Midlands and Lancashire Commissioning Support Unit

NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Collaborative Policy Development Project: Governing Body paper seeking sign off of all policies reviewed to date, ahead of implementation with Providers

Appendix 2

Comparison document demonstrating the proposed changes for PLCP Policy 2018-19 against the current PLCP Commissioning Policy 2014/15

December 2017

Contents

Guidance for reading the comparison tables

The current procedure or treatment name is listed in the first column of each table, with the current criteria from the Cheshire and Merseyside Commissioning Policy 2014/15 listed in the second column.

The third column captures the proposed policy wording and in some instances, a change to the policy title as well, for example ***Policy for non-invasive interventions for low Back pain and sciatica*** at page 40.

The final column summarises the difference between the current and the proposed policy.

Suite 1 Red rated Policies

Procedure	C&M Current Policy	Proposed Policy criteria 2018/2019	Difference
Policy for Surgical Treatments for Minor Skin Lesions	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.	The CCG will only fund this treatment if the patient meets ONE of the following: • Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway) ***OR*** • Symptomatic e.g. ongoing pain or functional impairment. ***OR*** • Risk of infection. ***OR*** • Significant facial disfigurement. ***OR*** • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins. *For any of the above scenarios, referral for treatment should be made to a community provider*	*Policies are aligned* *Suspected or proven malignancy (cancerous) (if suspected or proven malignancy refer via appropriate pathway) added.* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Rhinoplasty	This procedure is NOT available under the NHS on cosmetic grounds. • Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	The CCG will fund this treatment if the patient meets the following criteria: • Documented medical problems caused by obstruction of the nasal airway **OR** • Correction of complex congenital conditions e.g. Cleft lip and palate This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to remove the criteria around nasal deformity caused by trauma.* *Proposed policy does not refer to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.* *Proposed policy states 'This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgical removal of Lipoma	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.	The CCG will fund this treatment if the patient meets the following criteria: • Lipoma is on the face or neck ***AND*** one of the following: • suspected malignancy **OR** • significant functional impairment caused by the lipoma **OR** • to provide histological evidence in conditions where there are multiple subcutaneous lesions This excludes lipomas unless they are on the face (including pinna) or the neck and they become infected or be symptomatic. Lipomas on other areas of the body should be referred back to primary care as agreed locally This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to include the Lipoma now having to be on the face or neck in addition to one if the additional criterion listed.* *Lipoma needs to be present on the face or neck*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
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:- o Diet modification to relieve constipation. o Topical applications. o Stool softeners and laxatives. o Rubber band ligation. o Sclerosant injections. o Infrared coagulation. • Surgical treatment options include:- o Surgical excision (haemorrhoidectomy). o Stapled haemorrhoidopexy. o Haemorrhoidal artery ligation. Removal of skin tags is not routinely commissioned.	a) Haemorrhoidectomy for grades 1 or 2 is not routinely commissioned. b) Haemorrhoidectomy for grades 3 or 4 will be funded if the patient meets one or more of the following criteria. • Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding **OR** • Irreducible and large external haemorrhoids **Removal of skin tags is not routinely commissioned.** This means **(for patients who DO NOT meet the specified criteria)** that the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and new criteria, with Specific criteria for grade 3 and 4 haemorrhoids being introduced.* *In addition the proposed policy no longer commissions haemorrhoidectomy for grade 1 or 2 Haemorrhoids.* *Proposed policy states: 'Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding'* *Proposed policy no longer states that patients must have 'responded to the following non-surgical or out-patient treatments:-* o *Diet modification to relieve constipation.* o *Topical applications.* o *Stool softeners and laxatives.* o *Rubber band ligation.* o *Sclerosant injections.* o *Infrared coagulation.* • *Surgical treatment options include:-* o *Surgical excision (haemorrhoidectomy).* o *Stapled haemorrhoidopexy* o *Haemorrhoidal artery ligation.'* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for 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. 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.	The CCG will fund this treatment if the patient meets the following criteria: • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** • Is undergoing treatment for pilonidal sinuses to reduce recurrence This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and the new criteria. The criteria around an existing endocrine medical condition and severe facial hirsutism has been removed.* *Proposed policy no longer includes: 'Ferryman Gallwey (A method of evaluating and quantifying hirsutism in women) Score 3 or more per area to be treated.* *Medical treatments have been tried for at least one year and failed.* *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.'* *Proposed policy does not refer to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.* *Layout has been simplified and criteria are now clearer*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
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.	The CCG will fund this treatment if the patient meets the following criteria: • For severe post burn cases or severe traumatic scarring **OR** • Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and the proposed criteria. The criteria has been tightened to include 'severe' post-burn or 'severe' traumatic scarring.* *Layout has been simplified and criteria are now clearer*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Cataracts policy	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 **Appendix 1 Cataract Referral Guide** Referrals for cataract should only be made in the following context:- Questions / Responses: A / B / C How well can patient see objects in the distance? — without difficulty / with slight difficulty / with great difficulty How well can patient read writing on the TV and/or road signs? — without difficulty / with slight difficulty / with great difficulty How well can patient recognise people on the street? — without difficulty / with slight difficulty / with great difficulty How well can patient read from newspapers/books? — without difficulty / with slight difficulty / with great difficulty How often does patient suffer from glare at night? — never / occasionally / frequently **1) ASSESSMENT OF VISION AND QUALITY OF LIFE** **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**	Referral of patients to ophthalmologists for cataract surgery should be based on the following indications: 1. The patient has sufficient cataract to account for visual symptoms. It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired. A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any of the following factors, although this is not an exhaustive list: a. the patient is at significant risk of falls b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** 2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid For Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/ 3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery **Guidance for second eye surgery in patients with bilateral cataracts** **The second eye criteria is** • As for the first eye, i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon	*There are a number of differences between the current and the proposed criteria.* *In the revised criteria it is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired.* *In addition a description of the impact on quality of life must be documented and accompany the referral criteria, with a number of examples of impacts on the quality of life given.* *The proposed criteria no longer includes an example referral template* *The proposed criteria now draws out the criteria for second eye referral*

Suite 2 Red rated Policies

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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.	*Removal and/or replacement of silicone implants is not routinely commissioned.* *The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:* *Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants.* If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only, but will **not** replace them.	*There is some change to the criteria here: the proposed policy now states that patients should be referred back to the original provider and only if the clinic no longer exists or refuses to remove the implants will they be removed by the NHS. In this instance the NHS will only remove the implants on rupture or failure and will **not** replace them.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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 • 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.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). An individual funding request will be required.	Removal of Tattoos is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Abdominoplasty/Apronectomy (sometimes called '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:- • 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.	These procedures are not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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; • 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.	These procedures are not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same. Given the additional clarity, this has been rated as a red policy.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Surgical Treatments for hair Loss	**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. 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 **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. **Treatments to Correct Male Pattern Baldness** This is not routinely commissioned	Surgical Treatment for Alopecia, hair transplantation, Male Pattern Baldness and hair intralace systems will not be routinely commissioned. The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.	*The differences in this policy are as follows:* • *the title of the policy has been clarified as 'Surgical Treatments for hair loss'* • *the proposed position for treatments to correct alopecia is that these are no longer commissioned* • *the proposed position for hair transplantation is that these are no longer commissioned* • *under the current commissioning policy, there are separate entries for Treatments to Correct Hair Loss for Alopecia, Hair Transplantation and Treatments to Correct Male Pattern Baldness so these have all been merged into one policy statement* • *clarity around access to wigs via the NHS has been included* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: 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.	Rhytidectomy is restricted for non-cosmetic/other reasons. The CCG will fund this treatment if the patient meets the minimum eligibility criteria below. • Recognised diagnosis of Congenital (present from birth) facial abnormalities **OR** • Facial palsy (congenital or acquired paralysis) **OR** • As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis	*There are some differences between the current and the proposed criteria. The criteria has been laid out more clearly and the following criteria have been removed* • *To correct the consequences of trauma OR* • *For significant deformity following corrective surgery. However funding will not be approved to improve previous cosmetic surgery.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Policy for male circumcision for medical reasons only	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 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.	Circumcision will be funded in the following medical circumstances: • Balantis xerotica obliterans. • Traumatic foreskin injury/scarring where it 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. • Tight foreskin causing pain on arousal/ interfering with sexual function This is because if the patient does not meets the medical indications above non-medical circumcisions do not confer any health gain but do carry health risk. This procedure is not offered for social, cultural or religious reasons.	*There is some change to this policy:* • *The title has been clarified to now read 'Policy for male circumcision for medical reasons only'* • *the criteria now makes it clear that the procedure is not offered for social, cultural or religious reasons and* • *Congenital abnormalities are now provided for in the revised criteria.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Pinnaplasty	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 is not routinely commissioned.	*This procedure is moving from a criteria based position to a not routinely commissioned position.*

Suite 1 Green rated Policies

Procedure	C&M Current Policy	Proposed Policy 2018/2019	
Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias and 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.	Not routinely commissioned This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Surgery for Asymptomatic Gallstones	N/A - This procedure is not routinely commissioned.	This procedure is not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Dilatation and Curettage	**Not routinely funded**	Not routinely commissioned. This means the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Private Mental Health Care- Non-NHS Commissioned Services: including Psychotherapy, adult eating disorders, general in-patient care, post-traumatic stress, adolescent mental health	This will not normally be funded. Most mental health conditions can be managed in the community with input from Community Mental Health teams. 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.	Not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for Hyaluronic Acid and Derivatives Injections for Peripheral joint pain	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection.	Not routinely commissioned.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Knee Replacement Surgery	Referral is based on local referral pathways. **Funding for <u>total or partial knee replacement</u> <u>surgery</u> 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 is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Funding for <u>total or partial knee replacement</u> <u>surgery</u> 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.	*Policies are aligned with additional guidance around referral via the appropriate local referral pathway* *Proposed policy has an expanded reference: 'Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Hip Replacement Surgery	**Referral criteria for <u>Total Hip Replacements (THR)</u>** 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 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).	Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Referral criteria for <u>Total Hip Replacements (THR)</u>** 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 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).	*Policies are aligned with additional guidance around referral via the appropriate local referral pathway.* *Proposed policy includes: 'Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
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.	Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned. Reassurance that no treatment is required should be given to the patient.	*Policies are aligned*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Adenoidectomy	Commissioned only in either of the following clinical situations. <u>In Children</u> 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.	Adenoidectomy will only be funded if Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment. **Or** Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. This means **(for patients who do not require tonsillectomy and/or grommets)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to ensure: Primary and Secondary Care clinicians undertake maximum medical therapy by following the Royal College of Surgeons High Value Care Pathway for Rhinosinusitis, with surgery reserved for recalcitrant cases, with a diagnosis confirmed by radiology, after an appropriate trial of treatment.* *Proposed policy Includes adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions.* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Policy for 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. 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.	The CCG will fund this treatment if the patient meets one or more of the following criteria: • 7 or more documented clinically significant, adequately treated episodes in the preceding year; **OR** • 5 or more documented episodes in each of the preceding two years **OR** • 3 or more documented episodes in each of the preceding three years. **AND** • If symptoms are disabling and prevent normal functioning Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following: • Aural temperature of at least 38.3°C • Tender anterior cervical lymph nodes • Tonsillar exudates • Tonsillar enlargement giving rise to symptoms of upper airways obstruction **Note:** Walk in Centre or Out of Hours documented episodes that are communicated in writing to GP Practices are included in the episode count. There are a small proportion of patients with specific clinical conditions or syndromes, who require tonsillectomy as part of their on-going management strategy, and who will not necessarily meet the SIGN guidance below (e.g. those presenting with psoriasis, nephritis, Periodic fever, aphthous stomatitis, pharyngitis and adenitis (PFAPA) syndrome. Children or adults with sleep disordered breathing/apnoea confirmed with sleep studies undergo procedure in line with recognised management of these conditions. **Note:** When in doubt, implement a six month period of clinical watchful waiting. (Watchful waiting involves carefully monitoring your symptoms to see whether they improve or get worse.) This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*There is some difference between the current and new criteria, with tightening of the proposed criteria to ensure that episodes are documented.* *There is no longer any reference to peri-tonsillar abscess, tonsil stones. Halitosis or significant hypertrophy causing OSA* *Proposed policy includes: If symptoms are disabling and prevent normal functioning* *Proposed policy includes: Each episode of tonsillitis should be documented in the patient's medical records and characterised by at least one of the following:* • *Aural temperature of at least 38.3°C* • *Tender anterior cervical lymph nodes* • *Tonsillar exudates* • *Tonsillar enlargement giving rise to symptoms of upper airways obstruction* *Layout has been simplified and criteria are now clearer.*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Hysterectomy for Heavy Menstrual Bleeding	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 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)	Hysterectomy not commissioned unless all of the following criteria have been met: • The following treatments have failed, are not appropriate or are medically contra-indicated: ○ An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) ○ Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. ○ Norethisterone 15 mg daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens ○ Up to 4 courses of ulipristal acetate 5mg for women with heavy menstrual bleeding and fibroids of 3cm or more in diameter. ○ Endometrial ablation has been tried (unless patient has fibroids >3cm) The procedure should not be offered where a patient wishes to cease menstruation.	*There is some difference between the current and new criteria, with the addition of specific criteria around the use of ulipristal acetate 5mg.* *Criteria has also been tightened to state that the procedure should not be offered as an option to cease menstruation - proposed policy no longer includes: 'the woman has made an informed choice not to use this treatment.'*

Procedure	C&M Current Policy	Proposed Policy 2018/2019	Difference
Varicose Veins Treatments	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.	Treatment of varicose veins is only commissioned in the following circumstances: • Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended). ***OR*** • A history of varicose ulceration ***OR*** • Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes ***OR*** • Superficial thrombophlebitis in association with varicose veins **Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is unsuitable. This means **(for patients who DO NOT meet the specified criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.	*Policies are aligned.* *Proposed policy includes: 'Varicose veins which have bled and are at risk of bleeding again (immediate referral recommended).'* *Proposed policy describes 'signs of prolonged venous hypertension' more clearly.* *Proposed policy includes: 'Superficial thrombophlebitis in association with varicose veins.'* *Proposed policy includes: '**Note:** compression hosiery should not be offered to treat varicose veins **unless** interventional treatment is unsuitable.'*

Suite 2 Green rated Policies

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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.	The CCG will fund this treatment if the patient meets ALL of the following criteria • 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 – see the Breast Augmentation policy.	*Policies are aligned* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstances: 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.	Augmentation Mammoplasty will be funded if the patient meets ALL of the following criteria: • There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. AND • The patient's BMI is under 25 and has been stable for at least 12 months AND • Aged over 18 years old.	*Policies are aligned* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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 appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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.	This procedure is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Surgical Treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds	This procedure is not routinely commissioned.	*There is no change to this policy position.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Labiaplasty, Vaginoplasty and Hymenorrhaphy	This is not routinely commissioned.	These procedures are not routinely commissioned.	*There is no change to this policy position.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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 is not routinely commissioned.	*There is no change to this policy position.* *Additional information in the current criteria has been removed for clarity. The previous format of this criteria was misleading as it implied this was a criteria based policy. However the overall position remains the same.* *In addition, reference to Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 have been removed for additional clarity*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Policy for Diagnostic Interventions and Treatments for Early Management of Back Pain	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.	**Policy for non-invasive interventions for low Back pain and sciatica** **Acupuncture** Acupuncture for low back pain and sciatica is **not routinely commissioned** **Manual Therapy** The following procedures are **not routinely commissioned**: • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation. Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. **Orthotics** The following are **not routinely commissioned**: • Foot orthotics • Rocker shoes • Belts and corsets **Electrotherapy** The following are **not routinely commissioned:** • Transcutaneous electrical nerve stimulation (TENS) • Percutaneous electrical nerve stimulation (PENS) • Ultrasound • Interferential • Laser therapy The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain: • Paracetamol used alone • Selective serotonin re-uptake inhibitors (**SSRIs**) • Serotonin– norepinephrine reuptake inhibitors • Tricyclic antidepressants • Anti-convulsants • Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol) Patients with neuropathic pain should be managed in line with NICE CG 173: • Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia) • 1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated. • 1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).	*There is some difference between the current and proposed policy. The proposed policy is aligned with NG59.* *Treatment options have been clearly broken down in the proposed policy into 5 headings:* • *Acupuncture* • *Manual therapy* • *Orthotics* • *Electrotherapy* • *Pharmacology* *These make reference to specific treatments under these areas, all of which are not routinely commissioned.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
		• 1.1.11 Consider capsaicin cream[4] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments. *Treatments that should not be used* 1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so: • cannabis sativa extract • capsaicin patch • lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.	

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
X rays and MRI scans as diagnostic tools for back related problems	There is no specific C&M policy around X rays and MRI scans, however it is noted in the comments section of 16.1 that *'X Rays and MRI scans should not be offered unless in a context of referral for surgery.'*	**Imaging for patients presenting with back pain.** Imaging is commissioned in AED only where patients present with red flags or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management. X rays, MRI and CT scans are NOT routinely commissioned in non-specialist settings. Imaging for patients with non-urgent presentations should not be offered imaging in AED and is not routinely commissioned. Consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery.	*The proposed criteria provide a clear position that indicates imaging for patients presenting with back pain is not routinely commissioned in non-specialist settings.* *Imagining should only be considered in specialist musculoskeletal settings for patients with low back pain, with or without sciatica only if the result is likely to change management.* *Imaging is commissioned in AED only where patients present with red flags or concerns of serious underlying pathology and requires urgent management.*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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.	**Injections for back pain** Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned **<u>Epidural</u>** Single shot epidural steroid is of short-term benefit in acute and severe sciatica and may enable normal activity to resume. Benefits and risks should be discussed with the patient. Epidural injections should be targeted at the affected nerve root(s) and under image guidance where required. Only one injection should be offered and this should only be offered where: • symptoms are acute AND • The patient is experiencing severe sciatica. Epidural Injection for Non-specific Low Back Pain of greater than 12 months, is not routinely commissioned. Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned. **Radiofrequency Facet Joint Denervation** Treatments for low back pain will only be commissioned in line with NICE guidance NG59 'Low back pain and sciatica in over 16s: assessment and management' (November 2016) The CCG will fund a single procedure of radiofrequency denervation for people with chronic low back pain when: • comprehensive conservative treatment approach has not • worked for them	*There is some difference between the current and the proposed policy. The proposed policy is clear that Therapeutic Facet Joint injection, therapeutic medial branch block, prolotherapy, Botulinum Toxin and Trigger Point Injections are Not routinely commissioned.* *The proposed policy covers multiple injection options within one policy rather than having separate policies.* *The proposed policy states that for epidural injections, these should be offered only where symptoms are acute and the patient is experiencing severe sciatica and that only one injection should be offered.* *Epidural Injection for Non-specific Low Back Pain of greater than 12 months and Epidural injection for neurogenic claudication in patients with central stenosis is not routinely commissioned.* *The proposed policy now outlines 6 specific criteria a patient must meet in order for one procedure of radiofrequency denervation.*
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'.		
Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET) Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS)	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 thermocoagulation (**PIRFT**),		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
		AND • the main source of pain is thought to come from structures supplied by the medial branch nerve AND • The clinical presentation is consistent with symptoms arising from the facet joint: o Increased pain unilaterally or bilaterally on lumbar paraspinal palpation o Increased back pain on 1 or more of the following: o extension (more than flexion); rotation; extension/side flexion; extension/rotation o No radicular symptoms o No sacroiliac joint pain elicited using a provocation test AND • they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral AND • low back pain is chronic in nature AND • The patient has significant short term pain relief to a diagnostic medial branch block. Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation. Providers who offer radiofrequency denervation will be expected to submit patient outcome data to the UK National Spinal RF Registry http://cl1.n3-dendrite.com/csp/spinalrf/FrontPages/index.html	*IDET and PIRFT have now been grouped with the disc and decompression procedures, however these remain not routinely commissioned*.

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
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.	**Spinal Fusion** The following procedures are not routinely commissioned: • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed	*There is no difference between the current and the proposed criteria for Non-rigid stabilisation techniques, Lateral body fusion in the lumbar spine, Transaxial interbody lumbrosacral fusion.* *For fusion, the current criteria stating 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 has been removed.* *The proposed criteria now makes clear that ALIF and PLIF and any other combination of approach where surgical fixation is performed is not routinely commissioned.*
Non-Rigid Stabilisation Techniques	This procedure is NOT routinely commissioned.		
Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine	This procedure is NOT routinely commissioned.		
Transaxial Interbody Lumbosacral Fusion	This procedure is NOT routinely commissioned.		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Endoscopic Laser Foraminoplasty	This procedure is NOT routinely commissioned.	**Disc and Decompression procedures** Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where: • Patient presents with severe and acute sciatica AND • have failed to respond to conservative intervention AND • have imaging findings concordant with clinical presentation Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network. The following procedures are NOT routinely commissioned: • Endoscopic Laser Foraminoplasty • Endoscopic Lumbar Decompression • Percutaneous Disc Decompression using Coblation for Lower Back Pain • Percutaneous Intradiscal Laser Ablation in the Lumbar Spine • Automated Percutaneous Mechanical Lumbar Discectomy • Prosthetic Intervertebral Disc Replacement in the Lumbar Spine • Intradiscal Electro Thermal Annuloplasty (IDET) • Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)	*There is some difference between the current and the proposed policy.* *The proposed policy covers all types of disc and decompression procedures rather than having separate policies.* *Endoscopic Laser Foraminoplasty, Endoscopic Lumbar Decompression, Percutaneous Disc Decompression using Coblation for Lower Back Pain, Percutaneous Intradiscal Laser Ablation in the Lumbar Spine, Automated Percutaneous Mechanical Lumbar Discectomy, Prosthetic Intervertebral Disc Replacement in the Lumbar Spine, Intradiscal Electro Thermal Annuloplasty (IDET), and Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) all remain not routinely commissioned.* *The proposed policy states that Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:* • *Patient presents with severe and acute sciatica* *AND* • *have failed to respond to conservative intervention* *AND* • *have imaging findings concordant with clinical presentation*
Endoscopic Lumbar Decompression	This procedure is NOT routinely commissioned		
Percutaneous Disc Decompression using Coblation for Lower Back Pain	This procedure is NOT routinely commissioned.		
Percutaneous Intradiscal Laser Ablation in the Lumbar Spine	This procedure is NOT routinely commissioned.		
Automated Percutaneous Mechanical Lumbar Discectomy	This procedure is NOT routinely commissioned		
Prosthetic Intervertebral Disc Replacement in the Lumbar Spine	This procedure is NOT routinely commissioned		

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned.	This procedure is NOT routinely commissioned.	*There is no difference between the current and the proposed criteria*

Procedure	C&M Current Policy	Proposed Policy criteria 2017/18	Difference
Therapeutic Endoscopic Division of Epidural Adhesions	This procedure is NOT routinely commissioned.	This procedure is NOT routinely commissioned.	*There is no difference between the current and the proposed criteria*