result, the CCG needs to prioritise its commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.
- 2.3 The CCG's intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.
- 2.4 Using the criteria as presented in this document, the CCG can prioritise its 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.
- 2.5 The main objective for having a criterion-based Commissioning Policy is to ensure

that:

- a. Patients receive appropriate health treatments in the right place and at the right time
 - b. Treatments with no or a very limited clinical evidence base are not routinely undertaken.
- 2.6 This also means that certain procedures will not routinely be commissioned by the CCG unless patients meet the criteria set out in relation to a procedure or treatment or exceptional clinical circumstances can be demonstrated.
- 2.7 The CCG recognises there may be exceptional clinical circumstances where it may be clinically effective to fund any of the procedures listed in this Policy for individual patients where:
- a. The clinical threshold criteria as specified by this Policy is not met; or
 - b. The procedure is not routinely commissioned.
- 2.8 In accordance with the 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.

3. Principles

- 3.1 Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out as follows:
- a. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment
 - b. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment
 - c. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor
 - d. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment
 - e. 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
 - f. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance
 - g. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered
 - h. 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.

4. Core eligibility criteria

- 4.1 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.

4.2 These core clinical eligibility criteria are as follows:

- a. Any patient who needs 'urgent' treatment will always be treated.
- b. All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- c. 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.

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

- a. Reconstructive surgery post cancer or trauma including burns
- b. 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 NHSE Specialised Commissioning. 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
- c. Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis
- d. For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

5. Policy Statement

5.1 Not routinely Commissioned (NRC)

5.2 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.

6. Diagnostic Procedures

6.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a "routinely commissioned" 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.

6.2 Where a General Practitioner/Optomtrist/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/Optomtrist/Dentist, in order for them to make a decision on future treatment.

7. Psychological factors

- 7.1 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.
- 7.2 Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image, but it should not be regarded as a route into aesthetic surgery. Any application citing psychological distress will need to be considered as an IFR
- 7.3 Children under 16 are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions where such conditions cause psychological distress.

8. CBCT Referral/Treatment Listing Processes

8.1 Primary Care

- 8.1.1 Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optomtrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a 'not routinely commissioned', as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optomtrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.
- 8.1.2 If in doubt over the local process, the referring clinician should contact Knowsley CCG, for guidance. Failure to comply with the local process may delay a decision being made.
- 8.1.3 Any referral letter should include specific information regarding the patient's potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.
- 8.1.4 In cases where there may be an element of doubt the General Practitioner/Optomtrist/Dentist should discuss the case with the Knowsley Clinical Commissioning Group in the first instance.

8.2 Secondary Care

- 8.2.1 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.

8.2.2 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 CCG or the IFR Team for guidance. Failure to comply with the CCG's processes may delay a patient's treatment and/or release of funding resources.

8.2.3 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.

8.2.4 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/Optometrists/Dentist, explaining why the patient is not eligible for treatment.

9. Medicines

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

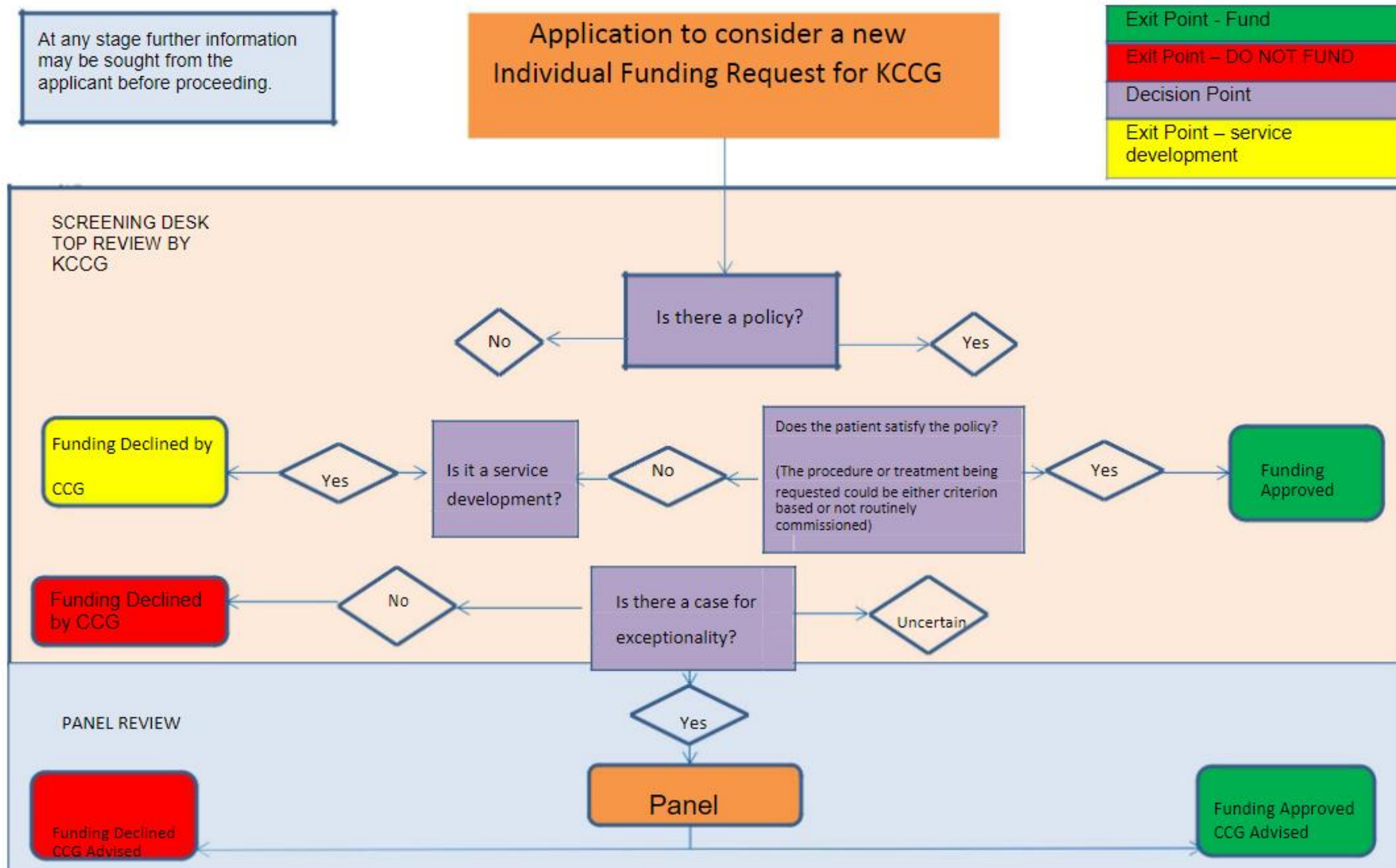
- a. Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG
- b. Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication
- c. Any PbR excluded drugs that are being used out with the parameters 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
- d. Any drug used out with NICE Guidance (where guidance is in existence)
- e. 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
- f. Any medicines that are classed by the CCG as being of limited clinical value
- g. Any medicines that will be supplied via a homecare company agreement

IFR APPLICATIONS

1. 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.
2. 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.
3. 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:
 - a. 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.
4. The CCG is of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS, namely that people with equal need should be treated equally. Therefore, non-clinical factors will not be considered except where this policy explicitly provides otherwise.
5. The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.
6. Individual Funding Requests (IFR) should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form can be found on the CCG website.
7. Individual funding requests will be considered by an IFR panel on behalf of the CCG, but the final decision is that of the CCG.
8. The CCG can choose to agree with the recommendation of the panel, request further information or choose to overrule the panel.
9. 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

The email address for the Individual Funding Request team of the CCG is: IFR.manager@nhs.net.
10. Process outlined below:



11. Clinical Trials

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

12. Photographic evidence

12.1 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.

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

12.3 If photographs are accepted for consideration in accordance with the CCG's 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.

13. Personal data

13.1 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:

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

13.1.2 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.

13.1.3 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.

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

14. Copies of this policy

14.1 Electronic copies of this policy can be found on the websites of the CCG. Alternatively, you may contact the CCG and ask for a copy of the Commissioning Policy 2019-21.

15. Monitoring and review

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

- a. Prior approval process
- b. Post activity monitoring through routine data
- c. Post activity monitoring through case note audits

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

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

16. Evidence

16.1 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.

Term	Meaning
Malignant/malignancy	Harmful.
Monocular vision	Vision in one eye only.
Multi-disciplinary	Involving several professional specialisms for example in a multi-disciplinary team (MDT).
NICE guidance	The guidance published by the National Institute for Health and Care Excellence.
Not routinely funded (a procedure)	This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
NSAIDS	Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation.
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	
Exceptionality – Prior Approval - Criteria	Not routinely commissioned unless recommended by NICE guidance.
Evidence	<i>Complementary and alternative medicine</i> – NHS Choices 2012. 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)	
Exceptionality – Prior Approval - Criteria	Only be commissioned in the following circumstances: <u>Severe</u> scarring following: Acne once the active disease is controlled.

B2.1 Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)

	<p>Chicken pox. OR Trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of “non-core” surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</p>
<p>Evidence</p>	<p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Haedersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. <i>Journal of the European Academy of Dermatology and Venereology</i>, 22, 267–78.</p> <p>Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT.</p> <p>www.evidence.nhs.uk</p> <p>Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>NHS England Interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.</p>

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

<p>Exceptionality – Prior Approval - Criteria</p>	<p>Will be commissioned in any of the following circumstances:</p> <p>Severe pain substantially interfering with functional abilities. Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. Extensive warts (particularly in the immune-suppressed patient). Facial warts. Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.</p>
<p>Evidence</p>	<p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>patient.co.uk/doctor/viral-warts-excluding-verrucae</p> <p>http://www.patient.co.uk/doctor/verrucae</p>
<p>Comments</p>	<p>Most viral warts will clear spontaneously or following application of topical treatments.</p> <p>65% are likely to disappear spontaneously within 2 years.</p> <p>There are numerous OTC preparations available.</p> <p>Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.</p>

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 Knowsley CCG standalone policy

A4.3a Policy for Grommets for Glue Ear (Children)
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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)	
Exceptionality – Prior Approval - Criteria	<p>Grommets in adults with OME will be funded only in the following circumstances:</p> <ul style="list-style-type: none"> • Significant negative middle ear pressure measured on two sequential appointments. <p>AND</p> <ul style="list-style-type: none"> • Significant ongoing associated pain. <p>OR</p> <p>Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.</p>
Evidence	<p>http://www.rcseng.ac.uk/healthcarebodies/docs/published-guides/ome Royal College of Surgeons (2013). http://www.england.nhs.uk/wpcontent/uploads/2013/11/N-SC015.pdf</p>

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	
Policy Statement	<p>Not routinely commissioned</p> <p>a) Rhinoplasty is not routinely commissioned for cosmetic reasons.</p> <p>b) Rhinoplasty is restricted for non-cosmetic/other reasons e.g. a septoplasty.</p>
Minimum eligibility criteria	<p>The CCG will fund this treatment if the patient meets the following criteria:</p> <ul style="list-style-type: none"> • Documented medical breathing problems caused by obstruction of the nasal airway OR • Correction of complex congenital conditions e.g. Cleft lip and palate <p>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.</p>
Rationale	<p>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.</p>
Evidence for inclusion and threshold	<p>Royal College of Surgeons – Rhinoplasty Guide Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/</p>

B4.8 Surgery of Laser Treatment of Rhinophyma	
<p style="color: red;">This policy has been superseded by ICB Policy CMICB_Clin41 - Rhinophyma, surgical management v1 1/04/2023</p>	

5. Equipment

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

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

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	
Exceptionality – Prior Approval - 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)

Exceptionality – Prior Approval - Criteria	Inpatient care for chronic fatigue syndrome is not routinely commissioned. If inpatient treatment is recommended an IFR referral will be required.
Evidence	<p>Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children – NICE 2007, CG53.</p> <p>Cognitive behaviour therapy for chronic fatigue syndrome in adults - Cochrane Depression, Anxiety and Neurosis Group 2008.</p> <p>Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis - . PLoS ONE 7(8): e40808. doi:10.137.</p> <p>Cost-effectiveness of counselling, graded- exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care - BMC Health Services Research 2012, 12:264.</p>

B9.1 Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)	
Comments	<p>Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary.</p> <p>NICE section 1.915 states:</p> <p>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</p>
B9.3 Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)	
Exceptionality – Prior Approval - Criteria	This is not routinely commissioned.
Evidence	<p>Interventions to reduce substance misuse among vulnerable young people –</p> <p>NICE Public Health Guidance 4 (2007)</p> <p>Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007).</p> <p>Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence –</p> <p>NICE Clinical Guideline 115 (2011).</p>

A9.4 Policy for Private Mental Health Care	
Policy Statement	Not routinely commissioned

10. Neurology

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

B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy
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B10.2 Trophic Electrical Stimulation for Facial/Bells Palsy	
Exceptionality – Prior Approval - Criteria	Not routinely commissioned.
Evidence	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).

B10.3 Functional Electrical Stimulation (FES)	
Exceptionality – Prior Approval - Criteria	<p>Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities. Exclusion Criteria:</p> <ul style="list-style-type: none"> • Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. <p>Ataxic and polio patients are generally poor responders although there are exceptions.</p>

B10.3 Functional Electrical Stimulation (FES)	
Evidence	<p>Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011.</p> <p>Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78.</p> <p>Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10.</p> <p>Functional electrical stimulation for drop foot of central neurological origin NICE, 2009.</p> <p>Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.</p>

11. Ophthalmology

B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	
Exceptionality – Prior Approval - Criteria	<p>Only commissioned in the following circumstances: Eyelid function interferes with visual field.</p>
Evidence	<p>Eyelid Surgery <i>The British Association of Aesthetic Plastic Surgeons 2011.</i></p> <p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.</p>

B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	
Comments	<p>Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.</p> <p>Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment.</p> <p>Impairment to visual field to be documented.</p>
B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid	
Exceptionality – Prior Approval - Criteria	<p>Only commissioned in any of the following circumstances:</p> <ul style="list-style-type: none"> • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.
Evidence	<p><u>Eyelid Surgery</u> The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted 2007. Modernisation Agency’s Action on Plastic Surgery 2005. <u>Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base</u> - London Health Observatory 2010.</p>
Comments	<p>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.</p>
B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)	
Exceptionality – Prior Approval - Criteria	<p>Only commissioned for Larger lesions which satisfy all of the following:</p> <ul style="list-style-type: none"> • Not responded to treatment for underlying familial lipoprotein lipase deficiency. • Failed topical treatment. • Causing significant disfigurement.

B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)	
	<ul style="list-style-type: none"> Causing functional impairment. Topical treatments may be available in a primary care or community setting.
Evidence	Local PCT consensus – review conducted 2007. DermNet NZ information resources updated Jan 2013. Commissioning Criteria – Plastic Surgery Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). http://www.patient.co.uk/doctor/xanthelasma
Comments	The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy. Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist. Lesions are harmless.

B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)
<p>This policy has been superseded by ICB Policy CMICB Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment v1 01/04/2023</p>

A11.5 Policy for Cataract Surgery	
Policy Statement	<p>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.</p> <p>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.</p> <p>This policy does not extend to cataract removal incidental to the management of other eye conditions.</p>
Minimum eligibility criteria	<p>Referral of patients to ophthalmologists for cataract surgery should be based on the following indications:</p> <ol style="list-style-type: none"> 1. The patient has sufficient cataract to account for visual symptoms. 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. 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: <ol style="list-style-type: none"> a. the patient is at significant risk of falls b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport c. including driving d. the impact of symptoms is compromising the patient's independence e. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities f. 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. g. the patient is experiencing disabling glare. <p>AND</p> 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/ 3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery


A11.5 Policy for Cataract Surgery	
	<p>Guidance for second eye surgery in patients with bilateral cataracts. The second eye criteria is:</p> <p>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</p>
Guidance/evidence	<p>Atlas of Variation <i>Tacking Unwarranted Variation in Healthcare across the NHS</i> Public Health England, NHS Right Care and NHS England September 2015 <i>Evidence Review Cataract Surgery</i> –ChaMPs May 2014 Royal College of Ophthalmologists <i>Commissioning Guide for Cataract Surgery</i> February 2015 NHS Choices NHS Patient Decision Aids – Cataract</p>

B11.6 Coloured (irlens) Filters for Treatment of Dyslexia
<p>This policy has been superseded by ICB Policy CMICB_Clin017 - Dyslexia Treatment using Coloured (Irlen) Filters v1 01/04/2023</p>

B11.7 Intra Ocular Telescope for Advanced Age-Related Macular Degeneration
<p>This policy has been superseded by ICB Policy CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT) v1 01/04/2023</p>

A11.8 Policy for Chalazia Removal
<p>This policy has been superseded by ICB Policy CMICB_Clin011 - Chalazia (meibomian cysts), removal v1 01/04/2023</p>

12. Oral Surgery

B12.1 Surgical Replacement of the Temporo- Mandibular Joint, Temporo-Mandibular Joint Dysfunction syndrome & Joint Replacement	
Exceptionality – Prior Approval - Criteria	<p>Only commissioned in the following circumstances:</p> <p>Any or a combination of the following symptoms are present:</p> <ul style="list-style-type: none"> • Restricted mouth opening <35mm). • Dietary score of < 5/10 (liquid scores 0, full diet scores 10). • Occlusal collapse (anterior open bite or retrusion). • Excessive condylar resorption and loss of height of vertical ramus. • Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). • Other significant quality of life issues. AND <p>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.</p>
Evidence	<p>Surgical Replacement of the Temporo- mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.</p> <p> TMJ Replacement Guidance .pdf</p> <p>Total prosthetic replacement of the Temporomandibular joint (IPG329)</p> <p>NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes</p>

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

Minimum eligibility criteria

Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria:

- There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. AND
- The patient's BMI is under 25 and has been stable for at least 12 months AND
- Aged over 18 years old.

<p>Evidence for inclusion and threshold</p>	<p>NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80 NICE Quality Standard 12 – Breast Cancer (2016) Weblink: https://www.nice.org.uk/guidance/qs12 British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0 Breast Cancer Care – Breast Reconstruction Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures”, 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf 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. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>
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<p>A14.3 Policy for Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation</p>	
<p>Minimum eligibility criteria</p>	<p>Removal and/or replacement of silicone implants is not routinely commissioned.</p> <p>The removal of ruptured silicone implants will only be commissioned in the following circumstances:</p> <p>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.</p>

Evidence for inclusion and threshold	<p>Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012). NHS Choices: PIP breast implants http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx NHS Choices: Breast Enlargement http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>
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A14.4 Policy for Mastopexy - Breast Lift

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	
Minimum eligibility criteria	<p>Not routinely commissioned except on an exceptional basis where all of the following criteria are met: True gynaecomastia not just adipose tissue.</p> <p>AND</p> <p>Underlying endocrine or liver abnormality excluded.</p> <p>AND</p> <p>Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this.</p> <p>AND</p> <p>Not due to prescribed drug use.</p> <p>AND</p> <p>Has not responded to medical management for at least three months e.g. tamoxifen.</p> <p>AND</p> <p>Post pubertal.</p> <p>AND</p> <p>BMI <25kg/m² and stable for at least 12 months.</p> <p>AND</p> <p>Patient experiences persistent pain.</p> <p>AND</p> <p>Experiences significant functional impairment.</p> <p>AND</p> <p>In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution.</p>
Evidence for inclusion and threshold	<p>Dickson, G. (2012). Gynecomastia. <i>American Family Physician</i>, 85(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf</p> <p>NHS Choices: Breast Reduction (male) http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-reduction-male.aspx</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>

A14.7 Policy for Hair Removal Treatments	
Minimum Eligibility Criteria	<p>Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence.</p> <p>In other circumstances only commissioned if either of the following clinical circumstances are met;</p> <ul style="list-style-type: none"> • Abnormally located hair-bearing skin following reconstructive surgery. • There is an existing endocrine medical condition and severe facial hirsutism. <ol style="list-style-type: none"> 1) Ferryman Gallwey (a method of evaluating and quantifying hirsutism in women). Score 3 or more per area to be treated. 2) Medical treatments have been tried for at least one year and failed. 3) Patients with a BMI of >30 should be in a weight reduction programme and should of lost at least 5% body weight. <p>All cases will be subject to an individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e., endocrinologist).</p> <p>Photographs will also be required to allow the CCG's to visibly assess the severity equitably. Funded for 6 treatments only at an NHS commissioned premises.</p> <p>Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.</p> <p>Where the provision of 'non-core' surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.</p>
Evidence for inclusion and threshold	<p>British Association of Dermatologists - hirsutism patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document</p> <p>NHS Choices – Laser Hair Removal Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx</p> <p>Pan Mersey APC Guidance for Eflornithine: http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=30670635620161221111329</p>

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	
Minimum eligibility criteria	<p>The CCG will fund this treatment if the patient meets the following criteria:</p> <ul style="list-style-type: none"> • For severe post burn cases or severe traumatic scarring <p>OR</p> <ul style="list-style-type: none"> • 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 <p>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.</p>
Evidence for inclusion and threshold	<p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p> <p>NHS Choices – Scars - Treatment http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx</p>

A14.10 Policy for Laser Tattoo Removal	
Minimum eligibility criteria	<p>Only commissioned in any of the following circumstances:</p> <ul style="list-style-type: none"> • Tattoo is result of trauma inflicted against the patient’s will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). <p>An individual funding request will be required.</p>
Evidence for inclusion and threshold	<p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service 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 NHS Choices – The NHS Guide to cosmetic procedures Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx</p>
A14.11 Abdominoplasty/Apronectomy (sometimes called ‘tummy tuck’)	
Minimum eligibility criteria	<p>Not routinely commissioned other than if all of the following criteria are met:</p> <p>The flap hangs at or below the level of the symphysis pubis.</p> <p>Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction).</p> <p>Bariatric surgery (if performed) was performed at least 3 years previously.</p> <p>AND any of the following:</p>

A14.11 Abdominoplasty/Apronectomy (sometimes called ‘tummy tuck’)	
	<p>Causes significant problems with activities of daily life (e.g. ambulatory restrictions).</p> <p>Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics.</p> <p>Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made)</p> <p>IFR information must contain the following information;</p> <ul style="list-style-type: none"> • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.
Evidence for inclusion and threshold	<p>A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).</p> <p>Royal College of Surgeons - Cosmetic Surgery Categorisation Weblink: https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file</p> <p>Royal College of Surgeons – Abdominoplasty Guide Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/</p> <p>NHS Choices: Tummy Tuck (abdominoplasty) http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>

A14.12 Policy for Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat

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

<p>Minimum eligibility criteria</p>	<p>Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned.</p> <p>The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx</p> <p>The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.</p>
<p>Evidence for inclusion and threshold</p>	<p>British Association of Dermatologists - alopecia areata patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document</p> <p>Interventions for alopecia areata – Cochrane Library 2008. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf</p> <p>Only one study which compared two topical corticosteroids showed significant short-term benefits.</p> <p>No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008.</p> <p>NICE Clinical Knowledge Summaries 2014. https://cks.nice.org.uk/alopecia-areata</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/</p>

A14.13 Policy for Surgical Treatments for hair Loss

	<p>Procedures not usually available on the National Health Service</p> <p>Modernisation Agency’s Action on Plastic Surgery 2005.</p> <p>http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2</p> <p>NHS Choices – Guide to Hair Loss Treatment Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx</p> <p>Hair transplantation</p> <p>A trial on subcutaneous pedicle island flap for eyebrow reconstruction – Mahmood & Mehri. <u>Burns</u>, 2010, Vol. 36(5), p692-697.</p> <p>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</p>
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A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy

<p>Minimum eligibility criteria</p>	<p>Not routinely commissioned</p>
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A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy	
Evidence for Inclusion and threshold	<p>rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6).</p> <p>http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf</p> <p>NHS Choices – Guide to Labiaplasty</p> <p>Weblink:</p> <p>http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx</p> <p>Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10.</p> <p>Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature.</p> <p>Goodman, M. P. (2009). Female Cosmetic Genital Surgery. <i>Obstetrics and Gynaecology</i>; 113: 154-159</p> <p>Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. <i>BJOG</i> 2007; 114:1493-1499.</p> <p>Department for Education and Skills. (2004). Local Authority Social Services Letter. LASSAL (2004)4, London, DfES.</p>
A14.17 Policy for Liposuction	
Minimum eligibility criteria	<p>May be commissioned as part of the management of true lipodystrophias or non-excisable clinical significant lipomata.</p> <p>An individual funding request will be required.</p>

A14.17 Policy for Liposuction	
Evidence for inclusion and threshold	<p>Royal College of Surgeons – Liposuction: Weblink https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/</p> <p>NHS Choices: Liposuction http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx</p> <p>Liposuction for chronic lymphoedema NICE 2008.</p> <p>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</p> <p>Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service</p>

A14.18 Policy for Rhytidectomy - Face or Brow Lift
This policy has been superseded by ICB Policy CMICB Clin042 – Rhytidectomy v1 01/04/2023

15. Respiratory

A15.1 Intervention for Snoring (not OSA)
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	
Minimum eligibility criteria	<p><u>Acupuncture</u></p> <p>Acupuncture for low back pain and sciatica is not routinely commissioned</p> <p><u>Manual Therapy</u></p> <p>The following procedures are not routinely commissioned:</p> <ul style="list-style-type: none"> • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation. <p>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.</p> <p><u>Orthotics</u></p> <p>The following are not routinely commissioned:</p> <ul style="list-style-type: none"> • Foot orthotics • Rocker shoes • Belts and corsets <p><u>Electrotherapy</u></p> <p>The following are not routinely commissioned:</p> <ul style="list-style-type: none"> • Transcutaneous electrical nerve stimulation (TENS)

A16.1 Policy for non-invasive interventions for low Back pain and sciatica

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

Pharmacological interventions

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

- Paracetamol used alone
- Selective serotonin re-uptake inhibitors (**SSRIs**)
- Serotonin– norepinephrine reuptake inhibitors
- Tricyclic antidepressants
- Anti-convulsants
- Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)

Patients with neuropathic pain should be managed in line with NICE CG 173:

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)

1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).

1.1.11 Consider capsaicin cream [4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

A16.1 Policy for non-invasive interventions for low Back pain and sciatica	
	<p><i>Treatments that should not be used</i></p> <p>1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:</p> <ul style="list-style-type: none"> • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.
Evidence for inclusion and threshold	<p>Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59</p> <p>National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf</p> <p>Osteoarthritis: the care and management of osteoarthritis in adults https://www.nice.org.uk/guidance/cg59</p> <p>The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012) http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf</p> <p>Final TAMARS report[1].pdf</p>

A16.2 Policy for Imaging for Patients Presenting with Low Back Pain	
Minimum eligibility criteria	<p>X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings. 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. 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.</p> <p>Emergency Spinal Referral</p> <ul style="list-style-type: none"> • Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms) • Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit) • Major motor radiculopathy • Suspected Spinal Infection <p>Priority Spine imaging (Protocol led MRI whole spine unless contraindicated)</p> <ul style="list-style-type: none"> • Past history of cancer *(new onset spinal pain) • Recent unexplained weight loss • Objectively unwell with spinal pain • Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity, CRP, ESR (according to local practice) • Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids). • Prolonged steroid use * • Known osteoporosis, with new severe spinal pain <p>Age <15, or >60 years new onset axial back pain</p> <p>*Statistically significant red flags. Although the others listed may not be</p>

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

A16.3 Policy for Injections for back pain	
Summary of Intervention	<p>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.</p> <p>Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.</p>

A16.3 Policy for Injections for back pain	
Minimum eligibility Criteria	<p>Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.</p> <p>For people with non-specific low back pain the following injections should not be offered:</p> <ul style="list-style-type: none"> • facet joint injections • therapeutic medial branch blocks • intradiscal therapy • prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis • Any other spinal injections not specifically covered above <p>Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.</p> <p>Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.</p> <p>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.</p> <p>For further information, please see: https://www.nice.org.uk/guidance/ng59</p>
Rationale	<p>Number of CCG interventions in 2017/18: 13,165</p> <p>NICE guidelines recommend that spinal injections should not be offered for nonspecific low back pain. 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.</p>

A16.3 Policy for Injections for back pain	
	<p>Exclusion criteria for the NICE (NG59) include: Conditions of a non-mechanical nature, including;</p> <ul style="list-style-type: none"> • Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera) • Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse) <p>Neurological disorders (including cauda equina syndrome or mononeuritis) Adolescent scoliosis Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease) Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.</p> <p>NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s</p> <p>Spinal injections 1.3.1 Do not offer spinal injections for managing nonspecific low back pain.</p> <p>Radiofrequency denervation 1.3.2 Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when: 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. 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. 1.3.4 Do not offer imaging for people with non-specific low back pain with specific facet joint pain as a prerequisite for radiofrequency denervation.</p> <p>References 1. NICE guidance: https://www.nice.org.uk/guidance/ng59, 2. United Kingdom Spine Societies Board: https://www.ukssb.com/improvingspinal-care-project</p>

A16.3 Policy for Injections for back pain	
	<p>3. 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 JulAug;15(4):E363-404.</p> <p>4. 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.</p> <p>5. 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.</p> <p>6. Royal College of Anaesthetists: https://www.rcoa.ac.uk/documentstore/core-standards-pain-management-services-the-uk</p>

A16.4 Policy for Spinal Fusion	
Minimum eligibility criteria	<p>The following procedures are not routinely commissioned:</p> <ul style="list-style-type: none"> • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed
Evidence for inclusion and threshold	<p>Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59</p> <p>National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf</p> <p>NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173</p> <p>IPG 387: https://www.nice.org.uk/guidance/ipg387</p> <p>Transaxial interbody lumbosacral fusion</p>

A16.5 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
Summary of Intervention	<p>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.</p> <p>Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery.</p> <p>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.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf</p> <p>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</p> <p>Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.</p>
Minimum Eligibility Criteria	<p>Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.</p> <p>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.</p>

A16.5 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
Rationale	<p>Number of CCG interventions in 2017/18: 13,930</p> <p>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. 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.</p> <p>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.</p> <p>Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails. There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.</p> <p>A review of the literature identified one further systematic review that looked at the effectiveness of surgery. 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.</p> <p>Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.</p> <p>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.</p> <p><u>References</u></p> <p>1. 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. <i>Lancet</i>. 2018 Jan 27;391(10118):329-</p>

A16.5 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
	<p>338. doi: 10.1016/S0140-6736(17)32457-1. Epub 2017 Nov 20. PubMed PMID: 29169668; PubMed Central PMCID: PMC5803129.</p> <p>2. 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.</p> <p>3. 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</p> <p>4. 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</p> <p>5. 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</p> <p>6. 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.</p> <p>7. https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-ShoulderCommissioning-Guide_final.pdf</p>

A16.6 Policy for Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain
This policy has been superseded by ICB Policy CMICB Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation v1 01/04/2023

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	
Exceptionality – Prior Approval -	<p>Dibotermin alfa is commissioned in the following situation:</p> <ul style="list-style-type: none"> The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and

B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha	
Criteria	<p>intramedullary unreamed nail fixation.</p> <ul style="list-style-type: none"> 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	<p>Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review</p> <p>Health Technology Assessment NHS R&D HTA Programme, 2007.</p> <p>Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI</p> <p>Annals of Internal Medicine Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data</p> <p>June 2013</p> <p>BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16</p>

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

<p>Minimum eligibility criteria</p>	<p>Referral is based on local referral pathways. The patient needs to be seen in an MCAS service before referral to a consultant.</p> <p>Referral criteria for <u>Total Hip Replacements (THR)</u> should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria:</p> <ol style="list-style-type: none"> 1. Patient complains of severe joint pain. <p>AND</p> <ol style="list-style-type: none"> 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. <p>OR</p> <ol style="list-style-type: none"> 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. <p>The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).</p>
<p>Evidence for inclusion and threshold</p>	<p>Royal College of Surgeons – Painful Hip Commissioning Guide https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/ NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014) Weblink: https://www.nice.org.uk/guidance/cg177 NHS Choices – Hip replacement Weblink: http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx</p>

A16.23b Policy for Knee Replacement Surgery	
Minimum eligibility criteria	<p>Referral is based on local referral pathways. The patient needs to be seen in an MCAS service before referral to a consultant.</p> <p>Funding for <u>total or partial knee replacement surgery</u> is available if the following criteria are met</p> <ol style="list-style-type: none"> 1. Patients with BMI <40. <p>AND</p> <ol style="list-style-type: none"> 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. <p>AND</p> <ol style="list-style-type: none"> 3. Has radiological features of severe disease. <p>OR</p> <ol style="list-style-type: none"> 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.
Guidance / evidence	<p>Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017) Weblink: https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en</p> <p>NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014) Weblink: https://www.nice.org.uk/guidance/cg177</p> <p>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</p> <p>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)</p> <p>NHS Choices – Knee replacement Weblink: http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx</p>

B16.24 Diagnostic Arthroscopy for Arthritis of the Knee

This policy has been superseded by [ICB Policy CMICB Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears v1 01/04/2023](#)

A16.25 Policy for Knee Arthroscopy with Osteoarthritis

This policy has been superseded by [ICB Policy CMICB Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023](#)

B16.26 Patient Specific Unicompartamental Knee Replacement

Exceptionality – Prior Approval - Criteria	This is not commissioned.
Evidence	IPG317 Individually magnetic resonance imaging- designedunicompartamental 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

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

This policy has been superseded by [ICB Policy CMICB_Clin010 – Carpal Tunnel interventions and surgery v1 01/04/2023](#)

B16.29 Surgical Removal of Muroid Cysts at Distal Inter Phalangeal Joint (DIP)

This policy has been superseded by [ICB Policy CMICB_Clin033 – Muroid 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 v1 01/04/2023](#)

B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement

Exceptionality – Prior Approval - 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:

- A definite diagnosis of hip impingement syndrome/femoro- acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans.
- An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.
- The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.

The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.

Evidence

[IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance](#) – NICE, 2011.
<http://www.hullccg.nhs.uk/uploads/policy/file/22/ hip-arthroscopy-hull-ccg.pdf>

B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement	
	<p>NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68.</p> <p>Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).</p> <p>Ng V Y et al.. Efficacy of Surgery for Femoro- acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345.</p> <p>Commissioning Guide: Painful osteoarthritis of the hip</p> <p>Royal College of Surgeons (2013).</p> <p>IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011</p>
Comments	<p>Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term.</p> <p>With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.</p>

B16.32 Surgical Removal of Bunions/Surgery for Lesser Toe Deformity

This policy has been superseded by [ICB Policy CMICB_Clin008 – Bunions, surgical removal v1 01/04/2023](#)

B16.33 Surgical Treatment of Morton’s Neuroma

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	
Exceptionality – Prior Approval - Criteria	<p>Surgical Treatment is not routinely commissioned unless the following pathway has been followed:</p> <ul style="list-style-type: none"> • Patient has documented evidence that they are not responding to conservative treatments • Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following: <ul style="list-style-type: none"> • Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss • Been referred to a podiatrist or physiotherapist <p>Not responded to corticosteroid injections</p>
Evidence	<p>Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008;38(4):A1-A18.</p> <p>Plantar fasciitis</p> <p>NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.</p>

B16.35 Treatment of Tendinopathies (Extracorporeal Shock Wave Therapy; Autologous Blood or Platelet Injection)
<p>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</p>

A16.36 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
Summary of intervention	<p>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. Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery.</p> <p>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</p> <p>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</p>
Policy Statement	<p>Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.</p>
Minimum eligibility criteria	<p>Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.</p> <p>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</p>
Rationale	<p>Number of CCG interventions in 2017/18 – 13,930</p> <p>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 function¹. 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.</p> <p>On the other hand, a more recent prospective randomised trial comparing the long-term outcome (10 year follow</p>

A16.36 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
	<p>up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment³</p> <p>Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-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</p> <p>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.</p> <p>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</p> <p>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.</p>
Evidence for inclusion and threshold	<p><u>References</u></p> <ol style="list-style-type: none"> 1. 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. <i>Lancet</i>. 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. 2. Dorrestijn O, Stevens M, Winters JC, van der Meer K, Diercks RL. Conservative or surgical treatment for subacromial impingement syndrome? A systematic review. <i>J Shoulder Elbow Surg</i> 2009; 18: 652–60. 3. 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. <i>Am J Sports Med</i>. 2018 May;46(6):1397-1407 4. 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. <i>BMJ</i>. 2012 Feb 20;344:e787. doi: 10.1136/bmj.e787 5. Magaji SA, Singh HP, Pandey RK. Arthroscopic subacromial decompression is effective in selected

A16.36 Policy for Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain	
	<p>patients with shoulder impingement syndrome. J Bone Joint Surg Br. 2012 Aug;94(8):1086-9</p> <p>6. 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.</p> <p>7. https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf</p>

17. Urology

A17.1 Policy for Circumcision for medical reasons only	
<p>Minimum eligibility criteria</p>	<p>Circumcision will be funded in the following medical circumstances:</p> <ul style="list-style-type: none"> • Balantia xerotica obliterans. • Traumatic foreskin injury/scarring where it cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. • Tight foreskin causing pain on arousal/ interfering with sexual function <p>This is because if the patient does not meet the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk.</p> <p>This procedure is not offered for social, cultural or religious reasons.</p>

A17.1 Policy for Circumcision for medical reasons only	
Evidence for inclusion and threshold	<p>2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis NICE Clinical Knowledge Summaries 2015 I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions--commissioning-guide.pdf Foreskin Conditions: Royal College of Surgeons guidance (2013). NHS Choices – Circumcision Weblink: http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2000 https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/</p>

B17.3 Reversal of Male Sterilisation
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	
Exceptionality – Prior Approval - Criteria	This is not commissioned as there is limited clinical evidence of effectiveness.
Evidence	<p>Guidelines on chronic pelvic pain European Association of Urology (2012). https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf</p>

B17.5 Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome	
Exceptionality – Prior Approval - Criteria	This is not commissioned as there is limited evidence of effectiveness.
B17.6 Surgery for Prostatism	
Exceptionality – Prior Approval - Criteria	<p>Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances:</p> <ul style="list-style-type: none"> • International prostate symptom score >7; dysuria; • Post voided residual volume >150ml; • Recurrent proven Urinary Tract Infections (UTI); • Deranged renal function; <p>Prostate-specific antigen (PSA) > age adjusted normal values.</p>
Evidence	<p>CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men</p> <p>NICE 2010.</p> <p>LUTS in men, age-related (prostatism)</p> <p>NICE Clinical Knowledge Summaries (2010).</p> <p>http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts</p> <p>Royal College of Surgeons (2013).</p>
Comments	No references to treatment thresholds found.

18. Vascular Surgery

B18.1 Surgery for Extreme Sweating (Hyperhidrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy)

This policy has been superseded by [ICB Policy CMICB Clin027 – Hyperhidrosis \(excessive sweating\), Surgical Management v1 01/04/2023](#)

B18.2 Chelation Therapy for Vascular Occlusions

This policy has been superseded by [ICB Policy CMICB Clin015 – Disodium Ethylenediaminetetraacetic Acid \(EDTA\) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction v1 01/04/2023](#)

A18.3 Policy for Varicose Veins Interventions

This policy has been superseded by [ICB Policy CMICB Clin049 – Varicose Veins v1 01/04/2023](#)

19. Other

B19.1 Botulinum Toxin A & B

Exceptionality – Prior Approval - Criteria

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

The use of botulinum toxin type A is commissioned in the following indications:

- Anal fissures only following a minimum of two months with standard treatment (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.

B19.1 Botulinum Toxin A & B

- Blepharospasm and hemifacial spasm.
- Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). <http://guidance.nice.org.uk/CG8>
- Focal dystonia, where other measures are inappropriate or ineffective.
- Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective.
- Idiopathic cervical dystonia (spasmodic torticollis).
- Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). <http://guidance.nice.org.uk/TA260>
- Refractory detrusor overactivity, only in line with NICE Clinical Guideline 171 (women) <http://guidance.nice.org.uk/CG171> and Clinical Guideline 97 (men) <http://guidance.nice.org.uk/CG97> where conservative therapy and conventional drug treatment has failed to control symptoms.
- Sialorrhoea (excessive salivary drooling), when all other treatments have failed.

Botulinum toxin type A is not routinely commissioned in the following indications:

- Canthal lines (crow's feet) and glabellar (frown) lines.
- Hyperhidrosis.
- Any other indication that is not listed above

The use of Botulinum Type B is not routinely commissioned.

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

For patients with conditions which are not routinely commissioned, as indicated above, requests will

B19.1 Botulinum Toxin A & B	
	<p>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.</p> <p>Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes.</p> <p>If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.</p>
Evidence	<p>NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260</p> <p>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.</p> <p>Diagnosis and management of hyperhidrosis British Medical Journal.</p>

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

Knowsley 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/B16.28	CMICB_Clin010	1	01/04/2023	Carpal Tunnel interventions and surgery
A11.8/B11.8	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/B16.21 / B16.22	CMICB_Clin016	1	01/04/2023	Dupuytren's Contracture release in adults
B11.6	CMICB_Clin017	1	01/04/2023	Dyslexia Treatment using Coloured (Irlen) Filters

NHS Knowsley Clinical Commissioning Group

Knowsley CCG Ref	ICB Policy Ref	ICB Version Number	ICB Date Published	ICB Policy Title
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	1	01/04/2023	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
A8.2/B18.1	CMICB_Clin027	1	01/04/2023	Hyperhidrosis (excessive sweating), Surgical Management
A16.25/B16.25	CMICB_Clin028	1	01/04/2023	Knee Osteoarthritis, Arthroscopic Lavage and Debridement
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)
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

Knowsley CCG Ref	ICB Policy Ref	ICB Version Number	ICB Date Published	ICB Policy Title
B17.3	CMICB_Clin040	1	01/04/2023	Reversal of Male Sterilisation
B4.8	CMICB_Clin041	1	01/04/2023	Rhinophyma, surgical management
A14.18	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/B16.18	CMICB_Clin048	1	01/04/2023	Trigger Finger release in adults
A18.3	CMICB_Clin049	1	01/04/2023	Varicose Veins

In addition to those policies listed readers should note the following NHS Knowsley CCG commissioning policies which stand as policies in their own right outside of this document, these include:

- Continuous Glucose Monitoring Policy
- Gluten Free Policy
- Pinnaplasty Policy
- Subfertility Policy