CHESHIRE & MERSEYSIDE

Commissioning Policy

CRITERIA

2014/15

Proposed Review Date: September 2015

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1. Introduction

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

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

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

The NHS Standard Contract requires that the provider must manage referrals in accordance with the terms of any Prior Approval Scheme. If the provider does not comply with the terms of any Prior Approval Scheme in providing a service, the commissioners will not be liable to pay for that service.

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

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

2. Core Clinical Eligibility

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

All NICE Technology Appraisals will be implemented.

In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2 week rule.

Reconstructive surgery post cancer or trauma including burns.

Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.

Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.

Any patient who needs urgent treatment will always be treated.

No treatment is completely ruled out if an individual patient's circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patient's responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.

Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

3. Referral & Approval Process

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

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

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

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

Have received prior approval by the CCG.

OR

Clearly state how the patient meets the criteria.

OR

Be for a clinical opinion to obtain further information to assess the patient's eligibility.

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

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

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

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

4. Exceptionality

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

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

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

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

5. Psychological Distress

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

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

6. Personal Data (including photographs)

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

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

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

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

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

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

7. Medicines Management

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

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

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

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

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

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

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

8. Evidence

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

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
1.	**Complementary Therapies**			
1.1	Complementary Therapies	Not routinely commissioned unless recommended by NICE guidance.	*Complementary and alternative medicine* – NHS Choices 2012. http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/	Individual CCG addendums apply.
2.	**Dermatology**			
2.1	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: Severe scarring following: • Acne once the active disease is controlled. • Chicken pox. OR • Trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Modernisation Agency's Action on Plastic Surgery 2005. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. www.evidence.nhs.uk Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
2.2	Surgical or Laser Therapy Treatments for Minor Skin Lesions e.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, corn/callous dermatofibromas, comedones, molluscum contagiosum chalazion	Will be commissioned in any of the following circumstances: • Symptomatic e.g. ongoing pain or functional impairment. • Risk of infection. • Significant facial disfigurement. • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Modernisation Agency's Action on Plastic Surgery 2005. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	Uncomplicated benign skin lesions should NOT be referred. Send suspected malignancy on appropriate pathway. Consider if benefit outweighs risk associated with surgery.

				Consider primary care or community service.
2.3	Surgical Treatment for Removal of Lipoma in Secondary Care.	Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position. Lipomas that are under 5cms should be observed only unless the above applies.	Noninvasive lipoma size reduction using high-intensity focused ultrasound – Dermatologic Surgery 2013 Oct;39(10):1446-51.	Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which have also shown rapid growth and are painful should be referred to an appropriate skin cancer clinic.
2.4	Treatments for Skin Pigment Disorders	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross.* Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	http://www.changingfaces.org.uk/Skin-Camouflage Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Initially the recommended NHS suitable treatment for hypo – pigmentation is biopsy of suspicious lesions only. Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage. *Access available for Wirral patients via Dermatology Department.
2.5	Surgical/Laser Therapy for Viral Warts (excluding	Will be commissioned in any of the following circumstances:	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management	Most viral warts will clear spontaneously or

	Genital Warts) from Secondary Care Providers	• Severe pain substantially interfering with functional abilities. • Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. • Extensive warts (particularly in the immune-suppressed patient). • Facial warts. • Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.	Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae	following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.
3.	**Diabetes**			
3.1	Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus	Not routinely commissioned and only considered if **ALL** of the following criteria are met; • Type I diabetes. AND • Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151. AND • HbA_{1c} 69 mmol/l OR experiencing severe hypoglycaemic attacks which require intervention by a carer. AND • Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value.	Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012. Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials. – European Journal of Endocrinology. 2012 Apr; 166(4):567-74. Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805. Continuous Glucose Monitoring for Patients with Diabetes – Ontario: Health Quality Ontario, 2011. Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British	PH Continuous Glucose Monitors Pap PH Continuous Glucose Monitors Add

		AND • Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum). AND • Motivated to comply with the requirements. • The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months. • All cases will be subject to individual approval by the IFR Team.	Society for Paediatric Endocrinology and Diabetes, 2009. For further references please refer to Public Health Continuous Glucose Monitors Paper.	
4.	**ENT**			
4.1	Adenoidectomy	Commissioned only in either of the following clinical situations. In Children For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy. In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 5.3 Adenoidectomy is not routinely commissioned as an isolated procedure.	http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0010/98659/FullReport-hta18050.pdf Health Technology Assessment Volume:18 Issue: 5 Tonsillectomy and Adenoidectomy in Children with Sleep Related Breathing Disorders – The Royal College of Anaesthetists - July 2010. Adenoidectomy for recurrent or chronic nasal symptoms in children The Cochrane Library 2010. Adenoidectomy for otitis media in children The Cochrane Library 2010. Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract) Centre for Reviews and Dissemination 2013. NICE “Do not do” recommendation: “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.” http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0004/98869/FullReport-hta18050.pdf	

			Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ.Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis. Health Technology Assessment 2014;18(5)	
4.2	Pinnaplasty – for Correction of Prominent Ears	May be commissioned in the following circumstances: Surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged 5 to 18 years at the time of referral. AND 2. With very significant ear deformity or asymmetry. Patients not meeting these criteria should not be routinely referred for surgery. Incisionless otoplasty is not commissioned.	Pinnaplasty Department of Health (2007). Local PCT consensus - review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. IPG 422: Incisionless otoplasty NICE 2012. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty Royal College of Surgeons (2013).	Children under the age of five are usually oblivious and referrals may reflect concerns expressed by the parents rather than the child.
4.3	Insertion of Grommets for Glue Ear (otitis media with effusion)	**CHILDREN** The CCG will commission treatment with grommets/myringotomy for children with otitis media with effusion (OME) where: There is a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year. OR There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon). AND • OME persists after three months. AND • The child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome Royal College of Surgeons (2013). NICE Pathway – Surgical management of Otitis Media with effusion in children (2012). CG60 Surgical management of children with otitis media with effusion (OME) (February 2008). The advice in the NICE guideline covers: • The surgical management of OME in children younger than 12 years. • Guidance for managing OME in children with Down's syndrome and in children with all types of cleft palate. It does not specifically look at the management of OME in: •Children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease).	

		confirmed over 3 months. OR Persistent bilateral OME with hearing loss less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child's developmental, social or educational status. Children with Downs Syndrome are normally fitted with Hearing Aids. Management of children with cleft palate is under specialist supervision. Do not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 5.1 Adenoidectomy. **ADULTS** Grommets in adults with OME will be funded only in the following circumstances: • Significant negative middle ear pressure measured on two sequential appointments. AND • Significant ongoing associated pain. OR • Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.	•Children with multiple complex needs. *Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children* - Cochrane Ear, Nose and Throat Disorders Group 2010. http://pathways.nice.org.uk/pathways/surgical-management-of-otitis-media-with-effusion-in-children - path=view%3A/pathways/surgical-management-of-otitis-media-with-effusion-in-children/assessment-and-treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf	
4.4	Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children	Tonsillectomy will only be commissioned where: • 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 previous two years; OR • Three or more such episodes in each of the preceding three years.	Scottish intercollegiate guidelines network. Management of sore throat and indications for tonsillectomy (April 2010) Guideline 117. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis - Cochrane Ear, Nose and Throat Disorders Group (2008). Evidence note 23: Tonsillectomy for recurrent bacterial tonsillitis – Health Improvement Scotland (2008). Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009.	Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.

		Is commissioned if appropriate following peri-tonsillar abscess. Tonsillectomy is not commissioned for tonsil stones or halitosis. Tonsillectomy may be appropriate for significant hypertrophy causing OSA. Tonsillectomy is recommended for severe recurrent sore throats in adults as above.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy - Royal College of Surgeons (2013)	
4.5	Surgical Remodelling of External Ear Lobe	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
4.6	Use of Sinus X-ray	X-rays of sinuses are not routinely commissioned.	BSACI guidelines for the management of rhinosinusitis and nasal polyposis Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007. NHS Choices Sinusitis http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitus Royal College of Surgeons (2013).	
4.7	Rhinoplasty - Surgery to Reshape the Nose	This procedure is NOT available under the NHS on cosmetic grounds. • Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment.

		Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
4.8	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Nuances in the management of rhinophyma Facial Plastic Surgery, 2012 Apr;28(2):231-7. http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm http://www.nhs.uk/Conditions/Rosacea/Pages/Treatment.aspx	The first-line treatment of this condition of the nasal skin is medical. However response is poor. Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances.
5.	**Equipment**			
5.1	Use of Lycra Suits	Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.	What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. For further references please refer to Public Health Lycra Suits Paper.	Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames. Public Health Recommendation: Current evidence does not support routine commissioning of Lycra suits in the management of

				Cerebral Palsy. Lycra suit orthoses for cerebral palsy should be assigned low priority. Individual CCG addendums apply. PH Lycra Suits Paper.pdf
6.	**Fertility**			
6.1	Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation	See Cheshire & Merseyside Infertility Policy.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	Individual CCG addendums apply.
7.	**General Surgery**			
7.1	Haemorrhoidectomy - Rectal Surgery: & Removal of Haemorrhoidal Skin Tags	Surgery commissioned for symptomatic: • Grade III and IV haemorrhoids. • Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments:- ○ Diet modification to relieve constipation. ○ Topical applications. ○ Stool softeners and laxatives. ○ Rubber band ligation. ○ Sclerosant injections. ○ Infrared coagulation. • Surgical treatment options include:- ○ Surgical excision (haemorrhoidectomy). ○ Stapled haemorrhoidopexy.	Haemorrhoidal artery ligation NICE 2010. TAG128: Stapled haemorrhoidopexy for the treatment of haemorrhoids NICE 2007. BMJ2008. Clinical Review: Management of Haemorrhoids. Austin G Acheson, John H Scholefield, BMJ 2008; 336:380. Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008. Long-term Outcomes of Stapled Hemorrhoidopexy vs Conventional Hemorrhoidectomy A Meta-analysis of Randomized Controlled Trials – JAMA Surgery March 16, 2009, Vol 144, No. 3.	There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure. Short term efficacy and cost effectiveness is similar.

		○ Haemorrhoidal artery ligation. Removal of skin tags is not routinely commissioned.	Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US. Management of haemorrhoids BMJ 2008;336:380. Haemorrhoids NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding Royal College of Surgeons (2013).	
7.2	Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias Surgical correction of Diastasis of the Recti	Surgery: not commissioned if no symptoms, easily reducible (i.e. can be 'pushed back in') and not at significant risk of complications. Surgical repair is not routinely commissioned.	A systematic review on the outcomes of correction of diastasis of the recti Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.	Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect.
7.3	Surgery for Asymptomatic Gallstones	This procedure is not routinely commissioned.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones Royal College of Surgeons (2013).	This procedure is considered a Low clinical priority for asymptomatic gallstones. Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for unrelated reasons.
7.4	Lithotripsy for Gallstones	Lithotripsy not routinely commissioned.		Lithotripsy rarely performed as rate recurrence high.
8.	**Gynaecology**			
8.1	Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has	CG44 Heavy menstrual bleeding: full guideline NICE 2007. QS47 Heavy Menstrual Bleeding *NICE 2013.*	

		made an informed choice not to use this treatment. • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance. ○ Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. ○ Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens. ○ Endometrial ablation has been tried (unless patient has fibroids >3cm)		
8.2	D&C (dilatation and curettage)	Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure.		
9.	**Mental Health**			
9.1	Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS)	Inpatient care for Chronic Fatigue Syndrome is not routinely commissioned. If inpatient treatment is recommended an IFR referral will be required.	*Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53. *Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008. *Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137. *Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012, 12:264.	Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family,

				and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital.
9.2	Treatment of Gender Dysphoria	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at either Charring Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Where the provision of ''non-core surgery'' is appropriate the GIC should apply for treatment funding through the CCG. Liverpool, Sefton and Knowsley have a local support service in place at LCH.
9.3	Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)	This is not routinely commissioned.	Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007) Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
9.4	Private Mental Health (MH) Care - Non-NHS Commissioned Services: including Psychotherapy,	This will not normally be funded. Most mental health conditions can be managed in the community with input from Community Mental Health teams.	Veterans' post traumatic stress disorder programme (Adult) Service Specification NHS England Specialised Commissioning 2013. Post –traumatic stress disorder (PTSD):The management of	

	adult eating disorders,general in-patient care,post-traumatic stresss,adolescent mental health	NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD. There is also a specialist NHS MH service provided for affective disorders. A request for private MH care should be initiated by a consultant psychiatrist and give full explanation as to why NHS care is inappropriate or unavailable.	PTSD in adults and children in primary and secondary care NICE Clinical Guideline 26 (2005). Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification NHS England Specialised Commissioning (2013) The use of motivational interviewing in eating disorders: a systematic review. Psychiatry Research, 2012 Nov 30;200(1):1-11. Depression in children and young people: Identification and management in primary, community and secondary care. NICE Clinical Guideline 2005. Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013.	
10.	**Neurology**			
10.1	Bobath Therapy	Bobath Therapy is not routinely commissioned by the NHS. The evidence base is poor for both children and adults.	The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme Physiotherapy Research International Volume 16, Issue 2, pages 69–80, June 2011. Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15. http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf Cambridge CCG (2013). A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy National Public Health Service for Wales (2008).	
10.2	Trophic Electrical Stimulation for	Not routinely commissioned.	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).	

	Facial/Bells Palsy			
10.3	Functional Electrical Stimulation (FES)	Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities. Exclusion Criteria: • Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. • Ataxic and polio patients are generally poor responders although there are exceptions.	Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10. Functional electrical stimulation for drop foot of central neurological origin NICE, 2009. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.	
11.	**Ophthalmology**			
11.1	Upper Lid Blepharoplasty - Surgery on the Upper Eyelid	Only commissioned in the following circumstances: • Eyelid function interferes with visual field.	Eyelid Surgery *The British Association of Aesthetic Plastic Surgeons 2011.* Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired

				vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.
11.2	Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	*Eyelid Surgery* The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus – review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.
11.3	Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids)	Only commissioned for: Larger legions which satisfy all of the following: 1. Not responded to treatment for underlying familial lipoprotein lipase deficiency. 2. Failed topical treatment. 3. Causing significant disfigurement. 4. Causing functional impairment. Topical treatments may be available in a primary care or community setting.	Local PCT consensus – review conducted 2007. DermNet NZ information resources updated Jan 2013. Commissioning Criteria – Plastic Surgery Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). http://www.patient.co.uk/doctor/xanthelasma	The following treatments should be considered for patients with xanthelasma: Topical trichloroacetic acid (TCA) or cryotherapy. Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist. Lesions are harmless.
11.4	Surgery or Laser Treatment for Short Sightedness	Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned.		

	(myopia) or Long Sightedness (hypermetropia)			
11.5	Cataract Surgery	See appendix 1 for details of Referral Guidance template. Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights. An example of a referral template for use by optometrists is given in appendix 1. There is good evidence that bilateral cataract replacement is beneficial.	Thresholds for cataract surgery – Shropshire and Telford Hospital NHS Trust, 2012. NHS Atlas of Variation, (cataract spend, cataract admissions) Don't turn back the clock: Cataract surgery - the need for patient centred care. RNIB / Royal College of Ophthalmologists (2011). Cataract surgery guidelines The Royal College of Ophthalmologists (RCOphth) 2010. Action on cataracts good practice guidance Department of Health (2000). Cataract care pathway Map of Medicine (2013). NHS UK - http://www.nhs.uk/conditions/Cataracts-age related/Pages/Introduction.aspx For further references please refer to Public Health Cataracts Paper.	 PH Cataract Paper.pdf
11.6	Coloured (irlens) Filters for Treatment of Dyslexia	There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.	Coloured filters for reading disability:A systematic review WMHTAC 2008	
11.7	Intra Ocular Telescope for Advanced Age-Related Macular Degeneration	This is not routinely commissioned as there is limited published evidence of effectiveness.	Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012).	
11.8	Surgical Removal of Chalazion or Meibomian Cysts	Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND	Guidance for the management of referrals for Meibomian Cysts NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013). http://www.kernowccg.nhs.uk/media/136633/chalazion__meibomian_cyst__guidance_16.01.2013.pdf NHS Cornwall & Isles of Scilly, Devon, Plymouth and Torbay	Individual CCG addendums apply.

		• Causes blurring or interference with vision. OR • Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk.		
12.	**Oral Surgery**			
12.1	Surgical Replacement of the Temporo-Mandibular Joint Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement	Only commissioned in the following circumstances: • Any or a combination of the following symptoms are present: ○ Restricted mouth opening <35mm). ○ Dietary score of< 5/10 (liquid scores 0, full diet scores 10). ○ Occlusal collapse (anterior open bite or retrusion). ○ Excessive condylar resorption and loss of height of vertical ramus. ○ Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). ○ Other significant quality of life issues. AND • Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.	Surgical Replacement of the Temporo-mandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests. TMJ Replacement Guidance .pdf Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes	
13.	**Paediatrics**			
13.1	Cranial Banding for Positional Plagiocephaly	Not routinely commissioned.	Nonsurgical treatment of deformational plagiocephaly: a systematic review Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27. What is the role of helmet therapy in positional plagiocephaly? BestBETS 2008.	Most childrens head shapes will improve naturally in their own time.

14.	Plastic & Cosmetic Surgery			
14.1	Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: • Musculo-skeletal symptoms are not due to other causes. AND • There is at least a two year history of attending the GP with the problem. AND • Other approaches such as analgesia and physiotherapy have been tried. AND • The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). AND • The wearing of a professionally fitted brassiere has not helped. AND • Patients BMI is <25 and stable for at least twelve months. AND • The patients breast is a cup size H or larger. AND • There is a proposed reduction of at least a three cup sizes. AND • Aged over 18 years old. AND • It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010. Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. *British Journal of Plastic Surgery*, *56*(3), 230–236. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. *Chiropractic & Osteopathy*, *16*(1), 1–7. An investigation into the relationship between breast size, bra size and mechanical back pain British School of Osteopathy (2010). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).	

			Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.2	Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstance: In all cases: • The BMI is <25 and stable for at least twelve months. AND • There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. OR • Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. All non-surgical options must have been explored e.g. padded bra. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 . Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Patients should be made aware that: 1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. Not all patients demonstrate improvement in psychosocial outcome measures following breast

				augmentation.
14.3	Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012). Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.
14.4	Mastopexy - Breast Lift	Not routinely commissioned. May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013).	

		appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.5	Surgical Correction of Nipple Inversion	This is not routinely commissioned. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule. This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months.
14.6	Male Breast Reduction Surgery for Gynaecomastia	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: • True gynaecomastia not just adipose tissue. AND • Underlying endocrine or liver abnormality excluded. AND • Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this. AND • Not due to prescribed drug use. AND • Has not responded to medical management for at least three months e.g. tamoxifen. AND	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf	Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer.

		• Post pubertal. AND • BMI <25kg/m2 and stable for at least 12 months. AND • Patient experiences persistent pain. AND • Experiences significant functional impairment. AND • In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.7	Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed.	Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70). cks.nice.org.uk/hirsutism#!scenario - NICE: Clinical Knowledge Summaries 2010. Laser and photoepilation for unwanted hair growth – Cochrane Library 2009. Management of hirsutism – Koulouri et al *BMJ* 2009; 338:b847. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.

		3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist). Photographs will also be required to allow the CCG's to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.8	Surgical Treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds.	nice.org.uk/guidance/IPG310 NICE (2009).	
14.9	Surgical Revision of Scars	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.10	Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not	

		• Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). An individual funding request will be required.	usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
14.11	Apronectomy or Abdominoplasty (Tummy Tuck)	Not routinely commissioned other than if all of the following criteria are met: The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made). IFR information ***must*** contain the following information:-	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).	Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced. Poor level of evidence of positive outcomes.

		• Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight/BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.		
14.12	Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. IFR information ***must*** contain the following information;	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring Royal College of Surgeons (2013).	The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is less likely to be indicated except for appearance. Therefore it will not be available on the NHS.

		• Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight/BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.13	Treatments to Correct Hair Loss for Alopecia	Only commissioned in either of the following circumstances: • Result of previous surgery. • Result of trauma, including burns. Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy.	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 Interventions for alopecia areata – Cochrane Library 2008. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. Alopecia areata – NICE Clinical Knowledge Summaries 2008. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	

			Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.
14.14	Hair Transplantation	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	*A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 further evidence provided within this document by Islington PCT to support funding. Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.
14.15	Treatments to Correct Male Pattern Baldness	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.
14.16	Labiaplasty, Vaginoplasty and Hymenorrhaphy	This is not routinely commissioned.	Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499. Department for Education and Skills. (2004). *Local Authority Social Services Letter. LASSAL (2004)4,* London, DfES.

			Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159.* Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women: a review of the literature. *BJOG: An International Journal of Obstetrics & Gynaecology; Volume 117: 20-25.* *Labiaplasty for labia minora hypertrophy - Centre for Reviews and Dissemination 2013.* Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6). http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf	
14.17	Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophies or non-excisable clinically significant lipomata. An individual funding request will be required. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Liposuction for chronic lymphoedema NICE 2008. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
14.18	Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances:	Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Changes to the face and brow result due to normal ageing; however, there are

		Congenital facial abnormalities. Facial palsy. Treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis. • To correct consequences of trauma. • To correct deformity following surgery. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.
15.	**Respiratory**			
15.1	Treatments for Snoring Soft Palate Implants and Radiofrequency Ablation of the Soft Palate Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty' Uvulopalatoplasty and Uvulopalatopharyngoplasy	Not Routinely Commissioned.	Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007). Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005). Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003). Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005). Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs – Health Technology Assessment (2009). Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36. The British Snoring & Sleep Apnoea Association	NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient's

				subsequent ability to use nasal CPAP. Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as 'Snoreplasty' is not well recognised in the UK as an effective method of treating snoring.
16.	**Trauma & Orthopaedics**			
16.1	Diagnostic, Interventions and Treatments for Early Management of Back Pain Persistent *non-specific* low back pain of duration 6 weeks to 12 months. Excluding spinal pathology, radiculopathy, and children.	The following treatments should not be offered for the early management of persistent non-specific low back pain. • Selective serotonin re-uptake inhibitors (**SSRIs**) for treating pain. • Injections of therapeutic substances into the back. • Laser therapy. • Interferential therapy. • Therapeutic ultrasound. • Transcutaneous electrical nerve stimulation (**TENS**). • Lumbar supports. • Traction.	http://www.nice.org.uk/guidance/CG88 NICE 2009. Review of Clinical Guideline (CG88) – Low back pain: early management of persistent non-specific low back pain NICE 2012.	X Rays and MRI scans should not be offered unless in a context of referral for surgery. Management should consist of a structured exercise programme, manual therapy or acupuncture.
16.2	Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (**IDET** Percutaneous intradiscal radiofrequency	The following should not be offered for the early management of persistent non-specific low back pain. Radiofrequency facet joint denervation. Intra Discal Electro Thermal Annuloplasty (**IDET**) Percutaneous intradiscal radiofrequency	IPG 319: Percutaneous intradiscal electrothermal therapy for low back pain NICE 2009. IPG83: Percutaneous intradiscal radiofrequency thermocoagulation NICE 2004.	

	thermocoagulation **PIRFT**) TAMARS (technology assisted micromobilisation and reflex stimulation)	thermocoagulation (**PIRFT**),	http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf Final_TAMARS_report[1].pdf	
16.3	Fusion	Not routinely commissioned. There is limited data on effectiveness and no data on superiority over other treatments. Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme. AND Still has severe non-specific low back pain for which they would consider surgery.	https://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-pain-commissioning-guide	
16.4	Facet Joint - Non Specific Back Pain Over 12 Months including radio frequency ablation	Non specific back pain over 12 months – Not routinely commissioned. May have a role as a diagnostic procedure when considering radio frequency ablation. This would require an individual funding request.	http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf	
16.5	Epidural Injection	Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc & spinal stenosis where surgery is not desirable.' 'Non Specific Back Pain – Not routinely commissioned'.	http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf	
16.6	Endoscopic Laser Foraminoplasty	This procedure is NOT routinely commissioned.	IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011.	
16.7	Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned.	IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.	
16.8	Endoscopic Lumbar Decompression	This procedure is NOT routinely commissioned.	IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009	
16.9	Percutaneous Disc Decompression using Coblation for Lower	This procedure is NOT routinely commissioned.	IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006	

	Back Pain			
16.10	Non-Rigid Stabilisation Techniques	This procedure is NOT routinely commissioned.	IPG 366: Non-rigid stabilisation techniques NICE 2010	
16.11	Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine	This procedure is NOT routinely commissioned.	IPG 321: Lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. NICE 2009.	
16.12	Percutaneous Intradiscal Laser Ablation in the Lumbar Spine	This procedure is NOT routinely commissioned.	IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.	
16.13	Transaxial Interbody Lumbosacral Fusion	This procedure is NOT routinely commissioned.	IPG 387: Transaxial interbody lumbosacral fusion NICE 2011.	
16.14	Therapeutic Endoscopic Division of Epidural Adhesions	This procedure is NOT routinely commissioned.	IPG 333: Therapeutic endoscopic division of epidural adhesions NICE 2010	
16.15	Automated Percutaneous Mechanical Lumbar Discectomy	This procedure is NOT routinely commissioned.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	
16.16	Prosthetic Intervertebral Disc Replacement in the Lumbar Spine	This procedure is NOT routinely commissioned.	IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009. Commissioning Guide – Low Back Pain. Royal College of Surgeons (2013). Total disc replacement for chronic back pain in the presence of disc degeneration The Cochrane Database of Systematic Reviews, Issue 9 (2012).	As effective as discectomy in the short term 2-3 years. but after that outcomes are similar. Long term follow-up data on efficacy and safety is lacking.
16.17	Bone Morphogenetic Proteins Dibotermin Alfa Eptotermin Alpha	Dibotermin alfa is commissioned in the following situation: The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. Eptotermin alfa is commissioned in line with its licensed indication: Treatment of non-union of tibia of at least 9	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data	

		month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
16.18	Surgery for Trigger Finger	Surgery not commissioned unless conservative treatments, (including at least 1 corticosteroid injections) have failed or are contraindicated AND Fixed flexion deformity that cannot be corrected easily is present.	Nimigan AS, Ross DC, Bing SG. Steroid injections in the management of trigger fingers. American Journal of Physical Medicine and Rehabilitation 2006; 85(1):36-43. BMJ review: Akhtar S, Bradley MJ, Quinton DN, Burke FD. Management and referral for trigger finder/thumb. BMJ 2005; 331(7507):30-33. NHS Oxfordshire, Interim Treatment Threshold Statement: Surgery for trigger finger (stenosing tenovaginosis) Corticosteroid injection for trigger finger in adults Cochrane Database of Systematic Reviews (2008). Trigger Finger Assessment Map of Medicine (2012) – for North Mersey Surgery versus ultrasound-guided steroid injections for trigger finger disease: protocol of a randomized controlled trial Danish Medical Journal 2013;60(5):A4633.	Conservative management (including splinting, steroid injections, NSAIDS) is adequate in the majority of cases. Local steroid injections should be the first line treatment unless the patient is diabetic (where surgery preferred).
16.19	Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection.	http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3a%2f%2fsearch.nice.org.uk%2fusingguidance%2fdonotdorecommendations%2fdetail.jsp%3faction%3ddetails%26dndid%3d961	
16.20	Secondary Care Administered Steroid Joint Injections	Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre.	Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012.	
16.21	Palmar Fasciectomy/Needle Faciotomy for Dupuytren's Disease	Requests for treatment will be considered when: • Metacarpophalangeal joint contracture of 30 degrees or more, (inability to place hand flat on table. OR • Any degree of proximal interphalangeal joint contracture. OR • Patients under 45 years of age with disease affecting 2 or more digits and loss of	IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004. Dupuytrens disease NICE Clinical Knowledge Summaries (2010). British society hand surgeons New guidelines awaited. NHS North West London commissioning policy – Dupuytren's	

		extension exceeding 100 or more. There should be significant functional impairment.	Disease April 2013. Common Hand Conditions NHS Dorset Clinical Commissioning Group (2011).	
16.22	Radiotherapy Collagenase Injections for Dupytren's Disease	These procedures are not commissioned.	IPG368: Radiation therapy for early Dupuytren's disease NICE 2010.	Individual CCG addendums apply.
16.23	Hip and Knee Replacement Surgery & Hip Resurfacing	Referral is based on local referral pathways. **Funding for total or partial knee replacement surgery is available if the following criteria are met** 1. Patients with BMI <40. AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease. OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint. **Referral criteria for Total Hip Replacements (THR)** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria; 1. Patient complains of severe joint pain. AND 2. Functional limitation, despite the use of non-surgical treatments such as adequate doses	NHS North West London commissioning policy – Hip Replacement (Total) April 2013. NHS North West London commissioning policy – Knee Replacement (Total) April 2013. Clinical thresholds knee replacement York & Humber Health Intelligence (2011). Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Relevant NICE Guidance (TA44) as referred to above http://www.nice.org.uk/guidance/ta304	A hip and knee score threshold can form part of a demand management approach.

		of NSAID analgesia, weight control treatments and physical therapies. OR 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).		
16.24	Diagnostic Arthroscopy for Arthritis of the Knee	Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate. However it is not routinely commissioned for any of the following indications: • Investigation of knee pain. • Treatment of Osteo-Arthritis including Arthroscopic washout. • If there is diagnostic uncertainty despite a competent examination or if there are ''red flag'' symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.	CG59 Osteoarthritis. Section 3.1 NICE 2008 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007. Knee replacement: A guide to good practice British Orthopaedic Association, 2000. Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177 CG177Osteoarthritis (NICE 2014)	
16.25	Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee	Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).		

16.26	Patient Specific Unicompartmental Knee Replacement	This is not commissioned.	IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009	Referral should be made to specialist centres only.
16.27	Patient Specific Total Knee Replacement	This is not commissioned.	EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates ECRI Institute (2012) IPG 345: Mini-incision surgery for total knee replacement NICE 2010	
16.28	Surgical Treatment for Carpal Tunnel Syndrome	Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases. Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied: • Patients have not responded to 3 months of conservative treatments, including: ○ 6 weeks of night-time use of wrist splints. ○ Corticosteroid injection in appropriate patients. • Conservative treatments contraindicated. Severe cases: Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment. The following treatments are not commissioned for carpal tunnel syndrome: • Diuretics. • NSAIDS. • Vitamin B6. • Activity modification. • Heat treatment. • Botulinum toxin.	Local corticosteroid injection for carpal tunnel syndrome Cochrane Database of Systematic Reviews, 2007. Clinical practice guideline on treatment of Carpal Tunnel Syndrome American Academy of Orthopaedic Surgeons, 2008. Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome NHS Oxfordshire, 2009. Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome - Cochrane Database of Systematic Reviews 2002. Surgical treatment options for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2007. Surgical versus non-surgical treatment for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2008. Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review Journal of Orthopaedic Surgery & Research 2011, 6:17. Median Nerve Lesions and Carpal Tunnel Syndrome Patient.co.uk. Commissioning Guide: Painful tingling fingers Royal College of Surgeons (2013).	Mild cases often resolve spontaneously after 6 months.
16.29	Surgical Removal of	Only commissioned for mucoid cysts under the	Digital Mucous Cyst	

	Mucoid Cysts at Distal Inter Phalangeal Joint (DIP)	following circumstance: Failure of conservative treatments including watchful waiting. AND any of the following: • Nail growth disturbed. • Discharging, ulcerated or infected. • Size interferes with normal hand function.	Overview of condition – Medscape.	
16.30	Surgical Removal of Ganglions	Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned. Reassurance that no treatment is required should be given to the patient.	Ganglions of the hand and wrist: determinants of treatment choice – Journal of Hand Surgery 2013 Feb. v.38(2) p151-7.	
16.31	Hip Arthroscopy for Femoro–Acetabular Impingement	CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months. The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7). Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.
16.32	Surgical Removal of Bunions/Surgery for Lesser Toe Deformity	Requests for the removal of bunions will only be considered where:	Bunions NICE Clinical Knowledge Summaries (2012)	

		Conservative methods of management* have failed. AND The patient suffers significant functional impairment** as a result of the bunions. AND Radiographic evidence of joint damage (at point of referral). *Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate. **Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living. Treatment will not be commissioned for cosmetic appearance only.	IPG 332: Surgical correction of hallux valgus using minimal access techniques NICE (2010) Commissioning Guide: Painful deformed great toe in adults Royal College of Surgeons (2013)	
16.33	Surgical Treatment of Morton's Neuroma	Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway. • The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads. • Been referred to an orthotist or podiatrist for an assessment. • Had a trial of local corticosteroid injection.	Therapeutic massage provides pain relief to a client with Morton's Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012. Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9. Morton's neuroma NICE Clinical Knowledge Summaries (2010).	
16.34	Surgical Treatment of	Surgical Treatment is not routinely	Heel pain--plantar fasciitis: clinical practice guidelines linked to the	

	Plantar Fasciitis	commissioned unless the following pathway has been followed: 1. Patient has documented evidence that they are not responding to conservative treatments 2. Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following. 3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss. 4. Been referred to a podiatrist or physiotherapist. 5. Not responded to corticosteroid injections.	international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18. Plantar fasciitis NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.	
16.35	Treatment of Tendinopathies Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection	These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.	IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis NICE 2009. IPG 312: Extracorporeal shockwave therapy for refractory Achilles NICE 2009. IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow NICE 2009. IPG 437: Autologous blood injection for plantar fasciitis NICE 2013. IPG 438: Autologous blood injection for tendinopathy NICE 2013.	
17.	**Urology**			
17.1	Circumcision	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies*. Indicated for the following condition; • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it	Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2002. 2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis	Race/cultural implications* Individual CCG addendums apply.

		cannot be salvaged. • 3 or more episodes of balanitis/balanoposthitis. • Pathological phimosis. • Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract.	NICE Clinical Knowledge Summaries 2009. I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions Royal College of Surgeons guidance (2013).	
17.2	Penile Implant: A Surgical Procedure to Implant a Device into the Penis	Penile prostheses for erectile dysfunction are not routinely commissioned. In rare circumstances, funding will be available for men who have failed to respond to the British Society for Sexual Medicine guidelines first and second line recommended treatments and who have one of the following conditions: Peyronie's disease. Post – priapism. Malformation of the penis.	Penile implants NHS NWL policy 2012. Telford and Wrekin CCG Penile Implants 2012. Guidelines Male Sexual Dysfunction European Association Urology (2010). Guidelines on the Management of ED British Society for Sexual Medicine(2007). CG175: Prostate Cancer NICE 2008. http://guidance.nice.org.uk/CG175 NICE 2014. Please refer to Public Health Penile Implants Paper	PH Penile Prosthesis Paper.pdf Individual CCG addendums apply.
17.3	Reversal of Male Sterilisation	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/contraception-sterilization#!scenario	
17.4	ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited clinical evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
17.5	Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012). https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf	
17.6	Surgery for Prostatism	Only commissioned where there are sound clinical reasons and after failure of conservative	CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men	No references to treatment

		treatments and in any of the following circumstances: • International prostate symptom score >7; dysuria; • Post voided residual volume >150ml; • Recurrent proven Urinary Tract Infections (UTI); • Deranged renal function; • Prostate-specific antigen (PSA) > age adjusted normal values.	NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts Royal College of Surgeons (2013).	thresholds found.
18.	**Vascular**			
18.1	Surgery for Extreme Sweating Hyperhydrosis – all areas Surgical Resection Endoscopic Thoracic Sympathectomy	Treatment is medical. Treatment of hyperhidrosis with surgery is not routinely commissioned. Risk of compensatory hyperhidrosis elsewhere is very high.	Hyperhidrosis – NICE Clinical Knowledge Summaries (2013). Hyperhidrosis Patient.co.uk.	
18.2	Chelation Therapy for Vascular Occlusions	This is not commissioned.	Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006. Effect of Disodium EDTA Chelation Regimenon Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.	A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.
18.3	Varicose Veins Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery.	Treatment of varicose veins is not commissioned except in the following circumstances: • Ulcers/history of ulcers secondary to superficial venous disease. • Liposclerosis. • Varicose eczema. • History of phlebitis.	CG168: Varicose Veins in the legs NICE 2013. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	 PH Varicose Veins Paper.pdf CCGs intend to conduct a further review within the next 12 months. Individual CCG addendums apply.

			A systematic review and meta-analysis of treatments for varicose veins – Centre for Reviews and Dissemination 2011 Ultrasound-guided foam sclerotherapy for varicose veins – NICE IPG 440 2013 A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein – Centre for Review and Dissemination 2013 CG 168: Varicose veins NICE 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins Royal College of Surgeons (2013)	
19.	**Other**			
19.1	Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane.	The use of botulinum toxin type A is commissioned in the following indications: • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. • Blepharospasm and hemifacial spasm. • Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8 • Focal dystonia, where other measures are inappropriate or ineffective. • Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. • Idiopathic cervical dystonia (spasmodic torticollis).	NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections. **Diagnosis and management of hyperhidrosis** British Medical Journal.	

		• Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260 • Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. • Sialorrhoea (excessive salivary drooling), when all other treatments have failed. Botulinum toxin type A is not routinely commissioned in the following indications: • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. • Any other indication that is not listed above The use of Botulinum Type B is not routinely commissioned. Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning		

		Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.		

9. Appendix 1 Cataract Referral Guide

Referrals for cataract should only be made in the following context:-

1) ASSESSMENT OF VISION AND QUALITY OF LIFE

Questions	Responses		
	A	**B**	**C**
1. **How well can patient see objects in the distance?**	without difficulty	with slight difficulty	with great difficulty
2. **How well can patient read writing on the TV and/or road signs?**	without difficulty	with slight difficulty	with great difficulty
3. **How well can patient recognise people on the street?**	without difficulty	with slight difficulty	with great difficulty
4. **How well can patient read from newspapers/books?**	without difficulty	with slight difficulty	with great difficulty
5. **How often does patient suffer from glare at night?**	without difficulty	with slight difficulty	with great difficulty

Interpretation

- If answer to question 4 is b or c, this is often an indication of macular problems rather than cataract. If this is the only problem, referral for cataract surgery is inappropriate. However, referral for an opinion on maculopathy might be required.
- If answers to questions 1 to 3 are mainly (c), this is probably cataract-related and referral may be appropriate.
- If glare is the ONLY problem (question 5), the referrer (after discussion with the patient) will need to make a judgment as to the potential impact of cataract removal before deciding whether surgery is appropriate.

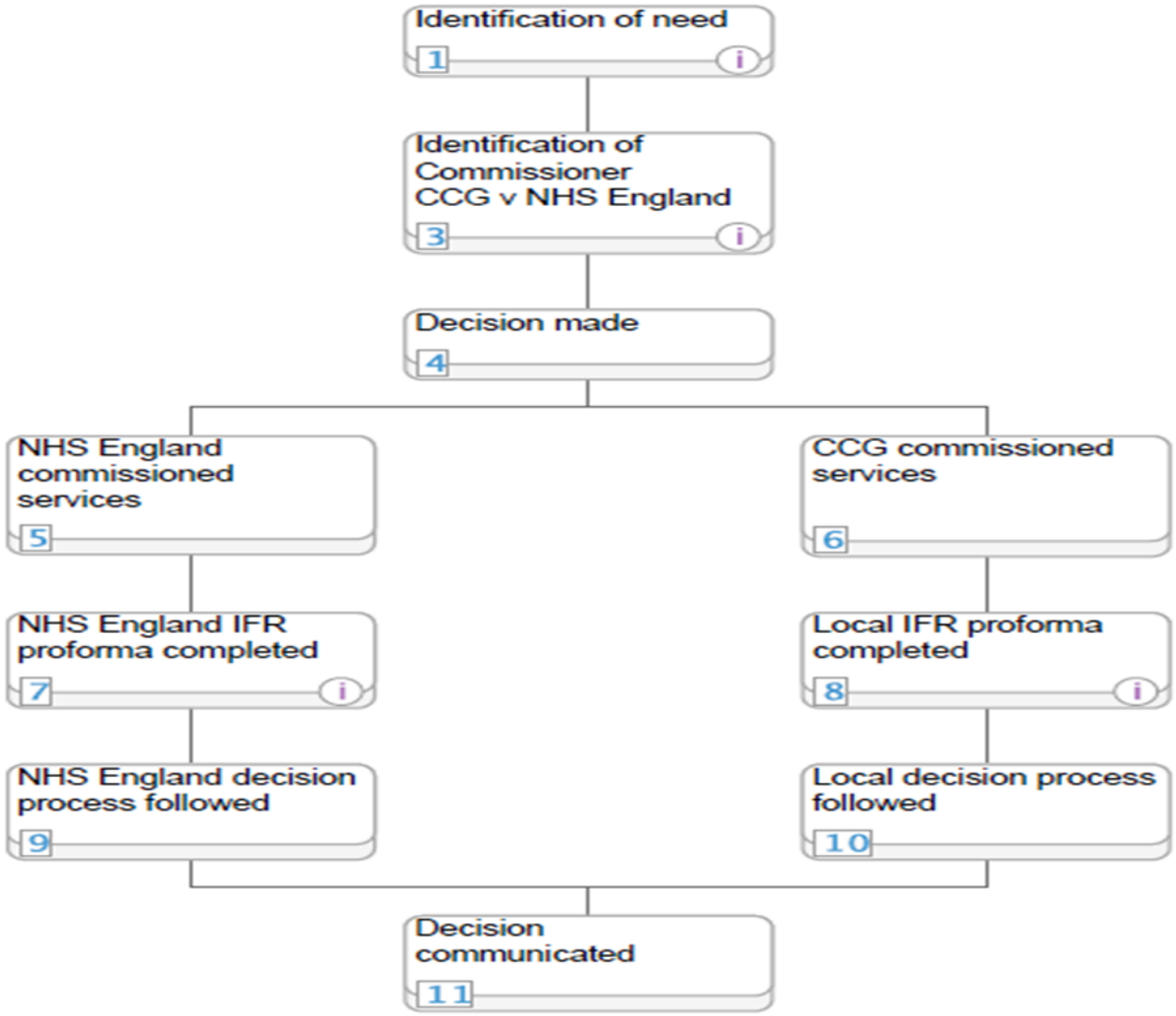
2) FITNESS FOR SURGERY

Is the patient medically fit for surgery?

3) RISKS AND CONSENT

Has the potential to benefit been explained?
Have details of the procedure and risks been explained to patient?
Is patient still willing to proceed?
The referrer should be satisfied that the criteria outlined in (1) to (3) have all been met before referring

10. Appendix 2 IFR Process



11. Appendix 3 IFR Panel Contact Details

Telephone: 01244 650 305
Email:

CCG	Email Address
Wirral CCG	Wirralccg.IFR@nhs.net
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South Cheshire CCG	Southcheshireccg.IFR@nhs.net
Vale Royal CCG	Valeroyalccg.IFR@nhs.net
Warrington CCG	Warringtonccg.IFR@nhs.net
Liverpool CCG	IFR.manager@nhs.net
Halton CCG	IFR.manager@nhs.net
Knowsley CCG	IFR.manager@nhs.net
Southport & Formby CCG	IFR.manager@nhs.net
South Sefton CCG	IFR.manager@nhs.net
St Helens CCG	IFR.manager@nhs.net