Midlands and Lancashire
Commissioning Support Unit

Criteria Based Clinical Treatments

Amended July 2024

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

Version control

Ref:	MERSCCG_2024
Version:	1.14
Purpose	This document is part of a suite of policies that the Clinical Commissioning Group (CCG) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
Supersedes:	Version 1.13
Author (inc Job Title):	Midlands and Lancashire Commissioning support Unit – Policy Development Programme
Ratified by: **(Name of responsible Committee)**	Produced in collaboration and ratified by the following CCG Governing Bodies (May 2019) • NHS Halton CCG • NHS Liverpool CCG • NHS Southport and Formby CCG • NHS South Sefton CCG • NHS St Helens CCG • NHS Warrington CCG
Date Ratified/Updated:	17 July 2024
Date Published and where (Intranet or Website):	17 July 2024 (Website)
Review date:	2024-25
Target audience:	All Cheshire & Merseyside NHS organisations

Document control			
Version	**Amendment**	**By who**	**Date amendment made**
1.0	Document Created	MLCSU Policy Development Team	29/06/2017
1.1	First review ahead of circulation to Working Group Members	MLCSU Policy Development Team	06/07/2017
1.2	Formatting suggestions from MLCSU MM team, St Helens CCG MM and Management team	MLCSU Policy Development Team	14/09/2017
1.3	Further formatting suggestions carried out and inclusion of suite 1 and 2 green policies in section A	MLCSU Policy Development Team	18/12/2017
1.4	Final version created	MLCSU Policy Development Team	20/02/2018
1.5	Title amended to remove reference to 2018-19	MLCSU Policy Development Team	22/02/2018
1.6	Amendment to CCG List	MLCSU Policy Development Team	22/02/2018
1.7	Amendments to overall policy to include policies issued in May 2018 under the Clarification document. This covers the updated policies for A2.2 Surgical Treatments for Minor Skin Lesions A2.3 Policy for Surgical removal of Lipoma A7.1 Policy for Hemorrhoidectomy. Rectal surgery and removal of haemorrhoidal and anal skin tags A14.2 Augmentation Mammoplasty - Breast Enlargement	MLCSU Policy Development Team	19/12/2018
1.8	Implementation of NHSE EBI policies: Adult snoring surgery (in the absence of OSA)	MLCSU Policy Development Team	18/02/2019

Document control			
Version	**Amendment**	**By who**	**Date amendment made**
	Dilatation & curettage for heavy menstrual bleeding in women Knee arthroscopy for patients with osteoarthritis Injection for nonspecific low back pain without sciatica Breast reduction Removal of benign skin lesions Grommets for glue ear in children Tonsillectomy for recurrent tonsillitis Haemorrhoid surgery Hysterectomy for heavy menstrual bleeding Chalazia removal Arthroscopic shoulder decompression for subacromial shoulder pain Carpal tunnel syndrome release Dupuytren's contracture release in adults Ganglion excision Trigger finger release in adults Varicose vein interventions		
1.9	Update to A14.6 Male Breast Reduction Surgery for Gynaecomastia. Policy now refers back to A14.1 Breast reduction	MLCSU Policy Development Team	02/04/2019
1.10	Remove all reference to '*Removal of Lipoma policy*' as now covered by EBI *'Removal of Benign Skin Lesions policy'*.	MLCSU Policy Development Team	24/05/2019
1.11	Policy amended and re-formatted to illustrate policy positions superseded by Cheshire and Merseyside ICB policies 01/04/2023 as	MLCSU Policy Development Team	01/04/2023

Document control			
Version	**Amendment**	**By who**	**Date amendment made**
	referenced and as listed in Appendix 1. Readers should note the following standalone CCG commissioning policies are documented separately, outside of this document, these will be subject to review and update as part of the ICB's policy harmonisation programme of work: • Gluten Free • Pinnaplasty • Subfertility		
1.12	Policy document amended to include hyperlinks to ICB policies (Phase 1).	MLCSU Policy Development Team	09/2023
1.13	Policy document amended to include hyperlinks to ICB policies (Phase 2).	MLCSU Policy Development Team	18/03/2024
1.14	Policy document amended to reinsert unilateral breast reduction policy and update IFR Team telephone number, email and address	MLCSU Policy Development Team	17/07/2024

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INTRODUCTION

Purpose and Scope

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

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

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

Context

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

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

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

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

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

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

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

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

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

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

Background

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

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

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

Principles

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

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

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

Core eligibility criteria

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

These core clinical eligibility criteria are as follows:

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

Policy Categories

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

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

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

Diagnostic Procedures

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

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

Psychological factors

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

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

Lifestyle and surgery

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

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

CBCT Referral/Treatment Listing Processes

Primary Care

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

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

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

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

Secondary Care

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

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

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

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

IFR APPLICATIONS/CLINICAL EXCEPTIONALITY

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

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

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

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

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

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

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

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

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

Email address: ifr.manager@nhs.net

NHS

Midlands and Lancashire Commissioning Support Unit

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

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

Application to consider a new Individual Funding Request

SCREENING (DESKTOP REVIEW)

Is there a policy?

No

Yes

Is it a service development?

Yes

Funding Declined CCG Advised

No

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

Yes

Funding Approved CCG Advised

Is there a case for exceptionality?

No

Funding Declined CCG advised

Uncertain

PANEL REVIEW

Yes

Panel

Funding Declined CCG Advised

Funding Approved CCG Advised

Medicines

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

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

Clinical Trials

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

Photographic evidence

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

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

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

Personal data

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

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

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

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

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

Copies of this policy

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

Monitoring and review

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

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

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

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

Evidence

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

GLOSSARY

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

Term	Meaning
Multi-disciplinary	Involving several professional specialisms for example in a multi-disciplinary team (MDT).
NICE guidance	The guidance published by the National Institute for Health and Care Excellence.
Not routinely funded (a procedure)	This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
NSAIDS	Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation.
Paediatric(ian)	Medical care concerning infants, children and adolescents usually under 18.
Pathology/pathological	The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing.
PCT	Primary Care Trust (PCTs were abolished on 31 March 2013 and replaced by Clinical Commissioning Groups).
PLCP	Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances.
Precipitates	Brings about/triggers.
Primary care	a patient's first point of interaction with NHS services e.g. a GP surgery.
Rationale	Explanation of the reason why.
Restricted (a procedure)	This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.
Secondary care	Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services.
Stakeholders	Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc.
Symptomatic	Something causing or exhibiting symptoms.

POLICY POSITIONS

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

1. Complementary Therapies

B1.1	Complementary Therapies
	This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin067 – Complementary and alternative therapies

2. Dermatology

B2.1	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)
Eligibility Criteria	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 partnership with the CCG.
Evidence	Modernisation Agency's Action on Plastic Surgery 2005. Haedersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. 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 & Service Guidelines 2013/14. NHS England Interim protocol NHS England (2013)

B2.1	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)
	Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.

A2.2	Policy for the Removal of Benign Skin Lesions
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin005 – Benign skin lesions	

B2.4	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	

B2.5	Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers
Eligibility Criteria	Will be commissioned in any of the following circumstances: 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.
Evidence	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
Comments	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.

B2.5	Surgical/Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers
	Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.

3. Diabetes

B3.1	Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus
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.*	

4. ENT

A4.1	Policy for Adenoidectomy
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin002 - Adenoidectomy	

A4.2	Policy for Pinnaplasty
See separate standalone policy	

A4.3a	Policy for Grommets for Glue Ear (Children)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin023 – Grommets for glue ear in children	

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

A4.4 Policy for Tonsillectomy for Recurrent Tonsillitis

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

B4.5 Surgical Remodelling of External Ear Lobe

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

B4.6 Use of Sinus X-ray

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

A4.7 Policy for Rhinoplasty

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

B4.8	Surgery of Laser Treatment of Rhinophyma

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

5. Equipment

B5.1	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)

6. Fertility/Assisted Conception

B6.1	Infertility Treatment for Subfertility e.g. medicines, Surgical procedures and assisted conception. This also Includes reversal of vasectomy or female sterilisation

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

7. General Surgery

A7.1	Policy for Haemorrhoid Surgery

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

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 NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin014 – Diastasis (divarication) of the Recti Repair
CMICB_Clin083 – Minimally symptomatic inguinal hermia repair

A7.3	Policy for Surgery for Asymptomatic Gallstones

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

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

8. Gynaecology

A8.1 Policy for Hysterectomy for Heavy Menstrual Bleeding
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy

A8.2 Policy for Dilatation and Curettage (D&C) for Heavy Menstrual Bleeding in Women
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage

9. Mental Health

B9.1 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

B9.3 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

A9.4 Policy for Private Mental Health Care
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin073 – Mental health disorders, specialist, general and non-NHS services

10. Neurology

B10.1 Bobath Therapy
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin063 – Bobath Therapy

B10.2 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

B10.3 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

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

B11.1 Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	
Comments	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.

B11.2 Lower Lid Blepharoplasty - Surgery on the Lower Eyelid	
Eligibility Criteria	Only commissioned in any of the following circumstances: • 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	*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.
Comments	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.

B11.3 Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)

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

B11.4 Surgery or Laser Treatment for Short Sightedness (myopia) or Long Sightedness (hypermetropia)

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

A11.5 Policy for Cataract Surgery

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

B11.6 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

B11.7 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)

A11.8 Policy for Chalazia Removal
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin011 - Chalazia (meibomian cysts), removal

12. Oral Surgery

B12.1 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

B13.1 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 Surgery

A14.1Policy for 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
- 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.

A14.2 Policy for Augmentation Mammoplasty - Breast Enlargement

Summary of intervention	**Breast Enlargement** Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape. Weblink: http://www.nhs.uk/conditions/Cosmeticsurgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmeticsurgery/Pages/Procedures.aspx
Eligibility Criteria	Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria: • There is congenital absence of breast tissue unilaterally ***(affecting one breast only)*** of three or more cup size difference as measured by a specialist. AND • The patient's BMI is under 25 and has been stable for at least 12 months AND Aged over 18 years old.
Evidence for inclusion and threshold	NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80

A14.2 Policy for Augmentation Mammoplasty - Breast Enlargement

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

A14.3 Policy for Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	
Summary of intervention	**COSMETIC SURGERY** Cosmetic surgery is often carried out to change a person's appearance in order to achieve what they perceive to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely funded by the CCG Commissioner. 1. CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment. 2. CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment 3. The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor. 4. CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment 5. CCG Commissioners will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community 6. CCG Commissioners will consider all relevant national standards and take into account all proper and authoritative guidance 7. Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered. A good summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx
Eligibility Criteria	Removal and/or replacement of silicone implants is not routinely commissioned. The removal of **ruptured** silicone implants will only be commissioned in the following circumstances: Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only but will **not** replace them.
Evidence for inclusion and threshold	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

A14.3 Policy for Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	
	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

A14.4 Policy for Mastopexy - Breast Lift
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin030 – Mastopexy (breast lift)

A14.5 Policy for Surgical Correction of Nipple Inversion
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin035 – Nipple inversion, surgical correction

A14.6 Policy for Male Breast Reduction Surgery for Gynaecomastia	
Summary of intervention	**Gynaecomastia** Gynaecomastia is enlargement of the male breast tissue. It is defined as the presence of >2 cm of palpable, firm, subareolar gland and ductal breast tissue. It may occur at any time and there are a number of causes, some physiological and others pathological. Pathological causes involve an imbalance between the activity of androgens and oestrogens - the former is decreased compared with the latter. http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx
Policy Statement	Surgery for gynaecomastia is not routinely commissioned. This policy does not apply to men undergoing treatment for prostate cancer who have not responded to tamoxifen or radiation.

A14.7 Policy for Policy for Hair Removal Treatments	
Summary of intervention	Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.

A14.7 Policy for Policy for Hair Removal Treatments	
	Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or Middle-Eastern descent. A range of treatment options are available: • Patients can self-fund options such as shaving, waxing, depilatories (hair removal creams) and bleaching creams. They can also self-fund the physical treatments listed below. • Co-cyprindiol tablets (anti-androgen) may be prescribed. It should be noted however that eflornithine cream has Black status on the Pan Mersey formulary and is not recommended for prescribing.
Eligibility Criteria	The CCG will fund this treatment if the patient meets the following criteria: • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** • Is undergoing treatment for pilonidal sinuses to reduce recurrence This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
Evidence for inclusion and threshold	British Association of Dermatologists - hirsuitism patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document NHS Choices – Laser Hair Removal Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx Pan Mersey APC Guidance for Eflornithine: http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=306706356201612211111329

A14.8 Policy for Surgical Treatment for Pigeon Chest - Pectus Anomaly
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin038 – Pectus Deformity, surgical treatment

A14.9 Policy for Surgical Revision of Scars	
Summary of intervention	The different types of scars include: • **Flat, pale scars** – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or

A14.9 Policy for Surgical Revision of Scars	
	dark and raised after the wound has healed, but will become paler and flatter naturally over time. This can take up to two years. • **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years. • **Keloid scars** – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed. • **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance. • **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement. **Treating scars** Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include: • pressure dressings • corticosteroid injections • cosmetic camouflage (make-up) • surgery It is often the case that a combination of treatments can be used.
Eligibility Criteria	The CCG will fund this treatment if the patient meets the following criteria: • For severe post burn cases or severe traumatic scarring **OR** • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
Evidence for inclusion and threshold	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service NHS Choices – Scars - Treatment http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx

A14.10 Policy for Laser Tattoo Removal	
Summary of intervention	Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks. The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all. A good summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx
Eligibility Criteria	Removal of Tattoos is not routinely commissioned.
Evidence for inclusion and threshold	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service 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

A14.11 Abdominoplasty/Apronectomy (sometimes called 'tummy tuck')

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

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

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

A14.13 Policy for Surgical Treatments for hair Loss

Summary of intervention

Alopecia

Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.

In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour. Some people go on to develop a more severe form of hair loss, such as:

- Alopecia totalis (no scalp hair)
- Alopecia universalis (no hair on scalp or body)

Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It's more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome.

It's also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.

Alopecia areata can occur at any age, although it's more common in people aged 15-29. It affects one or two people in every 1,000 in the UK.

Further information can be found at following link:
http://www.alopeciaonline.org.uk/treatments-and-wigs.asp

Hair transplantation

A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. ,It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant isn't normally available on the NHS, as it is regarded as cosmetic surgery.

Male Pattern Baldness

Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties.

It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon.

Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone

A14.13 Policy for Surgical Treatments for hair Loss	
Eligibility Criteria	Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned. The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.
Evidence for inclusion and threshold	British Association of Dermatologists - alopecia areata patient information leaflet Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document Interventions for alopecia areata – Cochrane Library 2008. 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. NICE Clinical Knowledge Summaries 2014. https://cks.nice.org.uk/alopecia-areata 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 – Guide to Hair Loss Treatment Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx **Hair transplantation** *A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin077 – Labiaplasty, vaginoplasty and hymenorrhaphy

A14.16 Policy for Labiaplasty, Vaginoplasty and Hymenorrhaphy

A14.17 Policy for Liposuction
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin0100 – Liposuction

A14.18 Policy for Rhytidectomy - Face or Brow Lift
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin042 – Rhytidectomy

15. Respiratory

A15.1 Intervention for Snoring (not OSA)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin043 – Simple snoring, surgical management

16. Trauma and Orthopaedics

A16.1 Policy for non-invasive interventions for low Back pain and sciatica	
Summary of intervention	Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer. Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur. Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities. For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner.

A16.1 Policy for non-invasive interventions for low Back pain and sciatica	
	Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that's the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery. If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help. You should seek early advice from your GP if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor.
Policy Statement	Restricted
Eligibility Criteria	**<u>Acupuncture</u>** Acupuncture for low back pain and sciatica is **not routinely commissioned** **<u>Manual Therapy</u>** The following procedures are **not routinely commissioned**: • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation. Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. **<u>Orthotics</u>** The following are **not routinely commissioned**: • Foot orthotics • Rocker shoes • Belts and corsets **<u>Electrotherapy</u>** The following are **not routinely commissioned:** • Transcutaneous electrical nerve stimulation (TENS) • Percutaneous electrical nerve stimulation (PENS) • Ultrasound • Interferential • Laser therapy **<u>Pharmacological interventions</u>**

A16.1 Policy for non-invasive interventions for low Back pain and sciatica	
	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 for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. ***Treatments that should not be used*** 1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.
Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 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

A16.1 Policy for non-invasive interventions for low Back pain and sciatica	
	Osteoarthritis: the care and management of osteoarthritis in adults https://www.nice.org.uk/guidance/cg59 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 Final_TAMARS_report[1].pdf

A16.2 Policy for Imaging for Patients Presenting with Low Back Pain
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin086 – Low Back Pain Imaging

A16.3 Policy for Injections for nonspecific low back pain without sciatica
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin060 – Spinal Injections for Low Back Pain

A16.4 Policy for Spinal Fusion
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin087 – Spinal fusion surgery for non-specific, mechanical back pain CMICB_Clin090 – Non-rigid stabilisation techniques for degenerative disease of the lumbar spine

A16.5 Disc and Decompression procedures	
Summary of intervention	**Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.** It's only recommended when non-surgical treatments haven't helped. The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine. Lumbar decompression surgery is often used to treat: •spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside •a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve •spinal injuries – such as a fracture or the swelling of tissue

A16.5 Disc and Decompression procedures	
	•metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves
Policy Statement	Restricted
Eligibility Criteria	Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where: Patient presents with severe and acute sciatica AND have failed to respond to conservative intervention AND have imaging findings concordant with clinical presentation Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network. The following procedures are NOT routinely commissioned: Endoscopic Laser Foraminoplasty Endoscopic Lumbar Decompression Percutaneous Disc Decompression using Coblation for Lower Back Pain Percutaneous Intradiscal Laser Ablation in the Lumbar Spine Automated Percutaneous Mechanical Lumbar Discectomy Prosthetic Intervertebral Disc Replacement in the Lumbar Spine Intradiscal Electro Thermal Annuloplasty (IDET) Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
Evidence for inclusion and threshold	Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59 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 NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173 IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011 – Decision taken that this policy does not require update. IPG570: https://www.nice.org.uk/guidance/ipg570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016) IPG543: https://www.nice.org.uk/guidance/ipg543

A16.5 Disc and Decompression procedures	
	Percutaneous coblation of the intervertebral disc for low back pain and sciatica IPG:357 https://www.nice.org.uk/guidance/ipg357 Percutaneous intradiscal laser ablation in the lumbar spine IPG141: https://www.nice.org.uk/guidance/ipg141 Automated percutaneous mechanical lumbar discectomy IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009.

A16.6 Policy for 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

A16.7 Policy for Therapeutic endoscopic Division of epidural adhesions
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division

B16.17 Bone Morphogenetic Proteins, Dibotermin Alfa, Eptotermin Alpha	
Eligibility Criteria	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.
Evidence	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

A16.18 Policy for Trigger Finger Release

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin048 – Trigger Finger release in adults

A16.19 Policy for 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)

B16.20 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

A16.21 Policy for Dupuytren's Contracture Release

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin016 – Dupuytren's Contracture release in adults

A16.23a Policy for Hip Replacement Surgery

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

A16.23b Policy for Knee Replacement Surgery

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

B16.24 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

A16.25 Policy for Knee Arthroscopy with Osteoarthritis

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

B16.26 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

B16.27 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

A16.28 Policy for Carpal tunnel Syndrome Release

This policy has been superseded by NHS Cheshire & Merseyside ICB Policy:
CMICB_Clin010 – Carpal Tunnel interventions and surgery
CMICB_Clin112 – Carpal Tunnel Syndrome, Nerve Conduction Testing

B16.29 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

A16.30 Policy for Surgical Removal of Ganglions

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

B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement

Eligibility Criteria	CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: • A definite diagnosis of hip impingement syndrome/femoro- acetabular impingement (FAI) has been made by appropriate investigations, X-rays,

B16.31 Hip Arthroscopy for Femoro– Acetabular Impingement	
	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 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
Comments	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.

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

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

B16.33 Surgical Treatment of Morton's Neuroma

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

B16.34 Surgical Treatment of Plantar Fasciitis

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

B16.35 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

A16.36 Policy for 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

17. Urology

A17.1 Policy for Circumcision for medical reasons only

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

B17.3 Reversal of Male Sterilisation

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

B17.4 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

B17.5 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

B17.6 Surgery for Prostatism

Eligibility Criteria	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: • 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.
Evidence	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

B17.6 Surgery for Prostatism	
	Royal College of Surgeons (2013).
Comments	No references to treatment thresholds found.

18. Vascular Surgery

B18.1 Surgery for Extreme Sweating (Hyperhydrosis – all areas; Surgical Resection Endoscopic Thoracic Sympathectomy)
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management

B18.2 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

A18.3 Policy for Varicose Veins Interventions
This policy has been superseded by NHS Cheshire & Merseyside ICB Policy: CMICB_Clin049 – Varicose Veins

19. Other

B19.1 Botulinum Toxin A & B	
Eligibility Criteria	Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane. 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).

B19.1 Botulinum Toxin A & B	
	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 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 manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.

B19.1 Botulinum Toxin A & B	
Evidence	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 and only one course of injections. Diagnosis and management of hyperhidrosis British Medical Journal.