Procedures of Low Clinical Priority (Cheshire Commissioning Policy)

NHS Eastern Cheshire, NHS South Cheshire, NHS West Cheshire and NHS Vale Royal CCGs

Version 6 – 17 July 2024

NOTE:
April 2023 – Document updated to reference Cheshire and Merseyside Integrated Care Board (ICB) harmonized policies.
September 2023 – Document updated to include hyperlinks to ICB harmonized policies.
18 March 2024 – Document updated to include additional hyperlinks to ICB harmonized policies.
17 July 2024 – Document updated to reinsert unilateral breast reduction policy and update IFR Team telephone number and address

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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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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
2017	1	First published by individual CCG organisations NHS Eastern Cheshire, NHS West Cheshire, NHS South Cheshire and NHS Vale Royal.
April 2019	2	Single policy adopted and ratified by NHS Cheshire CCG
April 2023	3	Policy amended to illustrate removal of policy positions as superseded by Cheshire and Merseyside ICB policies 01/04/2023 as referenced and as listed in Appendix 5. Readers should note the following standalone NHS Cheshire 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: • Continuous Glucose Monitoring • Gluten Free • Subfertility
September 2023	4	Policy document amended to include hyperlinks to ICB policies (Phase 1).
18 March 2024	5	Policy document amended to include additional hyperlinks to ICB policies (Phase 2).
17 July 2024	6	Policy document amended to reinsert unilateral breast reduction policy and amend IFR Team telephone number, email and address

Contents

A. INTRODUCTION

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

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

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

The NHS Standard Contract requires that the provider must manage referrals in accordance with the terms of any Prior Approval Scheme. If the provider does not comply with the terms of any Prior Approval Scheme in providing a service, the commissioners will not be liable to pay for that service. This includes compliance with terms SC28 to SC31 of the contract which specifically reference procedures included in this policy.

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

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

B. CORE CLINICAL ELIGIBILITY

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

- All NICE Technology Appraisals will be implemented.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis. Any patient who needs urgent treatment will always be treated.
- No treatment is completely ruled out if an individual patient's circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patient's responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.
- Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

C. REFERRAL & APPROVAL PROCESS

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

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

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

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

Have received prior approval by the CCG.
OR
Clearly state how the patient meets the criteria.
OR
Be for a clinical opinion to obtain further information to assess the patient's eligibility.

GPs should not refer unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. In cases where there may be an element of doubt the GP should discuss the case with the IFR Team in the first instance.

If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information and the CCG notified. Where a GP requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given to the GP and the patient returned to the GP's care, in order for the GP to make a decision on future treatment.

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

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

Where the treatment has changed in the middle of a care pathway and a decision to treat has been made based on the old criteria the treatment can be completed i.e. if the patient has been listed for surgery. Where a clinical decision as to the nature of treatment has not yet been made then the new

criteria should be applied with immediate effect.

D. EXCEPTIONALITY

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

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

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

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

E. PSYCHOLOGICAL DISTRESS

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

Unless specifically stated otherwise in the policy, any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

F. PERSONAL DATA (INCLUDING PHOTOGRAPHS)

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

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence: Clearly label the envelope to a named individual i.e. first name & surname, and job title.
Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.

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

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

G. MEDICINES MANAGEMENT

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

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

- Any medicines that will be supplied via a homecare company agreement.

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

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

Conditions & Interventions: The conditions & interventions have been broken down into speciality groups.

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

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

Where CCGs have variations in their local clinical policies/pathways or clinical thresholds then this will be highlighted in the comments section indicating there is a local CCG addendum.

H. EVIDENCE

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

I. POLICIES

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
1. Complementary Therapies				
1.1	**Complementary Therapies**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin067 – Complementary and alternative therapies		
2. Dermatology				
2.1	**Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)**	Only be commissioned in the following circumstances: Severe scarring following: • Acne once the active disease is controlled. • Chicken pox. OR • Trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & 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	Modernisation Agency's Action on Plastic Surgery 2005. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. www.evidence.nhs.uk Interim Gender Dysphoria Protocol &	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		partnership with the CCG.	Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
2.2	**Surgical or Laser Therapy Treatments for Minor Benign Skin Lesions e.g. sebaceous cyst**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin005 – Benign skin lesions		
2.4	**Treatments for Skin Pigment Disorders**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin009 – Camouflage Treatment for Skin Pigmentation and other disorders		
2.5	**Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Intermediate Tier/ Secondary Care Providers**	Will be commissioned in any of the following circumstances: • 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.	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae	Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
				to secondary care.
2.6	**Secondary Care treatment for Acne Vulgaris**	Will be commissioned in any of the following circumstances: • Patient has severe acne that is unresponsive to oral antibacterials • Patient has moderate to severe acne that is partially unresponsive to treatment that is starting to scar • Patients with acne who have failed two full courses of oral antibiotic treatment combined with appropriate topical treatment for a minimum of 6 months • Patients with severe nodulo-cystic, conglobate acne • Patients at risk of post-inflammatory hyperpigmentation • Patients with associated and severe psychological symptoms regardless of severity of acne Patients that do not meet this criteria should be managed in Primary Care.	https://cks.nice.org.uk/acne-vulgaris http://www.nhs.uk/conditions/acne/pages/treatmentoptions.aspx	ACNE VULGARIS.docx
2.7	**PMLE (Polymorphic Light Eruption) Treatment - Desensitising Light Therapy using UVB (ultra-violet shortwave) or PUVA (Psoralen combined**	Will be commissioned if ALL of the following criteria are met: • Diagnosis by Dermatology Consultant • Severe with symptoms causing significant functional impairment (Symptoms preventing the patient fulfilling vital work or educational	http://www.bad.org.uk/shared/get-file.ashx?id=117&itemtype=document http://www.nhs.uk/conditions/polymorphic-light-eruption/Pages/Introduction.aspx	Clinical discussion with the patient should include educating patients not to use sunbeds as an alternative. It is not comparable to desensitising light therapy and carries additional health risks.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	with UVA)	responsibilities - Symptoms preventing the patient carrying out vital domestic or carer activities) • Symptoms remain severe despite preventative treatments • Light therapy deemed likely to make significant improvement to patients symptoms		
3. Diabetes				
3.1	**Continuous Glucose Monitoring (CGM) Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus**	This policy has been superseded as follows: *At the NHS Cheshire & Merseyside ICB Board Meeting held on 27 October 2022, it was agreed that the former CCG commissioning polices in respect of CGMs be retired, and the recommendations within NICE guidance NG17, NG18 and NG28 be adopted.*		
3.2	**Monogenic Diabetes Testing Maturity Onset Diabetes of the Young (MODY)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin031 – Monogenic Diabetes Testing		
4. ENT				
4.1	**Adenoidectomy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin002 – Adenoidectomy		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.2	**Pinnaplasty – for Correction of Prominent Ears**	May be commissioned in the following circumstances: Surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged up to18 years at the time of referral. AND 2. With very significant ear deformity or asymmetry. AND 3. Patients present with significant detrimental impact on child's ability to lead a normal life Patients not meeting these criteria should not be routinely referred for surgery. Incisionless otoplasty is not commissioned.	Pinnaplasty Department of Health (2007). Local PCT consensus - review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. IPG 422: Incisionless otoplasty NICE 2012. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty Royal College of Surgeons (2013).	
4.3	**Insertion of Grommets for Glue Ear (otitis media with effusion)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin023 – Grommets for glue ear in children		
4.4	**Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin046 – Tonsillectomy		
4.5	**Surgical Remodelling of External Ear Lobe**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin45 – Split (cleft) Earlobe, surgical repair		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.6	**Use of Sinus X-ray**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin44 – Sinus X-Ray		
4.7	**Rhinoplasty - Surgery to Reshape the Nose**	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment.
4.8	**Surgery of Laser Treatment of Rhinophyma**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin41 - Rhinophyma, surgical management		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
4.9	**Septorhinoplasty**	Only commissioned where: • patient has a deviated septum causing significant and persistent nasal blockage AND • septoplasty alone will not improve functional impairment OR • significant symptoms post trauma/cancer treatment/ severe congenital abnormality This procedure is not commissioned for cosmetic reasons	http://www.lnwh.nhs.uk/services/a-z-services/e/ent-ear-nose-and-throat/ent-operations/nose-operations/septorhinoplasty/	
4.10	**Ear Wax removal including microsuction (excluding primary care)**	Only commissioned where: • Perforated ear drum OR • Otitis Externa OR • Hearing loss and all other methods of wax removal have been tried and failed OR • Enable inspection of ear drum due to clinical concern of other pathologies and other methods of wax removal have failed OR • Clinical risk of other methods of removal	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2907972/	Ear wax removal should be managed in primary care and does not require onward referral.
5. Equipment				
5.1	**Use of Lycra Suits**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin071 – Lycra™ Suits and Orthotics (Dynamic Elastomeric Fabric Orthoses)		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
6. Fertility				
6.1	**Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation.**	See Infertility Treatment for Subfertility Policy for Cheshire CCGs.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	Individual CCG addendums apply.
7. General Surgery				
7.1	**Haemorrhoidectomy - Rectal Surgery** **Removal of Haemorrhoidal Skin Tags**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin024 – Haemorrhoids, surgical management		
7.2	**Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias** **Surgical correction of Diastasis of the Recti**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin083 – Minimally symptomatic inguinal hermia repair This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin014 – Diastasis (divarication) of the Recti Repair		
7.3	**Surgery for Asymptomatic Gallstones**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin021 – Gallstones (Asymptomatic), Surgical Management		
7.4	**Lithotripsy for**	Lithotripsy not routinely commissioned.		Lithotripsy rarely performed

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Gallstones			as rate of recurrence is high.
7.5	**Rectopexy and STARR (Stapled Transanal Resection of the Rectum)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin108 – Rectal Prolapse (Internal or External), Surgical Management Policy		
8. Gynaecology				
8.1	**Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy with or without Oophrectomy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy		
8.2	**D&C (dilatation and curettage)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage		
8.3	**Hysteroscopy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin076 – Heavy menstrual bleeding – hysteroscopy policy		
8.4	**Fibroid Embolisation / uterine artery embolisation**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin075 – Fibroids (myoma, leiomyoma), uterine artery embolisation (UAE)		
8.5	**Surgical correction of vaginal/ uterovaginal prolapse**	This will only be commissioned if: • symptomatic prolapse (causing significant pressure and discomfort to affect activities of daily living) OR	http://www.nhs.uk/conditions/Prolapse-of-the- uterus/Pages/Introduction.aspx	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Prolapse combined with urethral sphincter incompetence/ urinary incontinence or faecal incontinence (significantly affecting urinary, bowel function or sexual function) • Key outcomes of intervention should be restoration of bladder, bowel and sexual function and long-term success AND • Evidence that for mild-to-moderate prolapse conservative management has been trialed and failed including; lifestyle modification, pelvic floor exercises, electrical stimulation, biofeedback, vaginal pessary, local oestrogen creams and oral treatments unless contraindicated. For severe prolapse consider non-surgical treatments first, after assessing likely impact (positive and negative) on the key outcomes. AND • If prolapse is severe or is mild-to-moderate but symptoms cause significant functional impairment (Symptoms significantly affecting the patient fulfilling activities of daily living vital work or educational responsibilities – including symptoms significantly affecting the patient carrying out vital domestic or carer activities)		
8.6	**Secondary Care**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	follow up of mirena coil insertion	CMICB_Clin078 – Intrauterine devices: secondary care checking following insertion		
9. Mental Health				
9.1	**Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin066 – Chronic fatigue syndrome/Myalgic Encephalomyelitis (CFS/ME): Inpatient Management		
9.2	**Gender Dysphoria**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin069 – Gender incongruence services		
9.3	**Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin072 – Private Drug and Alcohol Rehabilitation		
9.4	**Private Mental Health (MH) Care - Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care,post-traumatic stress adolescent mental health**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin073 – Mental health disorders, specialist, general and non-NHS services		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
10. Neurology				
10.1	**Bobath Therapy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin063 – Bobath Therapy		
10.2	**Trophic Electrical Stimulation for Facial/Bells Palsy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin062 – Idiopathic Facial Paralysis (Bell's Palsy) -Trophic Electrical Stimulation		
10.3	**Functional Electrical Stimulation (FES)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin064 – Foot Drop, Functional Electrical Stimulation (FES)		
11. Ophthalmology				
11.1	**Upper Lid Blepharoplasty - Surgery on the Upper Eyelid**	Only commissioned in the following circumstances: Eyelid function interferes with visual field.	Eyelid Surgery *The British Association of Aesthetic Plastic Surgeons 2011.*	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.
11.2	**Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.**	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	Eyelid Surgery The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.
11.3	**Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin005 – Benign skin lesions		
11.4	**Surgery or Laser Treatment for Short Sightedness**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	(myopia) or Long Sightedness (hypermetropia)			
11.5	**Cataract Surgery**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin097 – Cataract Surgery		
11.6	**Coloured (irlens) Filters for Treatment of Dyslexia**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin017 - Visual stress and reading difficulties treatment_using coloured filters or lenses		
11.7	**Intra Ocular Telescope for Advanced Age-Related Macular Degeneration**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT)		
11.8	**Surgical Removal of Chalazion or Meibomian Cysts**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin011 - Chalazia (meibomian cysts), removal		
11.9	**Surgical treatment for Proptosis/ Dysthyroid eye disease**	Only commissioned if: • condition caused by thyroid disease • artificial tears have been tried for at least 6 months and failed	http://patient.info/doctor/thyroid-eye-disease-pro	
11.10	**Photodynamic Therapy for ARMD**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin079 – Age Related Macular Degeneration (AMD)- Photodynamic Therapy		
11.11	**Multifocal (non-accommodative) intraocular lenses**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin003 – Age Related Macular Degeneration (AMD) – implantable miniature telescope (IMT)		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
12. Oral Surgery				
12.1	**Surgical Replacement of the Temporo-Mandibular Joint** **Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin093 – Temporomandibular joint, surgical replacement		
13. Paediatrics				
13.1	**Cranial Banding for Positional Plagiocephaly**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin039 - Positional Plagiocephaly/brachycephaly in children, helmet therapy		
14. Plastic & Cosmetic Surgery				
14.1	**Reduction Mammoplasty - Female Breast Reduction**	This policy for bilateral breast reduction has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin007 – Breast Reduction **14.1b Unilateral Breast Reduction Surgery: Breast Asymmetry** Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria below: • The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. • In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Body mass index (BMI) is <27 and stable for at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. • Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 - 200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months. Resection weights, for unilateral breast reduction should be recorded for audit purposes. This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment.		
14.2	**Augmentation Mammoplasty - Breast Enlargement**	This procedure is not routinely commissioned. The following exceptions apply: In all cases: • The BMI is <25 and stable for at least twelve months. AND • Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. Patients requiring reconstructive surgery post cancer treatment are excluded from	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	Patients should be made aware that: 1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		this policy. All non-surgical options must have been explored e.g. padded bra. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. 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. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning	Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			responsibilities.	
14.3	**Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation**	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision. 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.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012). Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.
14.4	**Mastopexy - Breast Lift**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin030 – Mastopexy (breast lift)		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
14.5	**Surgical Correction of Nipple Inversion**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin035 – Nipple inversion, surgical correction		
14.6	**Male Breast Reduction Surgery for Gynaecomastia**	Not routinely commissioned. The following exception will apply: • gynaecomastia caused by cancer treatment 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.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
14.7	**Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism**	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances not routinely commissioned. Will be considered via Individual Funding Request if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist). Photographs will also be required to allow the CCG's to visibly asses the severity equitably.	Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70). cks.nice.org.uk/hirsutism#!scenario - NICE: Clinical Knowledge Summaries 2010. Laser and photoepilation for unwanted hair growth – Cochrane Library 2009. Management of hirsutism – Koulouri et al *BMJ* 2009; 338:b847. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Funded for 6 treatments only at an NHS commissioned premises. 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.		
14.8	**Surgical Treatment for Pigeon Chest**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin038 – Pectus Deformity, surgical treatment		
14.9	**Surgical Revision of Scars**	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. 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.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
14.10	**Laser Tattoo Removal**	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). • An individual funding request will be required.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
14.11	**Apronectomy or Abdominoplasty (Tummy Tuck)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin099 – Abdominoplasty or Apronectomy (tummy tuck)		
14.12	**Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin006 – Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty)		
14.13	**Treatments to Correct Hair Loss for Alopecia**	Only commissioned in either of the following circumstances: • Result of previous surgery. • Result of trauma, including burns. Hair Intralace System is not commissioned.	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 Interventions for alopecia areata – Cochrane Library 2008.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		Dermatography is not commissioned. NHS wigs will be available according to NHS policy. 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	http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. Alopecia areata – NICE Clinical Knowledge Summaries 2008. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding).	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.14	**Hair Transplantation**	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. 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.	A trial on subcutaneous pedicle island flap for eyebrow reconstruction – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 further evidence provided within this document by Islington PCT to support funding. Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
			responsibilities.	
14.15	**Treatments to Correct Male Pattern Baldness**	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	
14.16	**Labiaplasty, Vaginoplasty and Hymenorrhaphy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin077 – Labiaplasty, vaginoplasty and hymenorrhaphy		
14.17	**Liposuction**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin0100 – Liposuction		
14.18	**Rhytidectomy - Face or Brow Lift**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin042 – Rhytidectomy		
14.19	**All procedures undertaken on cosmetic grounds**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin013 – Cosmetic Procedures		
15. Respiratory				
15.1	**Treatments for Snoring Soft Palate Implants and Radiofrequency Ablation of the Soft Palate** **Sodium Tetradecyl Sulfate (STS)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin043 – Simple snoring, surgical management		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Injection or 'snoreplasty' **Uvulopalatoplasty and Uvulopalatopharyngopl asy**			
15.2	**Investigations and treatment for Sleep Apnoea**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin074 – Sleep Apnoea or Narcolepsy referral and management		
15.3	**Sleep studies/ Hypersomnia**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin074 – Sleep Apnoea or Narcolepsy referral and management		
16. Trauma & Orthopaedics				
16.1	**Low back pain and sciatica in over 16's Diagnostic, Interventions and Treatments for acute and chronic low back pain. Excluding spinal pathology, radiculopathy and children.** **Pharmacological Intervention for lower back pain**	Diagnostic imaging should not be routinely offered unless: • in a specialist setting where the results are likely to change clinical management OR • Diagnostic imaging is required prior to referral for surgical intervention Management should be in line with NICE Guidance and should consist of advice and information to enable self-management. Patients should be encouraged to continue with normal activities. Structured exercise programmes (including group exercise),	https://www.nice.org.uk/guidance/NG59	Amendments made based on version developed by Lancashire & Midlands CSU in collaboration with the Walton Centre

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Pharmacological intervention for sciatica (neuropathic pain in adults)	psychological therapies and manual therapy should be considered. Manual therapy should only be offered as part of a treatment package, including exercise with or without psychological therapy. Spinal injections of local anaesthetic and steroid should not be offered for patients with non- specific low back pain. For people with non-specific low back pain the following injections should not be offered: • 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 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		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		diagnostic medical branch block. Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway. Consider oral non-steroidal anti-inflammatory drugs (NSAIDS) at lowest effective dose for shortest possible time. If NSAIDS are contraindicated/ not tolerated or ineffective, consider weak opiods. **Do <u>not</u>** offer: • Paracetamol alone • Opioids for acute low back pain (unless NSAIDs are contraindicated) • Opioids for chronic low back pain • Selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine, reuptake inhibitors or • tricyclic antidepressants		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• Anticonvulsants Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia). If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. Consider tramadol only if acute rescue therapy is needed (see NICE Guidance CG173 for long term use). Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		• tramadol (this is referring to long-term use) • venlafaxine		
16.2	**Radiofrequency Facet Joint Denervation**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin089 – Chronic Low Back Pain, Radiofrequency Denervation		
16.3	**Fusion**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain		
16.4	**Epidural Injection**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin060 – Spinal Injections for Low Back Pain		
16.5	**Spinal Decompression**	Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.		
16.6	**Endoscopic Laser Foraminoplasty**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin018 – Endoscopic Laser Foraminoplasty		
16.7	**Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation		
16.8	**Endoscopic Lumbar Decompression**	This procedure is NOT routinely commissioned.	IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.9	**Percutaneous Disc Decompression using Coblation for Lower Back Pain**	This procedure is NOT routinely commissioned.	IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006	
16.10	**Non-Rigid Stabilisation Techniques**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin090 – Non-rigid stabilisation techniques for degenerative disease of the lumbar spine		
16.11	**Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain		
16.12	**Percutaneous Intradiscal Laser Ablation in the Lumbar Spine**	This procedure is NOT routinely commissioned.	IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.	
16.13	**Transaxial Interbody Lumbosacral Fusion**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain		
16.14	**Therapeutic Endoscopic Division of Epidural Adhesions**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division		
16.15	**Automated Percutaneous Mechanical Lumbar Discectomy**	This procedure is NOT routinely commissioned.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	
16.16	**Prosthetic Intervertebral Disc Replacement in the**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin029 – Low back pain, disc replacement		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Lumbar Spine			
16.17	**Bone Morphogenetic Proteins - Dibotermin Alfa; Eptotermin Alpha**	Dibotermin alfa is commissioned in the following situation: The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. Eptotermin alfa is commissioned in line with its licensed indication: Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
16.18	**Surgery for Trigger Finger**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin048 – Trigger Finger release in adults		
16.19	**Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin036 – Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid)		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.20	**Secondary Care Administered Steroid Joint Injections**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin037 – Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids		
16.21	**Dupuytren's Disease Palmar Fasciectomy/Needle Faciotomy** **Radiotherapy Collagenase Injections for Dupuytren's Disease** **Dupuytren's Disease Surgical treatment** **Dupuytrens Contracture – conservative treatment**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin016 – Dupuytren's Contracture release in adults		
16.24	**Hip and Knee Replacement Surgery & Hip Resurfacing**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin084 – Hip and knee replacement surgery		
16.25	**Diagnostic Arthroscopy for Arthritis of the Knee**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.26	**Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement		
16.27	**Patient Specific Unicompartmental Knee Replacement**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: ICB Policy CMICB_Clin094 – Patient-specific unicompartmental knee replacement		
16.28	**Patient Specific Total Knee Replacement**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin047 – Total Knee Arthroplasty, patient specific instrumentation/implants		
16.29	**Surgical Treatment for Carpal Tunnel Syndrome**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin010 – Carpal Tunnel interventions and surgery		
16.30	**Nerve Conduction Studies for Carpal Tunnel Syndrome**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin112 – Carpal Tunnel Syndrome, Nerve Conduction Testing		
16.31	**Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin033 – Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal		
16.32	**Surgical Removal of Ganglions**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin022 – Ganglia, surgical removal and general management		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.33	**Hip Arthroscopy for Femoro–Acetabular Impingement**	CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months. The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. 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). 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. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.
16.34	**Surgical Removal of Bunions/Surgery for Lesser Toe**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin008 – Bunions, surgical removal		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
	Deformity			
16.35	**Surgical Treatment of Morton's Neuroma**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin032 – Morton's Neuroma, surgical treatment		
16.36	**Surgical Treatment of Plantar Fasciitis**	Surgical Treatment is not routinely commissioned unless the following pathway has been followed: 1. Patient has documented evidence that they are not responding to conservative treatments 2. Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following. 3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss. 4. Been referred to a podiatrist or physiotherapist. 5. Not responded to corticosteroid injections.	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. Plantar fasciitis NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.	
16.37	**Treatment of Tendinopathies Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin001 - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
16.38	**Injections for Tendonitis (Jumpers Knee)**	Injections for Tendonitis (Jumpers Knee) are not routinely commissioned.	http://www.nhs.uk/Conditions/Tendonitis/Pages/Treatment.aspx	
16.39	**Shoulder Arthroscopy (including arthroscopic shoulder decompression for subacromial shoulder pain)**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin092 – Subacromial shoulder pain, arthroscopic shoulder decompression surgery		
16.40	**Hip Injections**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin059 – Hip pain, intra-articular injections of corticosteroids		
17. Urology				
17.1	**Circumcision**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin104 – Penile circumcision in children and young people under 16 years		
17.2	**Penile Implant: A Surgical Procedure to Implant a Device into the Penis**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin020 – Erectile dysfunction, penile prosthesis surgery		
17.3	**Erectile Dysfunction – secondary care**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin110 – Erectile Dysfunction – secondary care referral		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
17.4	**Male sterilisation under Local Anaesthetic**	This is currently routinely commissioned via community providers ONLY (list of providers available from the Local CCG - unless attempted in community services but failed procedure due to patient discomfort or technical difficulty preventing completion. Direct referral will then be made by Community Provider to secondary care.		
	Male sterilisation under General Anaesthetic	This is not routinely commissioned and would require IFR. Criteria would include- significant scrotal/hemiscrotal pathology that would prevent safe management under local anaesthetic. Personal preference of patient for General Anaesthetic is not a reason for NHS funded care.		
17.5	**Reversal of Male Sterilisation**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: ICB Policy CMICB_Clin040 – Reversal of Male Sterilisation		
17.6	**ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin111 – Chronic Pelvic Pain Syndrome in Men, Hyperthermia, Extracorporeal Shockwave Therapy and Sacral Neuromodulation		
17.7	**Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin111 – Chronic Pelvic Pain Syndrome in Men, Hyperthermia, Extracorporeal Shockwave Therapy and Sacral Neuromodulation		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
17.8	**Surgery for Prostatism**	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: International prostate symptom score >7; dysuria; • Post voided residual volume >150ml; • Recurrent proven Urinary Tract Infections (UTI); • Deranged renal function; • Prostate-specific antigen (PSA) > age adjusted normal values.	CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts Royal College of Surgeons (2013).	No references to treatment thresholds found.
17.9	**Surgical treatment for Hydroceles – adults and children**	Only commissioned if: In the case of communicating hydrocele: • patient is aged over 18 months of age In the case of non-communicating hydrocele, the patient is experiencing: • discomfort and/or disfigurement resulting in functional impairment preventing individual fulfilling work/study/carer or domestic duties (adult) or • discomfort and/or disfigurement resulting in inability to participate in normal social and educational activity (adolescent)	http://patient.info/health/hydrocele-in-adults	
17.10	**Surgical removal of benign epididymal cysts**	Not routinely commissioned. Exclusion apply only if **ALL** the following criteria are met: • it is large enough to cause change in	http://patient.info/health/epididymal-cyst	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		shape and size of scrotum • cyst is putting pressure on other structures in the testes • cyst is causing prolonged or significant pain		
18. Vascular				
18.1	**Surgery for Extreme Sweating** **Hyperhydrosis – all areas** **Surgical Resection Endoscopic Thoracic Sympathectomy**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management		
18.2	**Chelation Therapy for Vascular Occlusions**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin015 – Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction		
18.3	**Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin049 – Varicose Veins		
19. Other				

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
19.1	**Botulinum Toxin A & B 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. • 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	NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 Diagnosis and management of hyperhidrosis British Medical Journal.	

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		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 detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. • 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		

	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
		manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Wirral Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Wirral. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.		
19.2	**Correction of privately funded treatment**	Correction of privately funded treatment is not routinely commissioned unless in an emergency.		

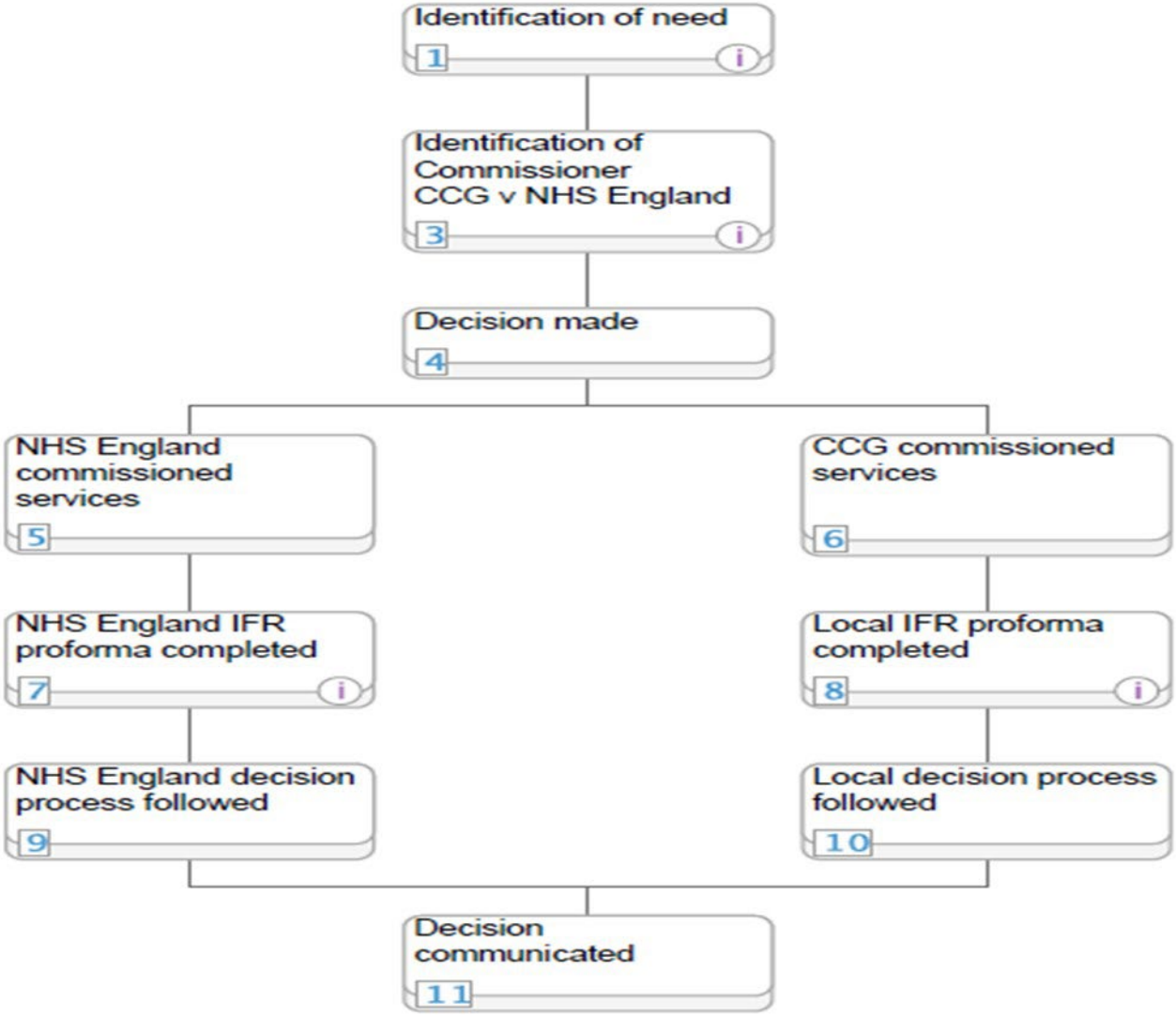
	Treatment / Procedure	Eligibility Criteria	Evidence	Comments
19.3	**Open MRI**	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin080 – Open MRI		

J. Appendix 1 – Cataract Referral Guide

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

CMICB_Clin097 – Cataract Surgery

L. Appendix 2 – IEFR Process


Identification of need
1
Identification of Commissioner CCG v NHS England
3
Decision made
4
NHS England commissioned services
5
CCG commissioned services
6
NHS England IFR proforma completed
7
Local IFR proforma completed
8
NHS England decision process followed
9
Local decision process followed
10
Decision communicated
11

M. Appendix 3 – IEFR Panel Contact Details

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

CONFIDENTIAL
1829 Building – Mail Account
Individual Funding Request Team (MLCSU)
Countess of Chester Hospital NHS Foundation Trust
Liverpool Road, CHESTER, Cheshire CH2 1UL
Telephone: 01782 916876

CCG	Email Address
West Cheshire CCG	Ifr.manager@nhs.net
Eastern Cheshire CCG	
South Cheshire CCG	
Vale Royal CCG	

N. Appendix 4 – Fusion Surgery – Clinical exceptions permitted

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

CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain