NHS
Stoke on Trent

Quality care, best value, better outcomes

NHS
North Staffordshire
Clinical Commissioning Group

Commissioning Policy

Excluded and Restricted Procedures

Version 4.4

April 2013

Name of Responsible Board / Committee for Ratification:	North Staffordshire CCG Stoke on Trent CCG
Date Issued:	April 2013
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Table of Contents by Specialty

Version Control Log

Version Number	Date	Outline of Amendments
4.1	03/06/2011	Facet Joint/Epidural policy amendments
4.2	17/06/2011	OPCS codes verified
4.2	03/08/2011	Version Control references in the body of the document corrected.
4.2	03/08/2011	Reference to the Regional Commissioning Board amended to read "Regional Commissioning Board (once established)"
4.3	15/05/2012	• Changes to the Blepharoplasty criteria • Additional policy as an appendix for gender reassignment • Removal of bobath therapy and pulmonary rehabilitation as both services routinely

		commissioned • Wisdom teeth criteria changed from excluded to restricted • Criteria added around spinal cord stimulation/dorsal column stimulation – changed from excluded to restricted • Removal of medicines management section of the policy • North Staffs CCG fertility criteria – additional policy as an appendix • Dermatology and Plastics merged • Carpal Tunnel criteria altered
4.4	20/03/2013	PCT removed and changed to CCG Addition of an excluded procedure based upon clinical evidence – Closure of PFO for prevention of Stroke Removal of the following due to move to specialised commissioning on the 1st April 2013: • Bi ventricular pacing for heart failure • Cardiac electrophysical ablation • Implantable cardioverter defibrillators • ECLS • Cochlear implants (adult and paediatric) • Gender Reassignment • Bariatric surgery • Carotid endartectomy for carotid stenosis • Extra corporeal photopherisis • Spinal cord stimulation for chronic pain • BTA for children with cerebral palsy • Therapy for Facial Nerve Palsy • All oral surgery • All maxillofacial surgery • Autologous chondrocyte implantation Wording amended for the following: • Skin procedures and lesions – clarity on criteria for commissioning • Abdominoplasty (Stoke CCG) – clarity on criteria for commissioning – no changes to the criteria • IUD's and Mirena Coils – criteria for commissioning extended and criteria changed to restricted • Hip and Knee replacements – criteria remains the same but correction on the thresholds added as requested by Mr Lim • Codes amended and corrected as highlighted in the main text

		• Commissioning statement on non-specific low back pain added

1.0 Purpose

1.1 The purpose of this Commissioning Policy (which replaces the Policy on Procedures of Limited Clinical Value and Low Priority Treatments) is to clarify the commissioning intentions of the Clinical Commissioning Groups in North Staffordshire and Stoke on Trent (referred to as the commissioners from here on in) in respect of treatments to which access is restricted or that are excluded from current Service Level Agreements on the grounds of limited clinical value. This Policy (Version 4.4) supersedes the existing PCT Policies ratified by the Boards of NHS North Staffordshire and by the Board of NHS Stoke on Trent.

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 two NHS organisations can demonstrate that their decision making processes are fair, equitable, ethical and legally sound.

2.3 This Policy is a development of previous commissioning policies submitted and approved by the Trust Boards of NHS North Staffordshire and NHS Stoke on Trent. This Policy (Version 4.4) has taken account of recommended models of good practice from across Staffordshire and the West Midlands and where appropriate the policy incorporates or responds to NICE guidance.

2.4 This single Policy will be shared across associates to all contracts managed by the NHS commissioners including the University Hospital of North Staffordshire NHS Trust (UHNS) contract. The Policy defines:

- referral guidance
- treatment thresholds
- low priority treatments

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 North Staffordshire's NHS Commissioning organisations to meet this 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.

4.3 This Policy takes account of the low priority procedures as set out in the West Midlands document 'Low Priority Procedures Process'. The West Midlands Specialised Commissioning team define low priority procedures as including:

- Procedures with limited evidence of effectiveness
- Procedures where initial conservative therapy is possible
- Effective procedures where a threshold for intervention may be appropriate
- Procedures where NHS Commissioned provision may be inappropriate

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. NHS Commissioners in North Staffordshire and Stoke on Trent share a responsibility to decide the priorities for commissioning in line with agreed criteria and they must adhere to guidance from the National Commissioning Board and the Department of Health.

5.2 Making Commissioning Decisions

5.2.1 Commissioning involves specifying, securing and monitoring services that are evidence-based, cost effective, of high quality and meet individuals' needs and provide "value for money in the use of public resources".

5.2.2 NHS Commissioners design and commission services in line with local and national priorities while responding to and taking account of the needs of local people and communities including those identified in the local Joint Strategic Needs Assessment.

5.3 Determining the Evidence Base

5.3.1 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 annually. Utilisation of these prioritisation frameworks informs the annual review of this policy and the procedures and treatments it covers.

5.5 Implementation

5.5.1 The schedule showing low priority treatments is set out in Appendix 1.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 in the policy)

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 including all primary care practices and dental practices 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 annual basis or where an urgent consideration of new evidence is justified.

5.7.2 The Policy will be reviewed annually.

6.0 Managing Expectations

6.1 The NHS Commissioners, where they are host or joint commissioners, expect all providers to adhere to this policy. 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

Behavioural Therapy

OPCS Codes	Procedures	Thresholds	Status
Not applicable	Borderline Personality Disorder	Not routinely commissioned	Excluded
Not applicable	Chronic fatigue syndrome – inpatient cognitive behavioural therapy	Not routinely commissioned	Excluded

Cardiology

OPCS Codes	Procedures	Thresholds	Status
K16.5	Closure of Patent Foramen Ovale (PFO) for Migraine Headache	Not routinely commissioned	Excluded
K16.5	Closure of Patent Formale Ovale (PFO) for the prevention of stroke	Not routinely commissioned	Excluded

Complementary Medicine/Therapies

OPCS Codes	Procedures	Thresholds	Status
X61.1, X61.2, X61.3, X61.4, X61.8, X61.9	Acupuncture	Acupuncture will only be commissioned as an adjunct to pain management and only through specialist pain clinics	Excluded
X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1.	Complementary Therapies/medicines	Alexander technique Aromatherapy Ayurveda Environmental medicine Healing Hypnosis Massage Naturopathy Reflexology Shiatsu Chelation Therapy Applied Kinesiology Autogenic training Chiropractic Osteopathy Herbal medicines Homeopathy Meditation Nutritional therapy Reiki Gerson Therapy Radiation Therapy	Excluded

Dermatology and Plastic Surgery			
OPCS Codes	Procedures	Thresholds	Status
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	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, warts, xanthelasma and neurofibromata	Only commissioned when the following criteria are met: • Suspicion of malignancy OR • Obstruction of orifice or vision OR • Functional limitation on movement or activity OR • Lesion is causing itching, bleeding, pain, active inflammation	Restricted
	Lipomas	Will be routinely commissioned under the following circumstances: • Severely functionally disabling and/or subject to repeated trauma due to size and/or position OR • Lipoma located on the body that are over 5cm in diameter, or in a sub-fascial position, which has also shown rapid growth and/or are painful should be referred to an appropriate skin cancer clinic. Lipomas that are under 5cm should be observed using soft tissue sarcoma guidelines (SIGN 2003)	Restricted
	Epidermoid/Pilar (sebaceous) cysts	Surgical excision will be routinely commissioned if one or more of the following criteria are met: • On the face (not scalp or neck) and greater than 1cm in diameter	Restricted

		OR • Greater than 1cm diameter on body (including scalp and neck) and associated with significant pain, recurrent infections, discharging or loss of function.	
S53.2 with X85.1 (to identify Botulinum Toxin) and Z49.2	Botox for excessive sweating	Not routinely commissioned	Excluded
X85.1 with Z60.1 (with or without X37.5)	Botox for facial aging or excessive wrinkles	Not routinely commissioned	Excluded
Not applicable	Congenital vascular abnormalities	Not routinely commissioned	Excluded
S02.1, S02.2, S02.8, S02.9	Abdominoplasty/Apronectomy **North Staffordshire CCG**	Not routinely commissioned	Excluded
S02.1, S02.2, S02.8, S02.9	Abdominoplasty/Apronectomy **Stoke on Trent CCG**	Will be considered providing that all the following criteria are met: • Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment for a minimum period of one year or disability resulting in severe restrictions in activities of daily living • The patients BMI before weight loss must have been no less than 40kg/m2 • The patients current BMI must be between 18kg/m2 and 25kg/m2 and has been within this range for a minimum of 1 year as measured and recorded by the NHS. If this is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.	Restricted

		• The patients weight must have been stable and within this range for a minimum of 1 year as measured and recorded by the NHS • An abdominoplasty/apronectomy has not already been performed	
D03.1, D03.2, D03.3, D03.8, D03.9, D06.2	Cosmetic operations on the external ear including Pinnaplasty, split earlobes, excision of lesion of external ear, others	Will be commissioned for children under the age of 16 at the time of referral who demonstrate evidence of congenital ear deformity. Earlobe repair will be routinely funded if there is a complete tear of the lobe (not partially split lobes or elongated holes on lobes	Restricted Restricted
S06.1, S06.2, S09.1, S09.2, S10.8, S10.9	Tattoo removal	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	Cosmetic Operations on Breast (female) **North Staffordshire CCG** Breast Augmentation Breast reduction Mastopexy Revision of breast augmentation	 Will be routinely funded following mastectomy, post burns or for breast asymmetry following prophylactic bilateral mastectomy for cancer prevention in high risk cases. Not routinely commissioned Not routinely commissioned The CCG will fund the following: • Removal of implants • Removal of implants complicated by recurrent infection • Removal of implants with Baker class IV contracture associated with severe pain • Intra or extra-capsular rupture of silicone gel filled	 Restricted Excluded Excluded Restricted

		implants. Please note that the following will not be routinely commissioned as part of this treatment of as a stand-alone treatment: • Insertion of new implants • Correction of any asymmetry	
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	Cosmetic operations on breast (female) **Stoke on Trent CCG** Breast enlargement (augmentation mammoplasty)	The CCG will routinely fund under the following circumstances: • Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry (congenital amastia) • Significant degree of asymmetry of breast shape and/or volume at least a difference of 2 cup sizes as a result off: • Previous mastectomy or excision breast surgery for cancer/lumpectomy or following prophylactic bilateral mastectomy for cancer prevention in high risk cases • Trauma to the breast – post burns. Breast asymmetry, endocrine abnormalities, developmental asymmetry The following criteria must be met for surgery to be routinely funded: • Patient must have a BMI within the range of 18kg/m2 to 25kg/m2 • Minimum age for surgery is 18 of age and evidence	Restricted

		that pubertal growth of breasts has ceased	
	Revision of breast augmentation	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 Please note that the following will not be routinely funded as part of this service: • Correction of any asymmetry as explained in the section above on breast enlargement • Mastopexy and other similar surgical procedures Stoke on Trent CCG will commission the insertion of breast implants, and their replacement if they need to be removed, if the procedure was performed during or after mastectomy for breast disease or a prophylactic mastectomy.	Restricted
	Breast Reduction	Will be routinely commissioned under the following circumstances: • Women with large breasts who are experiencing function symptoms which are not relieved by wearing a fitted brassiere (fitted by a trained bra fitter)	Restricted

		• If there is back/shoulder pain, there should be documented evidence of visiting their GP for this, duration of the problemand evidenece that other approaches such as physiotherapy or NSAIDS have been tried • There is an expected need to remove at least 500mg of tissue from each breast • The patient must have a BMI within the range 18kg/m2 and 25kg/m2.	
	Mastopexy	None	Excluded
	Surgery for inverted nipples	None	Excluded
B31.1	Male Breast Reduction for Gynaecomastia	Not routinely commissioned	Excluded
S06.3, S06.4, S06.9	Refashioning of scars/keloids	For scars that interfere with function following burns/trauma, serious scarring of the face and severe post-surgical scarring	Restricted
S01.1, S01.2, S01.3, S01.4, S01.5, S01.6, S01.8, S01.9	Cosmetic excision of skin of head or neck – e.g face left, brow lifts **North Staffordshire CCG**	Following facial paralysis only	Restricted
S01.1, S01.2, S01.3, S01.4, S01.5, S01.6, S01.8, S01.9	Cosmetic excision of skin of head or neck – e.g face left, brow lifts **Stoke on Trent CCG**	The following cases will be considered for routine funding: • Following facial paralysis (congenital or acquired) • Congenital facial abnormalities • To correct the consequences of trauma • To correct deformity following surgery • To correct visual impairment • As part of treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma	Restricted

		elasticum, neurofibromatosis These procedures will not be routinely commissioned to treat the natural process of aging	
S03.1, S03.2, S03.3, (S03.8 or 03.9 with Z49.5 or 50.1)	Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm. Buttock/Thigh/Arm lift or body contouring **North Staffordshire CCG**	Not routinely commissioned	Excluded
S03.1, S03.2, S03.3, (S03.8 or S03.9 with Z49.5 or 50.1)	Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm. Buttock/Thigh/Arm lift or body contouring **Stoke on Trent CCG**	Individual cases will be considered provided that all the criteria listed in the section on abdominoplasty/apronectomy are met.	Restricted
S62.1, S62.2	Liposuction of subcutaneous tissue of neck or head	Not routinely commissioned	Excluded
S62.1, S62.2	Liposuction of subcutaneous tissue	Not routinely commissioned	Excluded
C13.1, C31.2, C31.3, C31.4, C31.5, C31.8, C13.9	Blepharoplasty	Only proven visual field impairment (reducing visual field to 120° laterally and 40°vertically) Will be routinely commissioned for upper lids only Blepharoplasty will be commissioned as part of rehabilitative surgery for patients with thyroid eye disease who may have significant disfigurement as a result of their disease. This procedure will not be commissioned for cosmetic reasons.	Restricted
C 12.1	Excision of lesion of the eyelid	Will be routinely commissioned under the following circumstances: • Potentially malignant • Infected • Symptoms of pain, irritation, discomfort • Functional deficit	

		• Lid malposition • Interference with vision • Recurrent nuisance Cosmetic eyelid surgery to correct puffy, hooded, wrinkled tired looking eyes will not be commissioned	
Not applicable	Facial Atrophy – new fill procedures	Not routinely commissioned	Excluded
P05.5, P05.6, P05.7, P05.8, P05.9, N29.1, N29.2, N29.8, N29.9	Aesthetic/Cosmetic Genital Surgery	Not routinely commissioned	Excluded
S60.6, S60.7	Hair Depilation	Not routinely commissioned	Excluded
S21.2, S21.8, S21.9, S33.1, S33.8, S33.9.	Correction of hair loss	Not routinely commissioned	Excluded
S21.1, S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9.	Correction of male pattern baldness	Not routinely commissioned	Excluded
S21.1, S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9.	Hair Transplantation	Not routinely commissioned	Excluded
S09.1, S09.2, S10.3, S11.3, S60.1, S60.2.	Laser Treatment for birthmarks and scarring	Will be routinely commissioned under the following circumstances: • The area to be treated is on the face AND • The patient has been through all other recognised treatments or it has been considered that the treatment would not be effective due to the size or condition of the area affected.	Restricted
	Skin Resurfacing techniques: Dermabrasion, Chemical Peels and Laser treatment	Not routinely commissioned	Excluded
	Electrolysis treatment for any condition	Not routinely commissioned	Excluded

Ear, Nose and Throat			
OPCS Codes	Procedures	Thresholds	Status
E20.1, E20.8, E20.9	Adenoidectomy	<u>Children</u> • For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with a tonsillectomy • Chronic adenoiditis with persistent purulent nasal discharge for greater than 3 months that is unresponsive to medical therapy • Persistent nasal obstruction in children affecting quality of life or educational performance that is unresponsive to medical therapy • In conjunction with grommet insertion where there are significant nasal symptoms and in order to prevent repeat grommet insertion for the treatment of glue ear of recurrent otitis media <u>Adults</u> For those patients who have persistent nasal obstruction for a period of over 3 months with documented adenoidal hypertrophy or nasal endoscopy which is unresponsive to medical therapy	Restricted Restricted
F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9	Tonsillectomy	To be undertaken in line with the SIGN 2010 guidance:- The following are recommended as indications for consideration of tonsillectomy for recurrent acute sore throat in both children and adults: • 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	Restricted

		• Three or more such episodes in each of the preceding three years • Sore throats are due to acute tonsillitis • The episodes of sore throat are disabling and prevent normal functioning When in doubt as to whether a tonsillectomy would be beneficial, a six month period of watchful waiting is recommended NB A child is considered to be between the ages of 4-16 for the purpose of tonsillectomy	
D15.1, D15.8, D15.9, D20.2, D20.3	Grommets	To be undertaken in line with NICE clinical guideline 60 – Surgical Treatment of Otitis Media with Effusion Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25-30 dBHL or worse averaged at 0.5, 1,2 and 4 kHz (or equivalent dBA where dNHL not available) should be considered for surgical intervention. Grommet insertion (myingtomy) – not to be performed unless the child had a period of at least 3 months watchful waiting from onset of symptoms. They will not be inserted in an otherwise healthy child with no hearing problems or within 6 months from time of onset of symptoms or detection at screening. Alternative indications for Grommets. Children should only be considered for grommet insertion if:-	Restricted

		• 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. • 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.	
F32.4, F32.5, F32.6	Surgery for snoring (Uvulopalatopharyngoplasty)	Not routinely commissioned	Excluded
F32.8 plus Y02.1 (NICE guidance)	Surgical Treatment for Sleep Apnoea (Obstructive sleep apnoea)	Will be routinely commissioned under the following circumstances: • Patients have Epworth Sleepiness Score 15-18 or: Patient sleepy in dangerous situations such as driving AND • Patient has significant sleep disordered breathing (as measured during sleep study, usually by the Apnoea/ Hypopnoea Index: 15-30/hr. = moderate, >30/hr. = severe AND • Patient has already tried CPAP unsuccessfully for 6 months prior to being considered for surgery OR patient has major side effects to CPAP such as significant nose bleeds AND • A clinical decision is that the patient will significantly	Restricted

		benefit AND • The patient is fully informed as to the limited effectiveness of procedures, the lack of long term outcomes and likely adverse effects including pain following surgery	
E02.3, E02.4, E02.5, E02.6 E07.3 E02.1, E02.2, E02.6, E02.7, E02.8, E02.9	Operations on nose: e.g. rhinoplasty Septal Surgery	Will be routinely commissioned under the following circumstances: • Where there is significant airway obstruction • Where there are severe post-surgical complications, such as saddle nose Will be routinely commissioned when the patient has persistent symptoms of nasal obstruction and where they have failed medical therapy or where medical therapy in the form of nasal sprays are not working due to the septal deviation of the turbinate hypertrophy	Restricted Restricted

Gastroenterology			
OPCS Codes	Procedures	Thresholds	Status
Not applicable	Home Parental Nutrition (HPN) Total Parental Nutrition (TPN)	Will be routinely commissioned for adult patients who are assessed and managed by a specialist multi-disciplinary team with nutritional needs consistent with NICE guidance CG32 'Nutrition support in adults'	Restricted

General Surgery			
OPCS Codes	Procedures	Thresholds	Status
H48.2	Surgery for anal/rectal skin tags	Not routinely commissioned	Excluded

H22.1, H22.8, H22.9, H25.1, H25.8, H25.9, H28,1, H28,8, H28,9	Investigations for patients under 45 years of age who have had a single bright red rectal bleed Investigation of other rectal bleeds	Not routinely commissioned Patients referred with intermittent bright red rectal bleeding should be investigated and treated for piles	Excluded Restricted
H55.1	Haemorrhoidectomy	Will be routinely commissioned under the following circumstances: • Patient suffering for recurrent and persistent bleeding that fails to respond to conservative treatment AND • Haemorrhoids cannot be reduced	Restricted
J181, J182, J183, J184, J185, J188, J189, J211, J212, J213, J218, J219	Surgery for asymptomatic gallstones	Not routinely commissioned	Excluded

Gynaecology			
OPCS Codes	Procedures	Thresholds	Status
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383	Infertility and Assisted Reproduction **North Staffordshire CCG**	Please see CCGs Individual Commissioning Policy for Infertility and Assisted Reproduction	Excluded
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383	Subfertility services **North Staffordshire CCG**	Please see CCGs Individual Commissioning Policy for Infertility and Assisted Reproduction	
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383	Infertility and Assisted Reproduction **Stoke on Trent CCG**	Please see CCGs Individual Commissioning Policy for Infertility and Assisted Reproduction	
Q131, Q132, Q133, Q134, Q135,	Subfertility services	Please see CCGs Individual Commissioning Policy for Infertility and	

Q136, Q137, Q138, Q139, Q383	**Stoke on Trent CCG**	Assisted Reproduction	
Q12.1, Q12.2, Q12.3, Q12.4, Q12.8, Q12.9	Intra Uterine Contraceptive Devices (IUCDs) including mirena coils	Insertion, removal and checks of IUCDs should only be undertaken within primary care. It is not commissioned as a stand alone secondary care service. Patients requiring a fitting within secondary care for clinical reasons where a fitting in primary care is not possible. Removals of lost or displaced IUCDs will be commissioned within secondary care where circumstances dictate that this cannot be managed within primary care and the fitting is not for contraceptive reasons alone. IUCDs fitted as a secondary procedure/OPCS code will be commissioned within secondary care	Excluded Restricted Restricted Restricted
P26.2, P26.3	Vaginal Ring Pessaries Vaginal Shelf Pessaries	Insertion and removal of vaginal ring pessaries will only be commissioned within primary care Insertion and removal of shelf pessaries will be commissioned within secondary care but only within an outpatient setting. The original shelf pessary plus three replacements will be routinely commissioned	Excluded Restricted
Q18.8, Q18.9	Hysteroscopy	This procedure will be routinely commissioned within an outpatient setting Treatment carried out within an inpatient or daycase setting is not routinely commissioned	Restricted
Q07.2, Q07.4, Q07.8, Q07.9, Q08.2, Q08.8, Q08.9	Hysterectomy for menorrhagia	Will be routinely commissioned under the following circumstances: • As a first line treatment, there has been a prior trial with a	

		levonorgestrel-releasing intrauterine system (LNG-IUS), and it has failed to relieve symptoms or is not appropriate or contraindicated. AND • There has been a prior approval trial using second line pharmaceutical treatment with either tranexamic acid, non-steroidal anti-inflammatory agents or other hormone methods (combined oral contraceptives, progestogens, Gn-RH analogue) in line with NICE guidance, and it has failed to relieve symptoms or is not appropriate and contraindicated. AND • Surgical treatments such as endometrial ablation, uterine-artery embolisation, or myomectomy have been offered and failed to relieve symptoms **or** are not appropriate **or** are contra-indicated.	

Obstetrics			
OPCS Codes	Procedures	Thresholds	Status
R42.1, R42.2	Routine Doppler ultrasound of umbilical and uterine artery in low risk pregnancies	Not routinely commissioned	Excluded
R17.1, R17.2, R17.8, R17.9	Elective Caesarean Section	Should only be offered to women with: • A term singleton breach (if external cephalic version is contraindicated or has failed) • A twin pregnancy with breech first twin • HIV (only if recommended by HIV consultant) • Both HIV and hepatitis C (as above, there is no evidence that CS should be performed for hepatitis C alone) • Primary gential herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta praevia • Two previous caesarean sections or more • Previous upper segment caesarean section or type	Restricted

		unknown • Previous significant uterine perforation/ surgery breaching the cavity • Previous traumatic delivery • Previous third degree tear • Unstable lie transverse lie • ECV declines • Previous caesarean sections x1 • Twins with other complications e.g. MC twins • Twins with significant discordant growth • Elective pre-term delivery where vaginal delivery not appropriate e.g. abnormal dopplers, PET Caesarean sections will also be routinely commissioned in cases where two consultants have stated that it is clinically appropriate	

Ophthalmology			
OPCS Codes	Procedures	Thresholds	Status
C13.1, C31.2, C31.3, C31.4, C31.8, C13.9	Blepharoplasty	Only proven visual field impairment (reducing visual field to 120° laterally and 40°vertically) Will be routinely commissioned for upper lids only Blepharoplasty will be commissioned as part of rehabilitative surgery for patients with thyroid eye disease who may have significant disfigurement as a result of their disease. This procedure will not be commissioned for cosmetic reasons.	Restricted
C12.1, C12.2, C12.3, C12.4, C12.5, C12.8, C12.9	Excision of lesion of eyelid	Will be routinely commissioned under the following circumstances: • Potentially malignant • Infected • Symptoms of pain, irritation, discomfort • Functional deficit	Restricted

		• Lid malposition • Interference with vision • Recurrent nuisance Cosmetic eyelid surgery to correct puffy, hooded, wrinkled tired looking eyes will not be commissioned	
C44.2, C44.4, C44.5, C46.1	Laser Treatment for myopia (short sightedness)	Not routinely commissioned	Excluded
Not applicable	Screening for diabetic retinopathy by consultant ophthalmologists	Not routinely commissioned	Excluded
Not applicable	Screening for glaucoma by consultant ophthalmologists	Not routinely commissioned	Excluded
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	Cataract Surgery	**Threshold is visual acuity 6/12 in the worst eye.** 1. Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) 2. With Posterior subcaspular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions. 3. Driving: the legal requirement for driving falls between 6/9 and 6/12 (strictly speaking it is based on the number plate test). It is anticipated that the threshold will not render the majority of people unable to drive as it applies to the worst eye only. Exceptions will be considered for: • Patients who need to drive who experience significant glare which affects driving; • Patients who, for occupational reasons, need to drive at night and who experience glare that is related to cataract; • Patients with visual field defects borderline for	

		driving, in whom cataract extraction would be expected to significantly improve the visual field. • Patients with glaucoma who require cataract surgery to control intra ocular pressure • Patient with diabetes who require clear views of their retina to look for retinopathy. **Cataract Second Eye** 1. Where the cataract procedure on the first eye has achieved a VA of 6/9 or better, and the VA for the second eye is 6/12 or better, then the patient should be discharged, unless receiving treatment for any other eye condition. The patient should be advised to attend an optometrist for a sight test annually or earlier if they notice any deterioration of vision. 2. If the first eye does not achieve a VA of 6/9 or better, then the second eye should be dealt with on clinical merit, taking into account any directly related work circumstances (i.e. the requirement for night driving). There are circumstances, where despite good activities, there may still be a clinical need to operate on the second eye fairly speedily e.g. where there is resultant anisometropia (a large refractive difference between the two eyes) which would result in poor binocular vision or even diplopia. In these circumstances, the notes should clearly record this so that it can be identified during any future clinical audit.	

Respiratory			
OPCS Codes	Procedures	Thresholds	Status
Not Applicable	Non-surgical treatment for sleep apnoea (Obstructive sleep apnoea)	Will be routinely commissioned under the following circumstances: Patients should be referred for assessment and possible treatment to a specialist sleep unit when at least one of the following are	Restricted

		present in addition to snoring: • Daytime sleepiness (rather than tiredness) • Witnessed nocturnal apnoeic episodes of stopping breathing • Waking with sensations of choking/obstruction • Neck circumference of 17 inches or over • A degree of retrognathia NICE Technology Appraisal (TAG 239, March 2009)	
U06.1	Sinus X ray	Not routinely commissioned	Excluded

Trauma and Orthopaedics			
OPCS Codes	Procedures	Thresholds	Status
W37.1, W37.2, W37.8, W37.9, W38.1, W38.2, W38.8, W38.9, W39.1, W39.2, W39.8, W39.9 W40.1, W40.2, W40.8, W40.9, W41.1, W41.2, W41.8, W41.9, W42.1, W42.2, W42.8, W42.9	Hip and Knee Replacement	Will be routinely commissioned under the following circumstances: • Evidence that conservative means have failed to alleviate pain and disability e.g. analgesics, NSAIDS, physiotherapy. <u>HIPS</u>: Threshold for referral to MSK interface service Revised Oxford Score of 21 – 26 Threshold for referral to secondary care / surgery Revised Oxford Score of 20 and under. <u>KNEES</u>: Threshold for referral to MSK interface service Revised Oxford Score of 17 – 26 Threshold for referral to secondary care / surgery Revised Oxford Score of 16 and under Hips and knees – Revised Oxford Score of 27+ should be managed in primary care.	Restricted
Not applicable	Bespoke Knee Prosthetic	Not routinely commissioned	Excluded

	Endoscopic Lumber decompression	Not routinely commissioned	Excluded
A65.1, A65.9	Carpal Tunnel Syndrome Release of entrapment of peripheral nerve at Wrist OS/US	Surgery will only be commissioned under the following circumstances: • Patients must have tried all conservative measure AND • Patients must have been through the MSK service AND • Patients must be able to clinically demonstrate acutely severe symptoms via nerve conduction studies Patient must satisfy the Stothard questionnaire with a score of 5 or greater to be eligible for surgery and patients must have been through the MSK service.	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	Surgical removal of ganglion on wrist/feet Surgical removal of seed ganglia at base of digits Surgical Removal of mucoid cysts at DIP joint	Will be routinely commissioned where there is evidence of neurovascular compromise. Will be routinely commissioned where patients can demonstrate significant pain supported by a clinical decision that removal is required Will be routinely commissioned where nail growth is disturbed and the cysts are prone to discharge.	Restricted Restricted Restricted
T52.1, T52.2, T52.5, T52.6, T54.1	Dupuytren's Disease – palmer fasciectomy	Surgery will be routinely commissioned where: • Patients have been though the MSK service AND • The patient has failed the Heuston table top test	Restricted
T69.1, T69.2, T69.8, T69.9, T70.1, T70.2, T71.8, T71.9, T72.3, T72.8,	Trigger Finger – surgical treatment	Surgery will be routinely commissioned where: • There has been failure to respond to conservative measures	Restricted

T72.9		such as a hydrocortisone injection OR • The patient has a fixed deformity that is non-correctable	
V38.2, V38.3, V38.4, V38.8, V38.9, V39.3, V39.4, V39.5, V39.6, V39.7	Spinal Fusion	Will be routinely commissioned under the following circumstances: • Where the patient has unequivocal root compression • Where the patient has spinal stenosis • Where there is spinal instability • Where there has been a failure of an adequate conservative trial of over 6 month duration.	Restricted
A52.1, A52.2, (A52.8, A52.9 with Z06.3), (X30.6, X30.8, or X30.9 with Z06.3)	Spinal epidural injections/ therapeutic lumbar epidural injection	Epidural steroid injections are not permitted for isolated back or neck pain. The first epidural steroid injection will be funded if the patient meets ALL of the criteria in Box A **OR** Box B. **Box A** Leg pain is rated at a level of ≥6 on a scale of 0 to 10. The level of pain must be assessed using a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score); **AND** Pain causes significant impact on daily functioning which has been assessed using a validated tool (e.g. a score of ≥6 using the Brief Pain Inventory, >40% using the Oswestry Disability Index); **AND** Pain has not responded to physiotherapy interventions or appropriate medication. **AND**	Restricted

		For leg pain diagnosed as radicular in nature (i.e. related to compression or irritation of spinal nerve roots) based on clinical examination and best available imaging (ideally MRI if not contraindicated); **AND** Leg pain is worse than any associated back pain; **AND** Pain has lasted for more than 6 months **<u>BOX B</u>** For leg pain diagnosed as radicular in nature (i.e. related to compression or irritation of spinal nerve roots) based on clinical examination and best available imaging (ideally MRI if not contraindicated); **AND** Leg pain is rated at a level of ≥9 on a scale of 0 to 10 sufficient to mandate emergency hospital admission **OR** leg pain is ≥7 on a scale of 0 to 10 and coexistent disability prevents the patient being managed in the home environment. The level of pain must be assessed using a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score) **<u>Repeat Epidural Injections</u>** Repeat epidural steroid injections at a minimum interval of 6 months are permitted for the management of persistent radicular or nerve root pain in patients when ALL of the following criteria are met:	

		Patient has met policy criteria for a first epidural steroid injection (see 5.52); **AND** Pain has returned following previous epidural steroid injection; **AND** Previous epidural steroid injection gave ≥50% reduction in pain and associated disability as assessed by validated tools (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score, Brief Pain Inventory, Oswestry Disability Index) for at least 6 months; **AND** All other available conservative pain management options (e.g physiotherapy interventions, medication) have been exhausted; **AND** Patient either is not a suitable candidate for surgical intervention to decompress the nerve roots or does not want surgery.	
V54.4	Facet Joint Injections	NHS Stoke on Trent and NHS North Staffordshire will fund facet joint injections, medial branch blocks and radiofrequency denervation for the management of chronic back (or neck) pain when ALL of the following criteria are met: Chronic back (or neck) pain lasting of at least 12 months duration; **AND** Back (or neck) pain rated at a level of ≥6 on a scale of 0 to 10. The level of pain must be assessed using a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score); **AND**	Restricted

		Back (or neck) pain causes significant impact on daily functioning which has been assessed using a validated tool (e.g. a score of ≥6 using the Brief Pain Inventory, >40% using the Oswestry Disability Index); **AND** All available conservative management options have been tried for at least 12 months and failed e.g. advice to remain active/ continue usual activities as far as possible, exercise, physiotherapy interventions as appropriate (e.g. manual therapy, structured exercise programme), appropriate analgesic medications (see NICE Guideline CG88 on Early management of persistent non-specific low back pain). **Diagnostic phase** The facet joints must be confirmed as the primary source of the pain by controlled diagnostic local anaesthetic blocks under X-ray screening. Where radiofrequency denervation is being considered these must be medial branch blocks. **Therapeutic phase** Radiofrequency denervation may be offered to those patients meeting the following criteria: There is at least an 80% documented improvement in back (or neck) pain during activities which normally generate back (or neck) pain following one set of diagnostic local anaesthetic blocks as assessed using a validated tool (e.g. Pain Visual Analogue Score). A radiofrequency procedure will be considered successful in those patients who experience a documented improvement in back (or neck) pain of at least 80% following the procedure when this is accompanied by an ≥60% improvement in those aspects of function previously limited by back (or neck) pain as assessed by a	

		validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score, Brief Pain Inventory). If the back (or neck) pain returns as before, a 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. **Therapeutic facet joint injections** Repeat medial branch blocks or intra-articular facet joint injections are only permitted for those patients who obtained at least 50% reduction in pain and 50% improvement in function as assessed by validated tools (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score, Brief Pain Inventory) where the benefits of the procedure in terms of pain and function lasted for at least 6 months and where all other available therapeutic options (in terms of multidisciplinary pain management) have been exhausted. **OR** The patient met the criteria for radiofrequency denervation but did not have a successful response to the radiofrequency procedure BUT the benefit from the diagnostic blocks in terms of pain relief and improved function lasted at least 6 months and all other available therapeutic options (in terms of multidisciplinary pain management) have been exhausted.	
W82.2, W82.3, W83.3, W83.6, W85.2, W85.8, W85.9	Knee osteoarthritis – debridement	Will only be routinely commissioned where the patient has mechanical features of locking that are associated with severe pain	Restricted

W87.1, W87.8, W87.9	Diagnostic arthroscopy of the knee	Not routinely commissioned	Excluded
U13.3, U13.4	Plain X Ray and MRI of back	Plain x-rays are restricted in line with the criteria set out in NICE clinical guideline 88 and the Royal College of Radiologists guidelines. No not offer x-ray of the lumbar spine for the management of non-specific low back pain MRI scans should only be offered in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected: • spinal malignancy • infection • fracture • Cauda Equina Syndrome • Ankylosing Spondylitis or other	Restricted Restricted
W90.3, W90.4	General Joint Injections for pain (peripheral joints)	Not commissioned when a patient could be a candidate for joint replacement in the next 6-12 months except as a diagnostic tool prior to joint replacement in order to confirm the joint as the major source of pain/ symptoms and for patients who are currently unfit or unsuitable for surgery or who do not wish to proceed to surgery. Not commissioned in a sterile theatre unless x-ray screening or general anaesthesia is required and where they are performed with other procedures i.e. nerve blocks or manipulation.	Restricted
Not applicable – Commissioning Statement	Persistent non-specific low back pain	NICE guidance recommends that the following treatments should not be offered for the early management of persistent low back pain: • SSRIs for treating pain	

		• Injections of therapeutic substances into the back • Laser therapy • Interferential therapy • Therapeutic ultrasound • TENS • Lumbar Supports • Traction NICE guidance recommends that the following referrals should not be offered for the early management of persistent non-specific low back pain: • Radiofrequency facet joint denervation • IDET • PIRFT	
O29.1, (W08.5 or 08.9 or 57.2 with Z81.2)	Excision acromioclavicular joint; Surgical decompression subacromial space	Will be routinely commissioned where there is evidence of a conservative trial or treatment and temporary improvement has been demonstrated using injection surgery	Restricted
Not applicable	Therapeutic ultrasound in physiotherapy	Not routinely commissioned	Excluded

Urology			
OPCS Codes	Procedures	Thresholds	Status
N30.3	Circumcision	Will be routinely commissioned under the following circumstances: **Patients under 16 years of age** • Symptomatic phimosis or paraphimosis and recurrent (>3) balanitis or balanoposthitis	

		Not commissioned for social, cultural or religious reasons **Patients over the age of 16** • Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) and paraphimosis (inability to pull forward a retracted foreskin). • Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin). • Balanoposthitis (recurrent bacterial infection of the prepuce)	
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	Reversal of Sterilisation: reversal of vasectomy or reversal of tubal ligation (Male and Female)	Not routinely commissioned	Excluded
	Surgery for protatism	Will be routinely commissioned where there is evidence of one of the below: • International prostate symptom score >7; • Dysuria; • Post voided residual vol >150ml; • Recurrent UTI; • Deranged renal function; • PSA > Age adjusted normal values	
	Drug Treatment for Erectile Dysfunction – injection of therapeutic substance into penis	Not routinely commissioned	Excluded

	Penile Implants	Not routinely commissioned	Excluded
N17.1, N17.2, N17.8, N17.9	Vasectomy	Not routinely commissioned within secondary care unless there is a clinical reason why the patient needs a general anaesthetic	Restricted

Vascular Surgery			
L874, L832, L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888, L889	Surgical Treatment of uncomplicated varicose veins and reticular veins or telangiectasia	• Obvious skin changes included varicose eczema; • ulceration; • recurrent phlebitis (>2 episodes); • bleeding from a varicose vein; • patient has severe symptoms attributable to the venous disease (significant and persistent aching, discomfort or oedema) requiring analgesia and has not responded to the regular use of compression hosiery for a period of six months.	Restricted
	Asymptomatic or mild to moderate carotid stenosis	Not commissioned unless there is evidence of severe stenosis or bilateral stenosis and are low surgical risk	Restricted