NHS Cannock Chase Clinical Commissioning Group
NHS Stafford & Surrounds Clinical Commissioning Group
NHS South East Staffs & Seisdon Peninsula Clinical Commissioning Group
NHS East Staffordshire Clinical Commissioning Group
NHS Birmingham Cross City Clinical Commissioning Group
NHS Birmingham South Central Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group
NHS Sandwell and West Birmingham Clinical Commissioning Group
NHS Solihull Clinical Commissioning Group
NHS Walsall Clinical Commissioning Group
NHS Wolverhampton Clinical Commissioning Group

Procedures of Low Clinical Value (PoLCV) Commissioning Policy

April 2015

Version 1.1

Name of Responsible Board / Committee for Ratification:	
Date Issued:	
Review Date:	

Version Control:

Version No:	Date	Details	Clinical Input Provided by	Author
1.0	20/11/2014	Original South Staffs CCGs Procedures of Low Clinical Value Policy 2014 – review of former South Staffs Primary Care Trust policies.	South Staffs Clinical Policy Prioritisation Group (CPPG)*	Barry Weaver, IFR Commissioning Intelligence Manager
1.1	22/01/2015	Alignment of the South Staffs CCGs policy with the Harmonised West Midlands Policies.	CPPG Representatives: Dr Gary Free, Dr Marianne Holmes Mark Seaton, Dr Kamren Ahmed	Melanie Mahon, Senior Commissioning Manager

*South Staffs CPPG representatives:
Representing Cannock Chase and Stafford and Surrounds CCGs - Dr Marianne Holmes, Dr Murray Campbell, Tammy Lott, Dr Gary Free
Representing East Staffordshire CCG - Sarah Laing,
Representing South East Staffordshire & Seisdon Peninsula CCG - Dr Adrian Parkes, Frances Sutherland and Anna Hammond,
Representing Public Health - Trish Allan, Lucy Heath, Nicola Day,
Representing Medicines Management - Strategic Lead Mark Seaton

* West Midlands Harmonisation Group:

To be inserted

1.0 Purpose

1.0.1 The purpose of this Commissioning Policy is to clarify the commissioning intentions of the Clinical Commissioning Groups (CCG) across the West Midlands and South Staffordshire who consist of: NHS Wolverhampton CC, NHS Birmingham Cross City CCG, NHS Birmingham South Central CCG, NHS Dudley CCG, NHS Sandwell and West Birmingham CCG, NHS Solihull CCG, NHS Walsall CCG, NHS Cannock Chase CCG, NHS Stafford & Surrounds CCG, NHS South East Staffs & Seisdon Peninsula CCG, NHS East Staffordshire CCG,

2.0 Introduction

2.1 This Policy supports the decision making process associated with the allocation of resources for commissioning. It will be used to support the development of effective, efficient and ethical Service Level Agreements with provider organisations, and the procurement of interventions on an exceptional basis.

2.2 The Policy establishes the framework within which the CCGs can demonstrate that their decision making processes are fair, equitable, ethical and legally sound.

3.0 Background

3.1 NHS Commissioners receive funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations and guidance. NHS Commissioners have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them.

3.2 NHS Commissioners are required to commission comprehensive, effective, accessible services which are free to users at the point of entry (except where there are defined charges) within a finite resource. It is, therefore, necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.

3.3 This Policy is designed to help the CCGs to meet their obligation in providing equitable access to health care. It aims to achieve this by supporting a robust decision making process that is reasonable and open to scrutiny.

4.0 Definition of "Low Priority Treatments"

4.1 The term "treatment" describes clinical care and programmes of care that include:-

- Medicines
- Surgical procedures
- Therapeutic and other healthcare interventions

4.2 On systematic evaluation, some interventions have been identified as being either marginally effective or ineffective with limited clinical value in the vast majority of cases. Others have been shown to be an inefficient use of resource given their high cost per quality adjusted life year gained.

5.0 Operating Policy for the Development and Implementation of this Policy

5.1 Scope

5.1.1 A number of national organisations, such as NICE, and Public Health clinicians from across Staffordshire and the West Midlands have developed evidence-based advice to inform commissioning decisions on low priority treatments. Throughout this Policy these treatments or procedures are categorised as Excluded or Restricted. Excluded treatments or procedures will not be funded by the NHS Commissioners. Restricted treatments or procedures will only be funded for those patients where an appropriate threshold for the intervention as stated in this Policy has been met.

5.2 Determining the Evidence Base

5.2.1 Evidence for treatment effectiveness and efficacy is available from many sources, including NICE, the Cochrane Institute, Royal Colleges, other professional guidelines, and sources such as peer reviewed journals or technical notes. Evidence varies in its robustness, ranging from meta-analyses of randomised control trials with large populations of participants, to traditional consensus about best practice. The NHS Commissioners in arriving at this Policy have taken advice from Public Health locally on the source, extent and quality of the evidence in reaching their decisions.

5.4 Ethical and Legal Policy for Decision Making

5.4.1 The NHS Commissioners have Prioritisation Frameworks which are reviewed on an ongoing basis. Utilisation of these prioritisation frameworks informs the review of this policy and the procedures and treatments that it covers.

5.5 Implementation

5.5.1 The schedule showing low priority treatments is set within this policy. This can be incorporated into contractual and service level agreements. NHS Commissioners will require primary and secondary care service providers and other organisations acting on behalf of NHS Commissioners to embrace and abide by the policy and to advise patients accordingly.

5.5.2 The Policy is implemented by GPs and Primary Care health professionals when advising and referring patients and by providers when considering the treatment options for patients. Those making referrals should not refer to any provider for a treatment or procedure covered by this Policy. Providers should not suggest, recommend or otherwise offer excluded treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure.

5.5.3 Within the policy, and as stated against individual treatments or procedures listed in Appendix 1, treatments and procedures are classified as Excluded or Restricted. Unless specifically stated all treatments and procedures are classified as Excluded or Restricted by both NHS Commissioners.

5.5.4 Excluded procedures and treatments are not commissioned by the NHS Commissioners. Where individual patient circumstances require the escalation of their care and a procedure or treatment classified as excluded is being proposed then providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.

5.5.5 Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied. Where a patient satisfies the threshold statement or criteria the procedure or treatment is prior approved and can be undertaken. Where the threshold statement or criteria are not met then the procedure or treatment is excluded for that patient and paragraph 5.5.4 above applies.

5.5. This Policy is distributed to all providers, primary care contractors and CCG Localities.

5.6 Monitoring the Policy

5.6.1 NHS Commissioners will monitor the adherence to this policy through the contractual process, using contractual levers where breaches of the Policy are identified.

5.6.2 Referrals to secondary care that are outside of this Policy will be routinely monitored by the Commissioning Management and the Contracts Management Teams of the NHS Commissioners.

5.6.3 NHS Commissioners will provide periodic reports to their Boards reporting the number and nature of breaches of the Policy, by provider and by procedure.

5.6.4 Where there are defined thresholds, the compliance with the criteria will be subject to regular clinical audits carried out or organised by NHS Commissioners. The audit process will require providers to produce patient specific evidence that confirms the threshold criteria for procedures were satisfied at the time the decision to offer the procedure to the patient was taken. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the threshold criteria were met at the time the decision to perform the procedure was taken, then the default will be to consider the procedure was excluded and therefore it will not attract payment from the NHS Commissioners.

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5.6.5 NHS Commissioners reserve the right to reduce the value of all payments for procedures with OPCS codes that match those for Excluded and Restricted procedures (as listed within this policy)

5.6.6 Any procedures marked as 'Requires Prior Approval' must be approved by CCGs before the surgery is undertaken using the agreed form. Commissioners will not pay for any procedures undertaken without the required approval from the responsible commissioner.

5.7 Maintaining an Up-to-Date Policy

5.7.1 NHS Commissioners will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the NHS Commissioners is to:

- Monitor the implementation of the Policy and the impact it has on clinical decision making;
- Inform referrers of the Policy;
- Inform all service providers with whom the NHS Commissioners have formal contractual arrangements of the Policy;
- Review the policy and the accompanying schedule on an ongoing basis and/or where an urgent consideration of new evidence is justified.

6.0 Managing Expectations

6.1 In their dealings with patients and the public providers should, if necessary, make it clear that the decision by NHS Commissioners to consider treatments or procedures to be of low priority under this policy is a considered decision made against their responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them and that it is necessary for the NHS Commissioners to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the local population.

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6.2 Where individual patient circumstances require the escalation of their care providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.

OPCS Codes	Procedures	Thresholds	Status
1. Dermatology & Plastic Surgery			
S05.1, S05.2, S05.3, S05.4, S05.5, S05.8, S05.9, S06.1, S06.2, S06.3, S06.4, S06.5, S06.8, S06.9, S08.1, S08.2, S08.3, S088,S08.9, S09.1, S09.2, S09.3, S09.8, S09.9, S10.1, S10.2, S10.3, S10.4, S10.8, S10.9, S11.1, S11.2, S11.3, S11.4, S11.8, S11.9, D02.1, F02.1, S60.8	**1.1 Minor Skin Lesions**	Treatment of Minor Skin Lesions including benign pigmented moles, comedones, corns/callous. lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, epidermoid/pilar (sebaceous) cysts warts, xanthelasma and neurofibromata is not routinely commissioned by the CCGs except if the following criteria is met: • when there is a suspicion of malignancy (reason must be documented in notes) OR • Obstruction of orifice or vision	Restricted
	1.2 Lipomas	Not routinely commissioned by the CCG**s** except: • when there is a suspicion of malignancy ,**or** • if there is significant functional impairment caused by the Lipoma, **or** • if histological evidence in conditions where there are multiple subcutaneous lesions can be provided.	Restricted
	1.3 Paediatric haemangiomas	Treatment shall be offered for those which: • Threaten life or function, including compromising eyesight, respiratory, cardiac or hepatic functions • Other internal lesions sited in an area liable to scar • Large facial hemangiomas that have failed to regress by school age • Show a tendency to bleed or to become infected • Kasabach-Merritt syndrome (coagulopathy)	Restricted
S09.1, S09.2, S10.3, S11.3, S60.1, S60.2	**1.4 Port Wine Stain**	Not routinely commissioned	Excluded
	1.5 Rosecea	Laser Treatment for this condition is not routinely commissioned regardless of age	Excluded
S02.1, S02.2, S02.8, and S02.9	**1.6 Abdominoplasty / Apronectomy / Panniculectomy** Removal of redundant abdominal skin folds resulting from weight loss after surgery or	Not routinely commissioned by West Midlands **Prior Approval/ Individual Funding Request required by South Staffordshire CCGs**	Restricted

	planned weight loss		
D03.1, D03.2, D03.3, D03.8, D03.9, D06.2	**1.7 Cosmetic operations on external ear Pinnaplasty (also referred to as 'bat ears')**	Not routinely commissioned	Excluded
	1.8 Split earlobes, excision of lesion of external ear	Not routinely commissioned	Excluded
B29.5, B30.1, B30.2, B30.3, B30.8, B30.9, B31.1, B31.2, B31.3, B31.4, B31.8, B31.9, B33.2, S48.2, B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9, B37.5	**1.9 Breast Enlargement (Augmentation Mammoplasty)**	Breast Augmentation shall ONLY be routinely commissioned as reconstructive surgery following mastectomy for either suspected or proven malignancy. Treatment of unaffected breast following cancer surgery shall not be routinely commissioned. Congenital absence of breast shall not be routinely commissioned.	Restricted
B29.5, B30.1, B30.2, B30.3, B30.8, B30.9, B31.1, B31.2, B31.3, B31.4, B31.8, B31.9, B33.2, S48.2, B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9, B37.5	**1.10 Breast Reduction**	Patients are ONLY eligible for surgery to reduce breast size if the following criteria are met: • The patient is suffering from functional problems: neck ache, backache and/or intertrigo, where any possible causes of these conditions have been considered and excluded AND • Symptoms are not relieved by physiotherapy and a professionally fitted brassiere has not relieved symptoms AND • The patient has a body mass index (BMI) of less than 27kg/m^2 AND • Have a cup size of F+ AND • Be 21 years of age or over Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or following, this assessment, there should be access to a trained bra fitter where it is available.	Restricted
	1.11 Breast Lift (Mastopexy)	Not routinely commissioned	Excluded

B29.5, B30.1, B30.2, B30.3, B30.8, B30.9, B31.1, B31.2, B31.3, B31.4, B31.8, B31.9, B33.2, S48.2, B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9, B37.5	**1.12 Breast Implant Revision Surgery**	Breast revision surgery will only be supported if the original augmentation procedure was commissioned by the NHS and one of the following applies: •Breast disease •Implants with capsule formation that interferes with mammography •Implants complicated by recurrent infection •Implants with Baker Class IV contracture associated with pain •Intra or extra capsular rupture of silicone gel filled implants Breast implants will ONLY be replaced when the patient meets the acceptance criteria of the current breast augmentation policy.	Restricted
	1.13 Surgery to Correct Nipple Inversion	Not routinely commissioned	Excluded
	1.14 Removal of Supernumerary Nipples (Polymastia)	Not routinely commissioned	Excluded
	1.15 Gynaecomastia Surgery Male breast reduction	Not routinely commissioned, however if malignancy (either breast or testicular) is suspected, then normal cancer pathways should be followed. Chronic liver disease, thyroid disease, and renal disease should also be excluded.	Excluded
S09.1, S09.2, S10.3, S11.3, S60.1, S60.2, S06.3, S06.4, S06.9	**1.16 Skin Resurfacing** Skin Resurfacing techniques for acne and other scarring including Dermabrasion, Chemical Peels and Laser treatment	Not routinely commissioned	Excluded
S06.3, S06.4, S06.9	**1.17 Scars and Keloid**	Not routinely commissioned	Excluded

	Refashioning (Including "Stretch Marks")		
N/A	**1.18 Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring**	Not routinely commissioned	Excluded
S01.1, S01.2, S01.3, S01.4, S01.5, S01.6, S01.8, S01.9	**1.19 Buttock/Thigh/Arm lift or body contouring, cosmetic excision of skin of head or neck – e.g face lift, brow lifts, rhinoplasty and blepharoplasty to treat the natural process of ageing**	Not routinely commissioned	Excluded
S62.1, S62.2	**1.20 Liposuction**	Not routinely commissioned	Excluded
C13.1, C31.2, C31.3, C31.4, C31.5, C31.8, C13.9	**1.21 Blepharoplasty**	Blepharoplasty shall be routinely commissioned only for upper lids in the presence of: • **visual field impairment** (reducing visual field to 120° laterally and 40°vertically) • **Severe congenital ptosis** This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin. Note: Excessive skin in the lower lid may cause "eyebags" but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons. The following procedures will not be funded: • Surgery for cosmetic reasons • Surgery for cyst of moll • Surgery for cyst of zeis • Removal of eyelid papillomas or skin tags • Surgery for pingueculum • Excision of other lid lumps	Restricted

S21.1, S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9	**1.22 Correction of Hair Loss**	Surgical treatment is not routinely commissioned	Excluded
S60.6, S60.7	**1.23 Depilation Techniques for Excess Body Hair, Facial Hirsutism or Hypertrichosis**	Not routinely commissioned	Excluded
S06.1, S06.2, S09.1, S09.2, S10.8, S10.9	**1.24 Tattoo removal**	Not routinely commissioned	Excluded
S53.2 with X85.1 (to identify Botulinum Toxin) and Z49.2	**1.25 Botox for Axillary Hyperhydrosis (Excessive Sweating)**	Not routinely commissioned	Excluded
X85.1 with Z60.1, with or without X37.5	**1.26 Botox for Facial Aging or Excessive Wrinkles**	Not routinely commissioned	Excluded
2. Ear, Nose and Throat (ENT)			
F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, and F36.9	**2.1 Tonsillectomy for Adults and Children** (A child is considered to be between the ages of 4-16 for the purpose of tonsillectomy)	Tonsillectomies will **ONLY** be commissioned in the following circumstances: •**Seven** or more well documented, clinically significant, adequately treated sore throats in the preceding year, OR •**Five** or more such episodes in each of the preceding two years OR •**Three** or more such episodes in each of the preceding three years AND •Sore throats are due to acute tonsillitis AND •The episodes of sore throat are disabling and prevent normal functioning **<u>An eligible episode must have three of the following criteria:</u>** Tonsillar exudates /Tender anterior cervical lymph nodes/ History of fever/ Absence of cough When in doubt as to whether a tonsillectomy would be beneficial, a six month period of watchful waiting is recommended There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome	Restricted

		High Value Care Pathway: Children (<16) with sleep disordered breathing Refer if sleep disordered breathing is suspected, refer to secondary care	
D15.1, D15.8, D15.9, D20.2, D20.3	**2.2 Myringotomy With/Without Grommets for Otitis Media** **2.3 Alternative indications for Grommets**	Myringotomy With/Without Grommets for Otitis Media will ONLY be routinely commissioned in the following circumstances •Children with persistent bilateral OME documented over a period of 3 months **AND** •A hearing level in the better ear of 25-30 dBHL **OR** •The worse ear averaged at 0.5, 1,2 and 4 kHz (or equivalent dBA where dNHL not available) Children should only be considered for grommet insertion if:- •The child has experienced persistent hearing loss for more than a year with deficit estimated to be more than 25 decibels OR •More than 6 episodes of acute otitis media in previous 12 months OR •The child has developmental impairment (e.g. speech/ language/ cognitive/ behavioural) likely to be due to, or exacerbated by, clinically suspected hearing loss OR •Poor progress at school directly attributable to this condition, the child has proven hearing loss, plus a second disability such as Down's Syndrome or cleft palate	Restricted
	2.4 Adenoidectomy	**Adenoidectomy will only be funded if undertaken in conjunction with Tonsillectomy and/or Grommets** (Please refer to relevant guidance/policy for Tonsillectomy and/or Grommets).	Restricted
F32.4, F32.5, F32.6	**2.5 Treatments for Snoring** Uvulopalatopharyngoplasty, Uvulopalatoplasty, Palate Implants and Radiofrequency Ablation of the Soft Palate	Not routinely commissioned. If clinical assessment suggests serious underlying pathology rather than simple snoring, the patient should be referred accordingly. If Obstructive Sleep Apnoea Syndrome is suspected, the patient should be managed in accordance with NICE Technology Appraisal TA139. Surgery for snoring will only be considered for OSA when supported by a sleep study.	Excluded
E02.3, E02.4, E02.5, E02.6 E07.3, E02.1, E02.2, E02.6, E02.7, E02.8, E02.9	**2.6 Rhinoplasty and Septal Surgery** Operations to the Nose e.g.Rhinoplasty, Septal	Operations to the Nose will ONLY be commissioned in the following circumstances: •In the presence of functional airway obstruction (reduction of at least 30% air intake to one or more of the nares)	Restricted

	Surgery and variations thereof	OR •For the correction of a congenital abnormality e.g. cleft lip	
3. General Surgery			
T20.1, T20.2, T20.3, T20.4, T20.8, T20.9	**3.1 Inguinal Hernia**	An inguinal hernia repair is commissioned where a patient meets one or more of the following; • irreducible and partially reducible inguinal hernias • patients with suspected strangulated or obstructed inguinal hernia should be referred as an emergency • all children <18 years with inguinal hernia (should be referred to a paediatric surgical provider) • all hernias in women (should be referred urgently) Note: Except for patients with minimally symptomatic inguinal hernias who have significant comorbidity (ASA 3 or 4) AND do not want to have surgical repair after appropriate information has been provided	Restricted
T24.1, T24.2, T24.3, T24.4, T24.8, t24.9	**3.2 Umbilical and Para-umbilical Hernia**	Surgical treatment will only be approved in the following indication: To avoid incarceration or strangulation of bowel	Restricted
T25.1, T25.2, T25.3, T25.8, T25.9	**3.3 Incisional Hernia**	Not routinely commissioned	Excluded
	3.4 Laparoscopic hernia repair	Laparoscopic hernia repair is commissioned ONLY for bilateral hernia repair (where the patient has bilateral hernias with external swelling on clinical examination) OR •Recurrent hernia (2 or more episodes within 6 months)	Restricted
H55.1	**3.5 Haemorrhoidectomy**	Surgical treatment is commissioned for patients with the following; • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding OR • Irreducible and large external haemorrhoids	Restricted
	3.6 Botulinium Toxin Type A for Treatment of Chronic Migraine	ONLY to be routinely commissioned in accordance with NICE TA260	Restricted
G44.8, 11.4, O11.1	**3.7 Endoscopic radiofrequency ablation for Gastro Oesophageal Reflux Disease (GORD)**	Not routinely commissioned	Excluded

G24.8, Y75.2	**3.8 Linx for Gastro Oesophageal Reflux Disease GORD**	Not routinely commissioned	Excluded
4. Gynaecology & Obstetrics			
	4.1 Dilatation and curettage (D&C) in women under 40 for Menorrhagia	Not routinely commissioned	Excluded
Q07.2, Q07.4, Q07.8, Q07.9, Q08.2, Q08.8, Q08.9	**4.2 Hysterectomy for Menorrhagia**	Hysterectomy for heavy menstrual bleeding will ONLY be commissioned in the following circumstances: • There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) and it has failed to relieve symptoms unless it is medically inappropriate, or contraindicated. AND At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Experience (NICE) guidelines: • Non-steroidal anti-inflammatory agents • Tranexamic acid • Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) AND • Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated	Restricted
	4.3 A planned Caesarean Section should NOT be routinely offered to women An Elective Caesarean should only be offered to women where there are clinical indications. When a woman requests a caesarean section because she has anxiety about childbirth, she should	• With an uncomplicated twin pregnancy at term where the presentation of the first twin is cephalic • With a 'small for gestational age' baby. • On the grounds of HIV status to prevent mother-to-child transmission of HIV to: o women on highly active anti-retroviral therapy (HAART) with a viral load of less than 400 copies per ml or; o women on any anti-retroviral therapy with a viral load of less than 50 copies per ml. • with hepatitis B • with hepatitis C • with a recurrence of genital herpes simplex virus (HSV) at birth • with a body mass index (BMI) of over 50 alone as an indicator This is in line with the updated NICE 2012 guidance on Caesarean Section	Excluded

	be offered referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner		
	4.4 A planned Caesarean Section should be offered to women	• With a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful, • In twin pregnancies where the first twin is breach • A placenta that partly or completely covers the internal cervical os (minor or major placenta praevia) • A previous caesarean section where it is clinically indicated • With injury/tears to the vagina • With orthopaedic anomalies impeding the patient's ability of having a vaginal delivery • In patients with HIV who: o are not receiving any anti-retroviral therapy or o are receiving any anti-retroviral therapy and have a viral load of 400 copies per ml or more. • With both hepatitis C virus and HIV • With primary genital herpes simplex virus (HSV) infection occurring in the third trimester of pregnancy Pregnant women who may require a planned caesarean section should have consultant involvement in the decision-making process.	Restricted
5. Ophthalmology			
C71.1, C71.2, C71.3, C71.8, C71.9, C72.1, C72.2, C72.3, C72.8, C72.9, C74.1, C74.2, C74.3, C74.8, C74.0, C75.1, C75.2, C75.3, C75.8, C75.9	**5.1 Surgery for Cataracts**	Cataracts eye surgery is commissioned for both first and second eyes, when a patient meets the following criteria for each eye: • The patient should have sufficient cataract to account for the visual symptoms (6/12 or worse) AND • Should affect the patient's lifestyle: - Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc. - Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground. - Ability to work, give care or live independently is affected This information together with a report from a recent sight test should form the minimum data on the referral form.	Restricted

		Other indications for cataract surgery include; facilitating treatment for one or more of the following; • Monitoring posterior segment disease e.g. diabetic retinopathy • Correcting anisometropia • Patient with Glaucoma who require cataracts surgery to contract intraocular pressure Patients with Single Sight (Monocular Vision): The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur.	
	5.2 Laser Treatment of Myopia (short sightedness)	Not routinely commissioned	Excluded
C75.1	**5.3 Implantable Intraocular Lens Systems for Age-Related Macular Degeneration**	Not routinely commissioned	Excluded
	5.4 Ozurdex Intravitreal Implant 0.7mg (outside NICE recommendations)	Not routinely commissioned	Excluded
6. Trauma & Orthopaedics			
W87.1, W87.8, W87.9	**6.1 Diagnostic arthroscopy of the knee**	Not routinely commissioned	Excluded
W82.2, W82.3, W83.3, W83.6, W85.2, W85.8, W85.9	**6.2 Therapeutic arthroscopy of the knee**	Knee Washout and Debridement will only be routinely commissioned where the patient has mechanical features of locking that are associated with patient reported severe pain. Not routinely commissioned for symptoms of 'giving way' or x-ray evidence of loose bodies without true locking	Restricted
	6.3 Hip Arthroscopy	Not routinely commissioned	Excluded
	6.4 Primary Hip and Knee Replacement	Patients shall be eligible for surgery if the following criteria is met: • The patient has a BMI below 35 supported by a primary care and/or community service referral. **AND** • Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations , curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability **AND**	Restricted

		• Pain and disability should be sufficiently significant to interfere with the patients' daily life and or ability to sleep/patients whose pain is so severe **AND** • Patient must accept and want surgery Or • Mobility is so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat Or • Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure. **Guidance notes:** Total Hip Replacement- After appropriate diagnosis, consider total hip replacement when a patient meets all of the following: • pain is inadequately controlled by medication • there is restriction of function • the quality of life is significantly compromised • there is narrowing of the joint space on radiograph Hip Resurfacing Techniques- (primary resurfacing arthroscopy of joint) Except in the following, metal on metal hip resurfacing techniques are not normally funded: • Those who qualify for primary total hip replacements and • are likely to outlive conventional primary hip replacements	
T52.1, T52.2, T52.5, T52.6, T54.1	**6.5 Dupuytren's Disease – Palmer Fasciectomy**	Commissioned treatments, recommended by the British Society for Surgery of the Hand are set out below: **Mild** <u>Description:</u> • No functional problems • No contracture. • Mild metacarpo-phalangeal joint contracture only (<30 degrees) <u>Intervention:</u> Reassure. Observe **Moderate**	Restricted

		Description: • Notable functional problems or moderate metacarpo-phalangeal joint contracture (30 - 60 degrees • Moderate proximal inter-phalangeal joint contracture (<30 degrees) Intervention: Needle fasciotomy if appropriately trained; for MCPJ contracture Refer for surgery – limited fasciectomy **Severe** Description: • Severe contracture of both metacarpo-phalangeal (>60 degrees) joint and proximal inter-phalangeal joint (>30 degrees). Intervention: Refer for surgery - limited fasciectomy	
A65.1, A65.9	**6.6 Carpal Tunnel Syndrome**	Unless one or more of the minimum criteria are met, surgical treatment will not be funded; • Acute severe symptoms uncontrolled by conservative treatment OR • Chronic mild to moderate symptoms that have not responded to 4 months of conservative management (Injection and splints) OR • Neurological deficit i.e. sensory blunting or weakness, supported by Nerve Conductions studies	Restricted
T69.1, T69.2, T69.8, T69.9, T70.1, T70.2, T71.8, T71.9, T72.3, T72.8, T72.9	**6.7 Surgical release of trigger finger**	Standard treatment of trigger finger is to inject. Surgical treatment will only be routinely commissioned where patients meet the following criteria: • Patients who have a fixed flexion deformity that cannot be corrected by conservative measures i.e. exercise/massage, rest from aggravating activities, splinting, NSAIDs • Following unsuccessful injection	Restricted
T59.1, T59.2, T59.3, T59.4, T59.8, T59.9, T60.1, T60.2, T60.3, T60.4, T60.8,T60.9	**6.8 Excision of ganglia**	Surgical removal of **ganglion on hands** will ONLY be routinely commissioned where there is documented evidence of neurovascular compromise Surgical removal of **seed ganglia at base of digits**: will ONLY be routinely commissioned where patients report significant pain (as assessed by a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score, Brief Pain Inventory) and supported by a clinical decision that removal is required Surgical Removal of **mucoid cysts at DIP joint**: will ONLY be routinely commissioned where nail growth is disturbed and the cysts have a reported history of producing discharge	Restricted
A52.1, A52.2, (A52.8,	**6.9 Back Pain**	**NON SPECIFIC BACK PAIN**	Restricted

A52.9 with Z06.3), X30.6, X30.8, or X30.9 with Z06.3, V54.4	• Non-Specific • Specific • Chronic	•As per NICE guidance; Injections of therapeutic substances into the back for non-specific low back pain should not be offered – **Not routinely commissioned** Please refer to IFR Generic policies: • Therapeutic facet joint intra-articular injections are only to be done in the context of either special arrangements for clinical governance and clinical audit or research – **Not routinely commissioned** • Epidural injections, either sacral or interlaminar and nerve root injections are not of value for patients with non-specific low back pain - **Not routinely commissioned** **<u>SPECIFIC BACK PAIN</u>** Interventional pain therapies should be part of comprehensive treatment by a multidisciplinary team (MDT) where there should be arrangements for on-going assessment following a trial of treatment to show evidence of response. Facet Joint Injections & Medial Branch Block or Spinal/Epidural injections should be part of comprehensive treatment by an MDT. • Diagnostic Facet Joint injections are only commissioned for the assessment of patients being considered for surgical management of chronic back pain performed by a clinician trained in back pain assessment, diagnosis and management as part of an MDT process. -This should be used as a screening tool to improve specificity if radiofrequency lesioning is being considered. OR One injection will be funded if a patient meets ALL of the following criteria; • Pain lasting more than or equal to 12 months **AND** • Failed conservative treatment including maximum oral and topical analgesia **AND** • A Clinician trained in back pain assessment, diagnosis and management has assessed the patient and considers it would enable mobilisation and participation in rehabilitation as part of an MDT approach **AND** •Documented use of a standardised Pain and Quality Of Life (QOL) tool before and after procedure. Further injections will only be funded as part of a pain management pathway if significant improvement is seen on PAIN score & QOL score.	

		In such case no more than **TWO** injection sessions will be funded per year. **<u>CHRONIC BACK PAIN</u>** Radiofrequency & Endothermal Ablation for Chronic Back Pain - Denervation of Lumbar Spine: Radiofrequency denervation should be part of comprehensive treatment by a multidisciplinary team. There should be ongoing assessment following a trial of treatment to show evidence of response. ONE diagnostic Medial Branch Block will be funded prior to denervation techniques Radiofrequency denervation should only be undertaken after a successful - >80% improvement on a validated scoring tool - following one set of diagnostic local anaesthetic blocks and as part of a MDT managed programme of care. Repeat radiofrequency procedure may only be offered to those patients with a previous successful response (as above) if the benefits of the procedure lasted for at least 6 months. Repeat radiofrequency denervation is only permitted at a minimum interval of 12 months. Therefore those patients who consistently experience less than 12 months relief following two radiofrequency procedures will not be offered further radiofrequency treatment.	
W90.3, W90.4	**6.10 General Joint Injections / Trigger Point Injections for Pain** It is important to note this policy does not cover back pain due to malignancy, infection, fracture, ankylosing spondylitis and other inflammatory conditions, radicular pain resulting from nerve root compression or cauda equina syndrome	•Trigger point injections of therapeutic substances into peripheral nerves for persistent non-specific neck/back pain are not routinely commissioned	Excluded
	6.11 Low Intensity Ultrasound (Exogen) for the Healing of Fractures	Not routinely commissioned	Excluded

	6.12 Autologous Chondrocyte Implantation in the Ankle	Not routinely commissioned	Excluded
	6.13 Bone Stimulators for Non-Union (LIPUS)	Not routinely commissioned	Excluded
	6.14 Bone Stimulators for Non-Union (PEMF-Pulsed Electromagnetic Field)	Not routinely commissioned	Excluded
	6.15 Modular Rotating Hinge Knee System	Not routinely commissioned	Excluded
	6.16 Intramedullary Nail in Lower Limb Length Discrepancy	Not routinely commissioned	Excluded
7.Urology			
N30.3	**7.1 Male Circumcision** Male Circumcision for cosmetic, social, cultural and religious reasons	Not routinely commissioned	Excluded
	7.2 Male Circumcision <u>under 16 years of age</u> Male Circumcision for clinical indications	Clinical Indications: Recurrent episodes (more than 3) of severe and pathological phimosis (inability to retract the foreskin due to a narrow prepucial ring) OR Severe and recurrent episodes (more than 3) of paraphimosis (inability to pull forward a retracted foreskin) and balanitis (chronic inflammation leading to a rigid fibrous foreskin) OR Severe and recurrent episodes (more than 3) of balanoposthitis (recurrent bacterial infection of the glans and foreskin)	Restricted

	7.3 Male Circumcision <u>over 16 years of age</u>
	Male Circumcision for clinical indications
		Clinical Indications:
		• Pathological phimosis
		• 3 documented episodes of balanoposthitis
		• Relative indications for circumcision or other foreskin surgery include the following:
		  ○ Prevention of urinary tract infection in patients with an abnormal urinary tract
		  ○ Recurrent paraphimosis
		  ○ Trauma (e.g. zipper injury)
		  ○ Tight foreskin causing pain on arousal/ interfering with sexual function
			Restricted

		○ Congenital abnormalities	
	7.4 Absolute indications for circumcision	•Penile malignancy •Traumatic foreskin injury where it cannot be salvaged	Restricted
	7.5 Erectile Dysfunction Medical Management	Referrals to secondary care should not be made for the purposes of NHS prescribed medication. Medical management of erectile dysfunction should only be undertaken in accordance with current national restrictions reflected in GMS/PMS contract.	Restricted
	7.6 Penile Implants	Not routinely commissioned	Excluded
Q29.1, Q29.2, Q29.8, Q29.9 Q30.3, Q30.8, Q30.9, Q37.1, Q37.8, Q37.9, N18.1, N18.2, N18.8, N18.9	**7.7 Reversal of Sterilisation (Male and Female)** Reversal of Vasectomy or Reversal of Tubal Ligation	Not routinely commissioned	Excluded
	7.8 Stress Incontinence Surgery	Not routinely commissioned by CCGs. NHS England is now responsible for the commissioning of Stress Incontinence Surgery http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-recur-pro-urina-incon.pdf	Excluded
	7.9 Sacral Nerve Stimulation for Urinary or Faecal incontinence	Not routinely commissioned by CCGs. NHS England is now responsible for the commissioning of Sacral Nerve Stimulation for Urinary or Faecal incontinence http://www.england.nhs.uk/wp-content/uploads/2013/08/a08-p-b.pdf	Excluded

P05.5, P05.6, P05.7, P05.8, P05.9, N29.1, N29.2, N29.8, N29.9	**7.10 Cosmetic Surgery to Genitals** •Labiaplasty •Vaginoplasty or "vaginal rejuvenation" •Hymenorrhaphy	Female genital procedures for cosmetic purposes are not routinely commissioned. Labial surgery should ONLY be offered to patients who fulfil ONE of the following criteria: • Labiaplasty is required secondary to other medical conditions such as cancer • Where repair of the labia is required after trauma.	Restricted
	7.11 Gender Dysphoria	Not routinely commissioned by CCGs. Gender Reassignment is now the responsibility of NHS England and commissioned through specialised commissioning. GPs can refer directly to their contracted services http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf	Excluded
8. Vascular Surgery			
	8.1 Surgical Treatment of Uncomplicated Varicose Veins	Treatment is commissioned for varicose veins when the patient meets one or more of the following; • Varicose veins which have bled and are at risk of bleeding again OR • A history of varicose ulceration OR • Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes) OR • Superficial thrombophlebitis in association with varicose veins OR • Significant symptoms attributable to chronic venous insufficiency which are resulting in significant functional impairment.	Restricted

Medicines Management Statements

MM	**Infliximab in the treatment of sight threatening chronic non-infectious uveitis**	Not routinely commissioned	Excluded
MM	**Lucentis for Macular Oedema Post-Uveitis**	Not routinely commissioned	Excluded
MM	**Avastin for Macular Oedema Post-Uveitis**	Not routinely commissioned	Excluded
MM	**Lucentis for the Treatment of Neovascular Glaucoma**	Not routinely commissioned	Excluded
MM	**Hyaluronic Acid (& Derivatives) for Intra-Articular Injection in Osteoarthritis**	Not routinely commissioned	Excluded
MM	**Glucosamine Prescribing in Osteoarthritis**	Not routinely commissioned	Excluded
MM	**Teriparatide for Severe Osteoporosis in Men**	Not routinely commissioned	Excluded
MM	**Cystistat (Sodium Hyaluronate / Hyaluronic Acid)**	Not routinely commissioned	Excluded
MM	**Uracyst (Sodium Chondroitin)**	Not routinely commissioned	Excluded
MM	**DMSO (Dimethyl Sulfoxide)**	Not routinely commissioned	Excluded
MM	**Pentosan Polysulfate Sodium (Emiron) for Treatment of Interstitial Cystitis**	Not routinely commissioned	Excluded
MM	**Grazax** Grazax as a disease modifying treatment for grass pollen induced rhinitis and conjunctivitis in adults and children over 5 years, with a positive skin-prick or specific IgE test to grass pollen	Not routinely commissioned.	Excluded
MM	**Fampridine for walking difficulties associated with Multiple Sclerosis**	Not routinely commissioned by CCGs. NHS England Specialised Commissioning is the responsible commissioner for Multiple Sclerosis services; however they do not routinely fund this treatment. **http://www.england.nhs.uk/wp-content/uploads/2013/10/d04-ps-c.pdf**	Excluded
MM	**Melatonin for sleep disorders in children with neurodevelopment and**	Not routinely commissioned	Excluded

	neuropsychiatric conditions (ADHD)		
MM	**Melatonin for sleep disorders in children with neurodevelopment and neuropsychiatric conditions (ASD)**	Not routinely commissioned	Excluded
MM	**Benzodiazepine Withdrawal Programme**	Not routinely commissioned by CCGs. Local Authorities are the responsible commissioners for Drug and Alcohol rehabilitation services.	Excluded
MM	**High Flow Oxygen Therapy for Headaches**	Not routinely commissioned	Excluded
MM	**TMS for Migraine**	Not routinely commissioned	Excluded