VALUE BASED COMMISSIONING POLICIES

(formerly known as Procedures of Limited Clinical Value policy)

VERSION 30a – April 2017
Version Control

Note – please refer to Appendix for changes prior to Version 30

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Introduction

Since the CCG operates within finite budgetary constraints the policy makes explicit the need for the CCG to prioritise resources and provide interventions with the greatest proven health gain. The intention is to ensure equity and fairness in respect of access to NHS funding.

To do this, the policy provides the list of interventions ‘not routinely funded’ by the CCGs and the specified criteria required for the funding of certain other interventions. Please note that the policy guidance relating to these interventions should be read with reference to the principles detailed below.

Commissioners, general practitioners, service providers and clinical staff treating residents of Shropshire are expected to implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, this should be clearly documented within the clinical notes. Failure to do so will be considered by the CCGs as lack of compliance.

The CCGs explicitly recognise that for each of the interventions listed in this policy there may be exceptional clinical circumstances in which the CCG would consider the funding of these interventions. It is not feasible to consider every possible scenario within this document. In cases where specified criteria are not met, applications may be considered on an individual basis through an Individual Funding Request (IFR) process. The IFR policy for Shropshire is available at www.shropshireccg.nhs.uk/policies.

In considering individual cases the CCG applies following definition of exceptionality:

- Where care is not routinely funded by the respective CCG, evidence must be provided to show that the patient is significantly different to the population of patients with similar clinical needs who would also not be offered the treatment
- This should include evidence that the patient is likely to gain significantly more benefit from the treatment than would be expected for other patients not currently offered it

Exceptional clinical circumstances are defined as referring to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient. In making a case, therefore, the clinician must specify how this patient is clinically different from others currently excluded from treatment - either in reference to the clinical picture, the expected benefit, or both.

Unless a local commissioning policy is formally agreed with the CCG the following circumstances will be considered to fall within the scope of this policy, and the relevant interventions will be deemed ‘not normally funded’ by the either of the above CCGs:

- Newly developed, newly licensed or newly indicated interventions, including medical, surgical or drug-based treatments
- Interventions found not to be cost-effective by the National Institute for Health and Clinical Excellence (NICE)
- Interventions for which NICE Technology Appraisals Guidance (TAG) is pending or planned
- Interventions approved by a NICE TAG but prior to the implementation deadline (usually 3 months from publication)
If patients choose to privately fund an intervention that is not normally funded by the CCGs, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by the CCGs they will retain their entitlement to all the other elements of cancer care that other residents of Shropshire receive free of charge. However when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including Consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and the CCG’s funded care within the same appointment or intervention - they cannot ‘top-up’ a CCG’s funded appointment or intervention by paying for an additional intervention to be provided or monitored during the same consultation. The relevant CCGs policies can be found on the CCG websites.

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

Unless providers are notified otherwise, implementation of the policy will continue to be monitored by the Prior Approvals process, selected audit of interventions against the criteria and by the application of policies within the Referral Assessment Service (RAS) for Shropshire patients.

Implementation will be supplemented by continual monitoring of activity against the interventions. If substantial growth in activity occurs providers will be expected to investigate & confirm to the CCG that they are complying with the policy.
### 2.1 Varicose Veins

#### Intro
These criteria are in line with NICE guidance ‘Varicose veins: diagnosis and management’ (CG168, July 2013) and the Royal College of Surgeons ‘Commissioning guide – varicose veins’ (2013).

Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

Do not carry out interventional treatment for varicose veins during pregnancy other than in exceptional circumstances - consider compression hosiery for symptom relief of leg swelling.

#### Criteria

Unless one or more of the criteria below are met, interventional procedures for varicose veins are not routinely funded:

- Refer people with bleeding varicose veins to a vascular service immediately OR
- Symptomatic (veins found in association with troublesome lower limb symptoms - typically pain, aching, discomfort, swelling, heaviness and itching) primary or symptomatic recurrent varicose veins OR
- Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency OR
- Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence OR
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks) OR
- A healed venous leg ulcer

### 2.2 Haemorrhoidectomy

#### Intro
Haemorrhoids, also known as piles, are enlarged and swollen blood vessels in or around the lower rectum and anus. They can occur at any age and affect both sexes. Conservative management consists of high fibre diet, exercise, weight loss and topical preparations, followed by non-surgical ablative/fixative interventions and rubber band ligation. Surgical haemorrhoidectomy can be used for third or fourth degree haemorrhoids.

#### Criteria

Unless all the following criteria are met haemorrhoidectomy are not routinely funded:

- Recurrent third or fourth degree internal haemorrhoids AND
- Persistent pain or bleeding AND
- Failed conservative treatment OR
- Symptomatic external haemorrhoids

### 2.3 Hernia Management and Repair in Adults

#### Intro
There are many different types of hernia; those that are covered in this policy include inguinal, femoral, umbilical ventral and incisional hernias.

Abdominal Wall Hernia Repair is regarded as a procedure of low clinical priority and therefore not routinely funded.

Patients with BMI >35 - Referral to local weight management programmes should be offered. If in doubt, the clinician may refer the patient, but should advise them that surgery may not be an appropriate option for them.

#### Inguinal (groin)

#### Criteria

For asymptomatic or minimally symptomatic hernias, the commissioner advocates a watchful waiting approach including providing reassurance, pain management etc. under informed consent.

Surgical treatment will only be approved when one of the following criteria is met:

- symptomatic - symptoms are such that they cause significant functional
### Femoral

**Criteria**

- All suspected femoral hernias are approved for a referral to secondary care due to the increased risk of incarceration/strangulation and do not require prior approval to be sought.

### Umbilical

**Criteria**

- Surgical treatment will only be approved when one of the following criteria is met:
  - Pain/discomfort that causes significant functional impairment OR
  - Increase in size month on month OR
  - To avoid incarceration or strangulation of bowel.

### Incisional

**Criteria**

- Surgical treatment will only be approved when both of the following criteria are met:
  - Pain/discomfort that causes significant functional impairment AND appropriate conservative management has been tried first.

**Referral checklist**

- Pain/discomfort that causes significant functional impairment
- Appropriate conservative management has been tried first e.g. weight reduction where appropriate

### Impalpable hernia and groin pain

**Criteria**

- Hernia surgery is not commissioned in patients with groin pain, but no visible external swelling. Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair.

- Persistent groin pain not resolved after a period of watchful waiting should be based on a period of watchful waiting.

- Severe and persistent groin pain with diagnostic uncertainty - options include referral for musculoskeletal assessment or imaging. Ultrasound should not be routinely requested in the early management of groin pain.

### Laparoscopic hernia repair

**Criteria**

- Laparoscopic hernia repair is not commissioned for primary unilateral hernia repair. Hernia surgery is not commissioned for impalpable hernias found incidentally during laparoscopic repair of a hernia on the other side.

- Laparoscopic hernia repair is commissioned only for bilateral hernia repair (where the patient has bilateral hernias with external swelling on clinical examination) or for recurrent hernia.

### 2.4 Bariatric Surgery

**Intro**

- People whose BMI is significantly high are more likely to suffer a range of illnesses and have lower life expectancy. Bariatric surgery is a highly specialised intervention used in appropriate, selected patients with severe and complex obesity that have not responded to all other non-invasive therapies.

- The following NICE guidance should also be considered when applying this policy:
  - Patient has recent-onset type 2 diabetes with a BMI of 35 or over should be offered an expedited assessment.
  - Patient has recent-onset type 2 diabetes with a BMI of 30-35 should be considered for an assessment.
  - Patient has recent-onset type 2 diabetes with an Asian family origin should...
be considered for assessment at a lower BMI than other populations

This policy refers to Tier 4 ‘Specialised Complex Obesity services’ which includes bariatric surgery, and refers to obese II (BMI 35-40) and morbidly obese (BMI 40 and over) patients.

### Criteria

Patients will be considered for surgery if they meet the following criteria;

- aged 18 years or older
  - patient has BMI of 35 or over for at least 5 years with significant comorbidities OR
  - patient has BMI of 40 or over for at least 5 years without comorbidities

**AND**
- patient has recently completed a Tier 3 weight management programme for 12-24 months with a stabilisation period of at least 6 months before referral

**OR**
- the patient has BMI of 50 or over

### 2.5 Circumcision

#### Intro

Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications. Sometimes it is requested on cultural, social and religious reasons. These non-medical circumcisions do not confer any health gain but do carry measurable health risk.

#### Criteria

Unless one or more of the following criteria are met circumcision is not routinely funded:

- Phimosis in children with spraying, ballooning and/or recurrent infection OR
- Adult Phimosis or paraphimosis OR
- Recurrent (>3 documented episodes) of balantitis or balanoposthitis OR
- Balanitis xerotica obliterans OR
- Dermatological disorders unresponsive to treatment OR
- Congenital urological abnormalities when skin is required for grafting OR
- Interference with normal sexual activity in adult males

### 2.6 Surgery of Gallstones

#### Intro

This policy is based on the NICE guidance ‘Gallstone disease: diagnosis and management’ (CG188, 2014) and Royal College of Surgeons ‘Commissioning guidance for gallstones’ (2013).

The following cases will not be considered for treatment;

- Patients with asymptomatic gallbladder stones (people who have been completely symptom free for at least 12 months before diagnosis) found in a normal gallbladder and normal biliary tree do not need treatment
- Patients with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral

#### Referral Criteria

Patients with symptomatic gallstones when pain cannot be managed or if the patient are otherwise unwell (e.g. sepsis) should be referred to hospital as an emergency OR

- Patients with suspicion of acute cholecystitis, cholangitis or acute pancreatitis should be referred to hospital as an emergency OR
- Patients with known gallstones and jaundice or clinical suspicion of biliary obstruction (e.g. significantly abnormal liver function tests) should be referred urgently OR
- Patients with known gallstones with a history of acute pancreatitis OR
- Patients who fulfil the following criteria should be sent for assessment;
- Confirmation of symptomatic gallstones following liver function tests and ultrasonography AND
- The merits of a referral have been discussed with the patient
- Management with analgesia has been tried but symptoms have continued AND
- Management by following a low fat diet has been tried but symptoms have continued

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<tr>
<td>For Gallbladder empyema</td>
<td>• offer laparoscopic cholecystectomy OR</td>
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<td>• offer percutaneous cholecystectomy if</td>
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<td>- surgery is contraindicated at presentation AND</td>
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<td>- conservative management is unsuccessful</td>
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Managing common bile duct stones
- Offer bile duct clearance and laparoscopic cholecystectomy to people with symptomatic or asymptomatic common bile duct stones

### 2.7 Venous Angioplasty for Multiple Sclerosis

**Intro**
The effectiveness of venous angioplasty for stenotic and occlusive lesions in the extracranial venous systems of patients with MS has not yet been demonstrated in clinical trials. The American Academy of Neurology currently recommends that patients only use this treatment as part of a well-designed clinical trial.

**Criteria**
Venous angioplasty for the treatment of Multiple Sclerosis is not routinely funded.

### 2.8 Hyperhidrosis Treatment

**Intro**
Hyperhidrosis can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, and the face of otherwise healthy people.

There are a number of treatments available for focal hyperhidrosis:
- Aluminium chloride-based topical treatments e.g. Aluminium salts are the most common ingredient in over-the-counter antiperspirants. This can be initiated in primary care.
- Iontophoresis which is primarily used for the hands and feet (the easiest parts of the body to submerge), this procedure entails placing the hands or feet in a shallow basin of water, through which electric current is passed, this is normally arranged via the dermatologists.

Botulinum Toxin: inhibit the release of acetylcholine at the presynaptic nerve endings of the motor endplates, sweating be reduced/eradicated but may require further injections at a later date, i.e. it is not a permanent cure and needs repeating between 6 months and 2 years depending of severity of recurrent symptoms, initiated by referral to the vascular surgeons.

Invasive surgical treatments, such as endoscopic thoracic sympathectomy, offering permanent resolution, but with the risks associated with an interventional procedure, initiated by referral to vascular surgeon.

**Criteria**
1) **Botulinum Toxin.**
Funded as part of an appropriate clinical pathway for the treatment of focal
Hyperhidrosis. (for example, the CCGs recommend Botulinum toxin for hyperhidrosis of the axillae which does not respond to topical treatments with antiperspirants or antihidrotics).

2) **Endoscopic Thoracic Sympathectomy.**

Endoscopic Thoracic Sympathectomy for the treatment of hyperhidrosis is funded provided that the patient has been through a pathway of care involving assessment and then an appropriate trial of conservative treatment, including when appropriate topical treatment with Aluminium Chloride antiperspirants normally and if appropriate iontophoresis over a period of at least 6 months (including time treated within primary care or under the dermatologists).
### 3.1 Insertion of Grommets

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Grommet insertion is regarded as a procedure of low clinical priority and therefore not routinely funded.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>The CCGs will fund treatment for grommets in children with acute otitis media when there have been at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>The CCGs will fund treatment with grommets for children with otitis media with effusion (OME) where:</td>
</tr>
<tr>
<td>OME persists after a period of at least three months watchful waiting from the date that the problem was first identified by the GP to the date of referral AND</td>
<td>the child is 3 years or older AND</td>
</tr>
<tr>
<td>there is hearing significant hearing loss (of at least 25dB) - particularly in the lower tones (low frequency loss) - and evidence of a disability as a result of this hearing loss on at least 2 documented occasions (following repeat testing after 6-12 weeks) with either:</td>
<td></td>
</tr>
<tr>
<td>- Delay in speech development</td>
<td>OR</td>
</tr>
<tr>
<td>o educational or behavioural problems attributable to the hearing loss</td>
<td>OR</td>
</tr>
<tr>
<td>o a significant second disability that may itself lead to developmental problems e.g. Down’s syndrome, Turner’s syndrome or cleft palate</td>
<td></td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td>NHS England will fund grommets in adults with OME only in the following circumstances:</td>
</tr>
<tr>
<td>Significant negative middle ear pressure measured on two sequential appointments AND</td>
<td>significant on-going associated pain</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.</td>
</tr>
</tbody>
</table>

### 3.2 Snoring

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Surgery for snoring is not routinely funded.</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is recognised that some patients may have snoring in conjunction with obstructive sleep apnoea (OSA) if such patients are considered eligible for surgery this will be funded only when it is required for treatment of their OSA.</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Tonsillectomy

<table>
<thead>
<tr>
<th>Intro</th>
<th>These criteria are informed by ‘Management of sore throat and indications for tonsillectomy - A national clinical guideline’ (SIGN 117, 2010) and ‘Commissioning Guide – Tonsillectomy’ (Royal College of Surgeons, 2013) When in doubt as to whether tonsillectomy would be beneficial, a six month period of watchful waiting is recommended prior to consideration of tonsillectomy to establish firmly the pattern of symptoms and allow the patient to consider fully the implications of an operation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
<td>The following are recommended as indications for consideration of tonsillectomy for recurrent acute sore throat in both children and adults:</td>
</tr>
<tr>
<td>Benefits and risks of tonsillectomy vs. watchful waiting have been discussed with the patient/parents or carers &amp; documented and it is decided that removal is necessary AND</td>
<td></td>
</tr>
<tr>
<td>sore throats are due to acute tonsillitis AND</td>
<td>the episodes of sore throat are disabling and prevent normal functioning AND</td>
</tr>
</tbody>
</table>
• Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year or five or more such episodes in each of the preceding two years or three or more such episodes in each of the preceding three years OR

• for adults, if severe or uncontrolled symptoms, or if complications (e.g. quinsy) have developed

OR

Refer children (under 16) for assessment in secondary care with obstructive sleep disordered breathing following assessment in primary care;

Note that secondary care will need to identify clear obstructive sleep apnoea before seeking permission to undertake surgery.

If there are ongoing concerns about obstructive sleep disordered breathing

Children with suspected severe apnoea need urgent specialist assessment

3.4 Removal of Ear Wax

Criteria

Patients should only be referred for ear wax removal if the following criteria are met:

The person has (or is suspected to have) a chronic perforation of the tympanic membrane AND

There is a past history of ear surgery AND

There is a foreign body (including vegetable matter) in the ear canal AND

Ear drops have been unsuccessful and irrigation is contraindicated AND

The patient is suffering from significant symptoms due to ear wax build up including hearing loss or pain and the patient’s condition warrants microsuction AND

Has a recent history of Otalgia and/or middle ear infection (in past 6 weeks) AND

Has had previous complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo AND

Two attempts at Irrigation of the ear canal in primary care are unsuccessful

OR

• If ear wax is totally occluding the ear canal AND any of the following are present:
  • Hearing loss
  • Earache
  • Tinnitus
  • Vertigo
  • Cough suspected to be due to ear wax
  • If the tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis
  • If the person wears a hearing aid, wax is present and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle
## 4.1 Hip and Knee Replacement Surgery

### Intro
As per NICE guidance, prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. Prosthesis with less than 10 years of data can only be used provided that the revision rate was consistent with 5% or less at 10 years (as much as the shorter term follow up data allow).

### Criteria
Unless all of the following criteria are met primary Hip and Knee replacement surgery is not routinely funded:

- The patient has a BMI below 40 OR
- If the BMI is 40 or above there is documented participation in a weight management programme for at least 6 months prior to surgery

**AND**

- Conservative means (e.g. Analgesics, NSAIDs, physiotherapy) have failed to alleviate the patient’s pain and disability

**AND**

- Pain and disability should be sufficiently significant to interfere with the patient’s daily life and/or ability to sleep

**AND**

Surgical intervention will only routinely be offered to those patients with an Oxford hip and knee score of 20 or lower. Patients with a score of 21 and above should be seen in the interface service (e.g. SOOS) where the following exceptions would make a patient suitable for referral for joint replacement despite a score of 21 or above:

- The patient has been seen in the interface service
- Severe pain and objective evidence of arthritis
- Progressive deformity
- Bone erosion as identified on x-ray in the interface service or secondary care
- Deteriorating range of movement
- Fixed flexion deformity

## 4.2 Hip Resurfacing Techniques (primary resurfacing arthroplasty of joint)

### Intro
Metal on metal (MoM) hip resurfacing arthroplasty involves removal of the diseased or damaged surfaces of the head of the femur and the acetabulum. The femoral head is fitted with a metal surface and the acetabulum is lined with a metal cup to form a pair of metal bearings.

There is sufficient short-term evidence to conclude that hip resurfacing is clinically and cost-effective but the studies have been undertaken in people aged under 65 years. NICE guidance recommends their use in those likely to outlive a conventional THR (i.e. young and active), but advises surgeons to discuss the lack of long-term evidence on safety and reliability with patients.

As per NICE guidance Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. Prosthesis with less than 10 years of data can only be used provided that the revision rate was consistent with 5% or less at 10 years (as much as the shorter term follow up data allow).

### Criteria
Except in the following patients MoM hip resurfacing techniques is not routinely funded:

- Who otherwise qualify for a primary total hip replacement (see Section 4.1)
AND

- are likely to outlive conventional primary hip replacements

### 4.3 Femoroacetabular Impingement Syndrome

#### Intro
Hip impingement syndrome is caused by unwanted contact between abnormally shaped parts of the head of the thigh bone and the hip socket. This results in limited hip movement and pain. The provider will undertake local review of cases to monitor safety and short term outcomes. An annual audit will be completed to confirm that patients have been treated in accordance with these criteria. These changes reflect the Warwick Consensus Document - The Warwick Agreement on femoroacetabular impingement syndrome (FAI syndrome): an international consensus statement, Griffin et al, Br J Sports Med 2016;50:1169-1176

#### Criteria

**Open or arthroscopic femoroacetabular surgery for hip impingement is commissioned if the following criteria are met:**

- Pain – motion or position related, in the hip or groin AND
- Positive clinical signs – impingement test and restricted range of motion AND
- Labral tear or impingement has been confirmed on diagnostic imaging AND
- The patient has completed a trial of conservative therapy AND
- The surgeon must have completed specialist training and have experience of providing arthroscopic hip surgery AND
- The provider will provide full data on 100% patients undergoing this procedure to the British Hip Society register

### 4.4 Bunion Surgery

#### Intro
The removal of asymptomatic bunions (no symptoms present) is regarded as a procedure of low clinical priority and therefore not routinely funded by the Commissioner. Do not offer referral or surgery for concerns about the appearance of feet and ensure patients are aware of the pros and cons of surgery.

#### Criteria

**Requests for the removal of symptomatic bunions will ONLY be considered where:**

- patients have first been managed via MSK or podiatry services before consideration for Orthopaedic surgery AND
- Conservative methods have failed AND
  - Severe deformity (overriding toes) is causing significant (documented) functional impairment OR
  - Severe pain is causing significant functional impairment

### 4.5 Carpal Tunnel Syndrome

#### Intro
Carpal tunnel syndrome is a relatively common condition that affects the median nerve at the wrist - causing pain, numbness and a burning or tingling sensation in the hand and fingers. Symptoms can be intermittent, and range from mild to advanced. Patients with intermittent or mild/moderate/severe symptoms should be managed conservatively in the first instance. Carpal tunnel surgery is regarded as an effective intervention where cost effective alternatives should be tried first.

#### Criteria

The Commissioner will fund carpal tunnel surgery where:

- Mild - Intermittent pins & needles, worse at night, relieved with shaking, no
<table>
<thead>
<tr>
<th>objective sensory loss/weakness</th>
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<tbody>
<tr>
<td>• Patient information leaflet supplied AND</td>
</tr>
<tr>
<td>• Night Wrist Splint (neutral) – worn for up to 12 weeks AND</td>
</tr>
<tr>
<td>• Tendon/Nerve gliding Exercise sheet provided</td>
</tr>
<tr>
<td>• (Possible injection by GP in Moderate or Severe symptoms)</td>
</tr>
</tbody>
</table>

**Moderate/Severe - Daily symptoms, regular sleep disturbance, no objective sensory loss/weakness**

- Review of diagnosis and symptom severity reviewed AND
- Portable nerve conduction study (NCS) undertaken AND
- Splint and Injection

**OR**

The patient had advanced disease - Symptoms >1 year with frequent night waking, functional impairment (dropping small objects/ difficulty with buttons), objective altered sensation +/-or weakness, Thenar Muscle wasting, (moderate/severe symptoms & successful surgery on opposite side)

### 4.6 Dupuytren’s Disease

**Intro**

Dupuytren’s Disease can be managed conservatively with physiotherapy, wrist splints, NSAIDs, and steroid injections.

There are recognised criteria where surgical release may be beneficial.

**Criteria**

Requests for treatment will be considered when:

- The patient has a 30 degree fixed flexion deformity at either the metacarpophalanageal joint or proximal interphalangeal joint AND
- The patient cannot flatten their fingers or palm on a table

**OR**

- There has been rapid progression over a few months

### 4.7 Trigger Finger

**Criteria**

Unless one or more of the following criteria are met surgical treatment is not routinely funded:

- Failure to respond to conservative measures (for example, splinting or corticosteroid injections) OR
- Fixed deformity that cannot be corrected

### 4.8 Ganglion

**Intro**

Ganglions are benign fluid filled, firm rubbery lumps. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously. Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70%. Surgical excision is the most invasive therapy and recurrence rates of between 5% and 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

**Criteria**

Unless one or more of the following criteria are met surgical removal of ganglia is not routinely funded:

- The patient has had an ultrasound scan to ensure correct diagnosis
- A discussion has been had with a clinician about the nature of the condition.
- Aspiration has been offered

**AND**

- Ganglion(s) - symptomatic (painful) or neurovascular compromise OR
- Seed ganglia arising at the base of the digits - symptomatic (painful) OR
• Mucoid cysts arising at the DIP joint - disturbing nail growth or tendency to discharge

### 4.9 Knee Arthroscopy

#### Criteria

**Washout and debridement in Osteoarthritis**

- Unless there are documented mechanical features of true locking which is associated with severe pain, arthroscopic debridement and washout is not routinely funded for chronic pain relief of osteoarthritis of the knee

**Diagnostic Arthroscopy**

Unless one or more of the following criteria are met diagnostic arthroscopy of the knee is not routinely funded:

- Knee pain with diagnostic uncertainty following an MRI scan OR
- Infection, fracture or avascular necrosis

**Therapeutic Arthroscopy**

Unless all of the following criteria are met therapeutic arthroscopy of the knee is not routinely funded:

- Conservative treatment consisting of an evidence based rehabilitation protocol has failed, and there is as written report documenting this from a physiotherapist AND
- Clinical examination by a consultant specialist or an MRI scan in the interface surface or in secondary care, has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body)

OR

- There is a clear history of trauma

### 4.10 Autologous Cartilage Transplantation

#### Intro

NICE guidance states that autologous chondrocyte implantation (ACI) is not recommended for the treatment of articular cartilage defects of the knee joint, except in the context of on-going or new clinical studies that are designed to generate robust and relevant outcome data, including the measurement of health-related quality of life and long-term follow-up. Patients should be fully informed of the uncertainties about the long term effectiveness and the potential adverse effects of this procedure

#### Criteria

This procedure is not routinely funded

### 4.11 Subacromial Decompression and/or Excision of Acromioclavicular Joint

#### Criteria

**Exclusion criteria**

- Under 18
- Traumatic shoulder injury
- Suspicion of underlying sinister cause

Unless the following criteria are met this is not routinely funded:

- Diagnosis provided
- Failure of physiotherapy
- Failure of injection therapy in the long-term (with evidence that this has been followed by physiotherapy)
- A report has been provided by the interface team

### 4.12 Joint Injections – Site of Procedure

#### Intro

This policy statement relates only to adults (i.e. aged 18 and over), as it is recognised that children often require joint injections under general anaesthesia.

#### Criteria

Policy statement: Joint injections in adults should not be done in a sterile theatre
unless general anaesthetic is required. If imagery guidance is required then they should be done in a suitable area with the approved technology. They will normally be funded as an outpatient procedure.

### 4.13 Spinal Fusion for Chronic Low Back Pain

<table>
<thead>
<tr>
<th>Intro</th>
<th>There is no evidence demonstrating that spinal fusion is more clinically effective or cost-effective than a multi-disciplinary rehabilitation programme (physiotherapy, exercise and psychological input) for chronic (&gt;1 year) degenerative back pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Any patient with Chronic low back pain must have had</td>
</tr>
<tr>
<td></td>
<td>• A StartBack score recorded</td>
</tr>
<tr>
<td></td>
<td>• An agreed structured physiotherapy programme with a written report from the physiotherapist</td>
</tr>
<tr>
<td></td>
<td>• Attended Pain Management Solutions Service – with a written report from PMS</td>
</tr>
<tr>
<td></td>
<td>• The low back pain has lasted more than one year and is documented as significantly interfering with daily life (e.g. loss of function &gt; 50% on EuroQol 22 or BPI tool</td>
</tr>
<tr>
<td></td>
<td>• The CCG requires written reports from the Physiotherapist and PMS service, plus a request from an Orthopaedic Spinal Consultant before agreeing to fund surgery. This will occur via the prior approval process and ultimately through Blueteq</td>
</tr>
</tbody>
</table>

N.B There are a number of other exclusions to this statement, recognising indications other than chronic degenerative low back pain for Spinal Fusion – these are:

- Children and adolescents
- Malignancy
- Benign Tumour
- Congenital defect
- Deformity including
  - Scoliosis
  - Kyphosis
- Inflammatory arthropathy
- Revision surgery
- Concomitant neurological problem
  - Spinal Stenosis
  - Nerve root compression
  - Spondylolisthesis
## 5.1 Facet Joint Injections for Axial (non-radicular) Back Pain of suspected Facet Joint origin

### Intro
Axial (non-radicular) Back Pain is the commonest clinical presentation. Sometimes termed ‘mechanical back pain’, it is the default designation for symptoms not attributable to neural impingement or medically significant other causes. NICE is clear that there is no place for intra-articular facet joint steroid injections in the management of facetogenic axial back pain.

It is the guidance of NICE, the standards set by the Spinal Intervention Society and the joint standards of the British Pain Society and the Faculty of Pain Medicine that one should use:

- Medial Branch Block as a diagnostic procedure leading to
- Radiofrequency neurotomy of the medial branch if diagnostic block is positive

Up to four facet joint denervations on one occasion (one treatment episode) will be funded.

One denervation per facet joint per year will be funded. If more than 1 per year is required, this would need explicit approval from CCG MSK Advisor.

Intra-articular facet joint injections will only be funded if the initial medial branch block has had a proven therapeutic benefit but the patient is not suitable for Thermal Radiofrequency Denervation (RFD) or a Pain Management Programme (PMP) (patients with multiple co morbidities; cardiological and or respiratory dysfunction; cardiac pacemaker or other nerve stimulator; frail and elderly patients). For those who are not suitable for RFD or PMP, up to two intra-articular facet injections per year will be funded.

### Criteria
The CCG will fund medial branch blocks for the management of cervical, thoracic and lumbar back pain only as a diagnostic procedure leading to radiofrequency neurotomy of the medial branch if diagnostic block is positive AND

- The treatment of facet joint pain is provided as part of a comprehensive pain management programme AND
- All conservative management options, (physiotherapy, exercise, pharmacotherapy including analgesia) have been tried and failed and the pain has resulted in moderate to significant impact on daily functioning for greater than 12 months

Radiofrequency facet joint denervation of the medial branch of the dorsal rami of the lumbar and cervical facet joints (medial branch neurotomy) will be funded in the following circumstances:

- Patients aged over 18
- Non-radicular lumbar (all levels) or cervical (C3-4 and below) facet joint pain
- Failure of a one year trial of non-invasive therapy, such as medication and physiotherapy
- Two comparative anaesthetic diagnostic blocks, which must be of the medial branch of the dorsal rami innervating the target facet joint
- A significant reduction in pain following the block during activities that normally generate pain should be demonstrated and recorded (>70%). The pain relief must be consistent with the expected duration of the anaesthetic block
- All procedures must be performed under fluoroscopy (x-ray guidance)
### 5.2 Epidural Injections for Radicular Back Pain (‘Sciatica’)

**Intro**
Discal prolapse causing spinal nerve root irritation is a common occurrence and, as with many causes of back pain, is usually self-limiting with suitable modification of activity (although not ceasing activity), analgesia and time. Epidurals are the instillation of local anaesthetic and/or corticosteroids into the potential space between the membranes which surround the spinal cord. As per NICE guidance, the CCG will not fund epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

**Criteria**
The CCG will fund epidurals:
- In people with acute sciatica (<12w) (maximum of 2)
- In patients with chronic radicular back pain (>12w) where all conservative management options, (physiotherapy, exercise, pharmacotherapy) have been tried and failed and the pain has resulted in moderate to significant impact on daily functioning (maximum of 2)

### 5.3 Spinal Cord Stimulation for Chronic Pain

**Intro**
Spinal cord stimulators stimulate the dorsal columns of the spinal cord with an implanted device, with the aim of modifying the perception of pain. They have been assessed by NICE as cost-effective in neuropathic pain, with more recent reviews identifying subgroups where they are cost-effective.

**Criteria**
Unless all of the criteria below are met spinal cord stimulation is not routinely funded for chronic pain:
- Adults with chronic pain of neuropathic origin that is either Failed Back Surgery Syndrome or Complex regional Pain Syndrome Type I AND
- On-going chronic pain (measuring at least 50 mm on a 0-100 mm visual analogue scale) for at least 6 months despite a comprehensive pain management Programme (physiotherapy guided exercise, maximal analgesia and muscle relaxants, psychological treatment) AND
- Have been assessed by a multidisciplinary team experienced in chronic pain assessment and in management of people with spinal cord stimulation devices, including experience in the provision of on-going monitoring and support of the person assessed AND
- Have had a successful trial of stimulation as part of that assessment AND
- When there are equally suitable spinal cord stimulation systems for a particular patient, the least expensive is used
6.1 Treatment for Erectile Dysfunction

Intro

This policy refers to non-pharmacological treatment. Pharmacological treatment will be provided in line with the latest guidance.

Erectile dysfunction affects 30-50% of men aged 40-70 years, with age, smoking and obesity being the main risk factors, although 20% of cases have psychological causes. Evidence suggests that drugs such as Sildenafil, Tadalafil, vardenafil, Intracavernosal alprostadil, intraurethral alprostadil, and intracavernosal papaverine improve erections and increase the likelihood of successful intercourse. Sublingual apomorphine, ginseng and yohimbine may increase successful erections and intercourse compared with placebo. Vacuum devices may be as effective as intracavernosal alprostadil at increasing rigidity, but less effective for orgasm, and may block ejaculation. There is consensus that penile prostheses may be beneficial, but they can cause infections and are only used if less invasive treatments have failed.

Psychosexual counselling and cognitive behavioural therapy may improve sexual functioning in men with psychological erectile dysfunction, but few good quality studies have been found.

Criteria

Unless erectile dysfunction is due to one or more of the following medical conditions, medical and surgical treatment for erectile dysfunction is not routinely funded:

- Diabetes OR
- Multiple sclerosis OR
- Parkinson’s disease OR
- Poliomyelitis OR
- Prostate cancer OR
- Prostatectomy OR
- Radical pelvic surgery OR
- Severe pelvic injury OR
- Renal failure treated by dialysis or transplant OR
- Single gene neurological disease OR
- Spinal cord injury OR
- Spina bifida

In patients with Peyronie’s disease and erectile dysfunction not responding to medical treatments, the surgical correction of the curvature with concomitant penile prosthesis implantation should be considered.

6.2 Dilatation And Curettage for Menorrhagia

Intro

Dilatation and curettage (D&C) is a common gynaecological operation performed for both diagnostic and therapeutic purposes for a range of conditions including menorrhagia. NICE guidelines recommend the replacement of D&C with endometrial biopsy for investigation of menorrhagia, and do not support its use as a therapeutic procedure.

Criteria

Dilatation of Cervix Uteri and Curettage of Uterus is not routinely funded for the investigation or management of menorrhagia, except in the 2 following circumstances:

- Molar pregnancy
- Failed endometrial preparation for re-section

6.3 Hysteroscopy for Menorrhagia

Intro

Investigation of menorrhagia. Unless all of the following criteria are met hysteroscopy is not routinely funded for the investigation of menorrhagia:
Imaging of the uterus as per NICE guidelines is inconclusive and/or the full range of NICE recommended pharmacological interventions have failed. NICE 2007 recommended pharmacological treatments for menorrhagia are:

- Levonorgestrel-releasing intrauterine system (LNG-IUS) provided long-term use (for at least 12 months) is anticipated
- Tranexamic acid or non-steroidal anti-inflammatory drugs (NSAIDs) or combined oral contraceptives (COCs)
- Norethisterone (15 mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens

N.B. this does not relate to endometrial biopsies undertaken endoscopically for the investigation of suspected atypical hyperplasia or malignancy (OPCS code Q18.1). However the hysteroscopic element of these procedures is included within current coding structures, and it is not anticipated that additional funding is required.

### 6.4 Hysterectomy +/- Oophrectomy

**Intro**

Management of menorrhagia

Hysteroscopy is not routinely funded for the management of menorrhagia.

**Criteria**

N.B. It is recognised that hysteroscopy may be required to confirm placement of devices for ablative procedures, but it is anticipated that this will not attract additional funding as it is included within the tariff and/or coding of ablative procedures.

### 6.5 Mirena Coils

**Intro**

Insertion and removal of IUCD should only be undertaken in a primary care setting, it is not normally commissioned as a secondary care service unless specific medical issues prevents fitting or removal by primary care or if fitted as part of contraception provided in conjunction with Termination of Pregnancy. Patients requiring a Mirena insertion for family planning purposes should access the community family planning service.

**Criteria**

Mirena Coils should be fitted and removed for the management of heavy menstrual bleeding by primary care and not secondary care unless:

- Facilities and appropriately trained staff are not available to provide a Mirena fitting service in the community – referral to secondary care to be made
- It is fitted as part of a surgical procedure in secondary care, i.e. following an endometrial ablation or resection
- It is unable to be removed in the community

### 6.6 Reversal of Female Sterilisation

**Intro**

Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

**Criteria**

Reversal of female sterilisation is not routinely funded

### 6.7 Reversal of Male Sterilisation

**Intro**

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.

**Criteria**

Reversal of male sterilisation is not routinely funded
### 6.8 IVF

<table>
<thead>
<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>The existing detailed Shropshire IVF policy can be found on the Shropshire CCG website at <a href="http://www.shropshire.nhs.uk/Publications/Policies/">http://www.shropshire.nhs.uk/Publications/Policies/</a>.</td>
</tr>
</tbody>
</table>

### 6.9 Routine Doppler Ultrasound Of Umbilical + Uterine Artery In Antenatal Care

<table>
<thead>
<tr>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine doppler ultrasound of umbilical and uterine arteries is not routinely funded for low risk pregnancies.</td>
</tr>
</tbody>
</table>
### 7.1 Laser Surgery for Short Sight (Myopia)

**Intro**
Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. However there are alternative methods of correction such as spectacles and contact lenses.

**Criteria**
Laser surgery for correction of short sight is not routinely funded.

### 7.2 Cataract Surgery

**Intro**
Please Note: the reasons why the patient’s vision and lifestyle are adversely affected by cataracts and the likely benefits the patient would gain from having surgery, or any other exceptional circumstances, must be clearly documented in the clinical records.

This policy applies to both first and second eyes, with a best corrected visual acuity of 6/12 or worse in the affected eye being used as the threshold for cataract surgery.

**Criteria**
Unless one or more of the following agreed exceptions are met, cataract surgery will not normally be funded:

- A best corrected visual acuity of better than 6/12 in the affected eye
- **OR** any of the following:
  - Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker) **OR**
  - Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions **OR**
  - Patients who need to drive at night who experience significant glare due to cataracts which affects driving **OR**
  - Patients who have difficulty with reading due to lens opacities **OR**
  - Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field **OR**
  - Patients with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye **OR**
  - Patients with glaucoma who require cataract surgery to control intraocular pressure **OR**
  - Patient with diabetes who require clear views of their retina to look for retinopathy **OR**
  - Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs)
8.1 Abdominoplasty or Apronectomy

**Intro**
Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.

N.B. Purely cosmetic procedures such as removal of surplus skin irrespective of site will not be funded.

**Criteria**
Refer only if:
Age over 19 years
AND
Starting BMI above 40 OR
- Starting BMI above 35 with co-morbidities AND
- Current BMI of less than or equal to 26 AND
- Weight stability of 12 months AND
- Significant functional disturbance (both physical and psychological)

Physical problems include:
- Recurrent severe infection or ulceration beneath the skin fold
- Experiencing severe difficulties with daily living i.e. ambulatory/urological
- Problems associated with poorly fitting stoma bags

Exceptions to general criteria:
- Starting BMI above 40kg/m² or above 35kg/m² with co-morbidities and 75% excess body weight – should be eligible for apronectomy only - if they are unable to slim down to a BMI of 26 or less. A BMI of up to 40kg/m² can be considered here
- Weight stability of 12 months and significant functional disturbance applies here too

8.2 Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat

**Intro**
These surgical procedures are performed to remove loose skin or excess fat to reshape body contours.

Not routinely funded. Purely cosmetic procedures such as removal of surplus skin irrespective of site will not be funded.

**Criteria**
Buttock, thigh and arm surgery will only be commissioned in exceptional circumstances, as follows;
- Cutis laxa (rare inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds) OR
- Severe weight loss with resulting functional problems

AND
- Age over 19 years AND
- Significant functional disturbance (both physical and psychological) AND
  - Starting BMI above 40 or above 35 with co-morbidities OR
  - Current BMI of less than or equal to 26 AND Weight stability of 12 months

Exceptions to general criteria:
- Starting BMI above 40 or above 35 with co-morbidities and 75% excess body weight – should be eligible for apronectomy only - if they are unable to slim down to a BMI of 26 or less. A BMI of up to 40 can be considered here
- Weight stability of 12 months and significant functional disturbance applies here too
### 8.3 Liposuction

**Intro**
Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.

**Criteria**
Not routinely funded.

Cosmetic liposuction is not available but may be used as a technique in the management of true lipodystrophies, lymphoedema or lipomas, or as part of other surgery e.g. thinning of transplanted flap.

### 8.4 Breast Augmentation

**Intro**
Breast augmentation/enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

Not routinely funded. Note - Transsexual patients will be considered under the gender dysphoria policy.

**Criteria**
- The minimum age for surgery is 19 years of age and evidence that pubertal growth of breasts has ceased must be documented

**AND**
Referrals should only be made for women with a:
- Complete absence of breast tissue (amastia) OR
- Absence of breast tissue unilaterally OR
- Significant degree of asymmetry of breast shape and/or volume

**OR**
- Where clinically indicated and where the original surgery was carried out under the NHS only

**OR**
- Surgery may be supported when there is a pathological condition relating directly to the implant

### 8.5 Breast Asymmetry

**Criteria**
Patients will be considered eligible for surgery to correct breast asymmetry if the following criteria are met and normal diagnostic tools are available;
- Aged 19 years or over AND
- There is a natural absence of breast tissue unilaterally where there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra) (patients with Poland’s Syndrome meet this criterion) AND
- There is a difference of at least 3 cup sizes AND
- Where relevant, treatment of the underlying cause of the problem has been undertaken (including advice, support and professionally fitting bra service) AND
- If asymmetry relates to a reduction surgery, then the patient’s BMI is ≤ 27 for one year as measured and evidenced in the patient’s clinical records

**Note** - breast reduction of the larger breast should be the preferred option for patients considering surgery

### 8.6 Breast Lift (Mastopexy)

**Intro**
This is included as part of the treatment of breast asymmetry but will not be available for purely cosmetic reasons, for example post lactation or age related breast ptosis (drooping)
Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.

| Criteria | Not routinely funded |

### 8.7 Breast Reduction

**Intro**
Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape.

**Criteria**
Patients are eligible for surgery to reduce breast size if all of the following criteria are met:
- The patient’s breast size is cup size H or larger
- The breast reduction surgery should result in a reduction in breast size of at least three cup sizes
- The patient has a BMI of ≤ 27
- Is 19 years of age or over
- All other advice and support has failed (including professionally fitting bra service) and evidence of which will be supplied
- There are significant musculo-skeletal pain or symptoms that are causing significant functional impairment which in the opinion of the referrer are likely to be corrected or significantly improved by surgery

### 8.8 Revision Mammoplasty (including prosthesis removal or replacement)

**Intro**
The term mammoplasty refers to both breast reduction and breast augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or as a result of problem with implants.

**Criteria**
Unless one or more of the following criteria are met, revision mammoplasty and breast prosthesis removal or replacement is not routinely funded. Revision of breast augmentation is considered only where the original surgery was an NHS procedure.
- Urgent post-operative complications (such as infection or haemorrhage)
- For patients whose implants where provided by the NHS, to avoid further harm from leakage or rupture
- Routine replacements of implants and revision following private operations will not be supported. However, surgery may be supported when there is a pathological condition relating directly to the implant.

### 8.9 Inverted Nipple Correction

**Intro**
Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.

**Criteria**
Not routinely funded
- Surgical correction of nipple inversion should only be available for functional reasons in post pubertal women and if the inversion has not been corrected by correct use of a non-invasive suction device

### 8.10 Male Breast Reduction Surgery for Gynaecomastia

**Intro**
Most cases of gynaecomastia are idiopathic. It can also occur during puberty, when it tends to resolve as the post-pubertal fat distribution is complete. It can also occur secondary to medication such as oestrogens, gonadotrophins, digoxin, spironolactone and cimetidine, as well as anabolic steroids. More rarely it can be due to endocrinological disorders and malignancy. This policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected
malignancy

Criteria  Not routinely funded

- Surgery to correct gynaecomastia may be considered if the BMI is in the normal range (18.5 – 24.9) and when the reduction to be obtained will be significant i.e. greater than 100g per side (estimated), or where there is gross asymmetry
- Individuals who are taking sport performance-enhancing drugs, in whom the gynaecomastia is potentially drug induced, should be refused surgery unless such drugs have not been taken for more than 12 months and they meet the criteria above

8.11 Labial Trimming and Cosmetic Genital Procedures

Criteria  Labial trimming and other cosmetic genital procedures are not routinely funded.

8.12 Labiaplasty

Intro  Labiaplasty is generally a cosmetic procedure to change appearance alone and is not routinely funded.

Criteria  Requests for labiaplasty will be considered for the following indications:

- Where repair to the labia is required after trauma
- In cases of female genital mutilation

8.13 Vaginoplasty

Intro  Non-reconstructive vaginoplasty or “vaginal rejuvenation”, is used to restore vaginal tone and appearance and is not routinely funded

Criteria  Requests for Vaginoplasty will be considered for the following indications:

- Congenital absence or significant development/endocrine abnormalities of the vaginal canal
- Where repair of the vaginal canal is required after trauma

8.14 Hymenorrhaphy

Criteria  Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely funded

8.15 Pinnaplasty

Intro  Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. Some patients are only able to seek correction once they are in control of their own healthcare decisions. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child.

Criteria  The following criteria must be met:

- The patient must be under the age of 19 years at the time of referral, where the child rather than the parent alone expresses concern
- Patients seeking pinnaplasty should be seen by a plastic surgeon following assessment
- Referral is only indicated when there is obvious deformity or ear asymmetry

Patients under 5 years of age at the time of referral may benefit from referral with their family for a multi-disciplinary assessment that includes a child psychologist.
### 8.16 Blepharoplasty

**Intro** Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. The CCG will not normally fund this intervention for purely cosmetic reasons.

**Criteria** Not routinely funded, except for cases where:
- The patient’s field of vision is significantly obscured by this condition OR
- Documented clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening at end of day and/or evidence of chronic compensation through elevation of the brow

### 8.17 Face Lift or Brow Lift

**Intro** These surgical procedures are performed to lift the loose skin of face and forehead to get a firm and smoother appearance of the face. The CCG does not commission these interventions to treat the natural processes of ageing.

**Criteria** Not routinely funded. These procedures will be considered for the treatment of:
- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- Brow Ptosis affecting vision
- To correct the consequences of trauma
- To correct deformity following surgery

### 8.18 Hair Depilation (Hair removal)

**Intro** Hair depilation can be used for excess hair in a normal distribution pattern, or for abnormally placed hair. It is usually achieved permanently by electrolysis or laser therapy. The CCGs do not routinely fund hair depilation for cosmetic purposes.

**Criteria** Not routinely funded.

### 8.19 Hair Grafting - male pattern baldness

**Intro** Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Hair grafting is mostly done for aesthetic reasons.

**Criteria** Hair grafting for male pattern baldness is not routinely funded
- Correction of hair loss (alopecia) is only available under the NHS when it is a result of previous surgery or trauma including burns

### 8.20 Removal of Tattoos

**Intro** A tattoo can be removed by laser, surgical excision, or dermabrasion

**Criteria** Tattoo removal is not routinely funded

### 8.21 Skin Lesions, Cysts, etc.

**Intro** This policy covers lesions such as suspected basal cell carcinoma, seborrheic warts, Bowen’s disease, atypical naevi, sebaceous cysts, keratin horn, pyogenic granuloma. Please note this list is not exhaustive.

The removal of benign skin lesions is not routinely funded by the CCG

**Criteria** Please refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more;
- Weighted 7-point checklist
  - Major features of the lesions (scoring 2 points each):
If the lesion is a suspected Basal Cell Carcinoma (BCC) please refer for excision.

### 8.22 Removal of Lipomata

**Intro**
Lipomata are fat deposits underneath the skin. They are usually removed on cosmetic grounds, although patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis. The following criteria are based on Department of Health guidelines relating to risk of underlying malignancy.

**Criteria**
Unless one or more of the criteria below are met, removal of lipomata is not routinely funded:
- The Lipoma (-ta) is / are painful OR
- There is functional impairment caused by the Lipoma OR
- The lump is rapidly growing or abnormally located (e.g. sub-fascial, submuscular) OR
- To provide histological evidence in conditions where there are multiple subcutaneous lesions

### 8.23 Repair of Lobe of External Ear (Split earlobes)

**Intro**
The external ear lobe can be damaged partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk. The CCG does not commission procedures such as repairing enlarged holes made by pierced earrings.

**Criteria**
Not routinely funded

### 8.24 Resurfacing Procedures: Dermabrasion, Chemical Peels and Laser Treatment

**Intro**
Dermabrasion, involves removing the top layer of the skin to make it look smoother and healthier. Scarring and permanent discolouration of skin are rare complications.

**Criteria**
Unless the following criteria is met, resurfacing procedures including dermabrasion, chemical peels and laser treatment is not routinely funded:
- Post-traumatic scarring (including post-surgical)

### 8.25 Rhinoplasty

**Intro**
Rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People often ask for this procedure to improve self-image.

**Criteria**
Not routinely funded. Rhinoplasty is not normally commissioned unless there are significant functional problems. Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an ENT consultant for assessment and treatment
- Post traumatic rhinoplasty
- Complete congenital conditions e.g. cleft lip and palate
- Airway problems
<table>
<thead>
<tr>
<th>8.26</th>
<th>Scars and Keloids</th>
</tr>
</thead>
</table>
| Criteria | Scarring as a result of acne will not routinely be funded on the NHS.
Not routinely funded. Will only be funded in accordance with the criteria specified below: |
|      | • For scars that interfere with function following burns/trauma OR |
|      | • Serious scarring of the face OR |
|      | • Severe post-surgical scarring |

<table>
<thead>
<tr>
<th>8.27</th>
<th>Botox Injection for the Ageing Face</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Botox Injection for the ageing face will not normally be funded</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.28</th>
<th>Congenital Vascular Lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Not routinely funded, with the exception of;</td>
</tr>
<tr>
<td></td>
<td>• Treatment of facial and neck port wine stains in adolescents and adults</td>
</tr>
<tr>
<td></td>
<td>• Facial port wine stains and strawberry haemangiomas in children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.29</th>
<th>Anal Skin Tag Removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intro</td>
<td>Skin tags are small flesh-coloured or brown growths that hang off the skin and look a bit like warts. They are very common and harmless. Skin lesions are often referred for specialist opinion because of concerns that there may be a malignancy. This should be done through the appropriate referral route if malignancy is suspected. Once it is established that a skin lesion is not malignant, its removal will not normally be funded, though a surgeon may request funding in exceptional cases.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Removal of Anal Skin Tags is regarded as a procedure of low clinical value and therefore not routinely funded</td>
</tr>
<tr>
<td>9.1</td>
<td><strong>Inpatient Neuro-Rehabilitation</strong></td>
</tr>
<tr>
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</tr>
<tr>
<td>Intro</td>
<td>Inpatient Neuro-Rehabilitation</td>
</tr>
<tr>
<td>Criteria</td>
<td>Unless there are exceptional circumstances the preferred provider would be RJaH. Inpatient Neuro-Rehabilitation within other specialist units (e.g. Mosley Hall, Frenchay) will not routinely be funded for more than three months.</td>
</tr>
<tr>
<td>10.1</td>
<td><strong>Therapeutic Community Method Treatment for Borderline Personality Disorder</strong></td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Intro</td>
<td>Therapeutic Community Method Treatment for Borderline Personality Disorder</td>
</tr>
<tr>
<td>Criteria</td>
<td>This is not routinely funded</td>
</tr>
</tbody>
</table>
### 11.1 Inpatient Cognitive Behavioural Therapy

**Criteria**

This is not routinely funded

### 11.2 Complementary Medicines/Therapies

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unless patients meet one or more of the criteria below, complementary therapies such as homeopathy, acupuncture, osteopathy and chiropractic therapy is not routinely funded:</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Acupuncture will only be funded as part of a comprehensive pain management programme provided by a specialist pain clinic (see below)</td>
</tr>
<tr>
<td>Osteopathy and chiropractic therapy</td>
<td>Osteopathy and chiropractic therapy will only be funded as part of a comprehensive musculoskeletal service pathway, within service agreements, and developed with providers</td>
</tr>
</tbody>
</table>

Consider acupuncture as a treatment option when:

- The duration of non-specific low back pain has been less than 12 months
- Prophylaxis of primary headache is required and for migraines when topiramate and propranolol have been ineffective or unsuitable
- There is a need to reduce medication, medication intolerance or psychological dependence on medication are strong issues for the patient

**Note:**

- The CCG will not fund acupuncture for a person who has not or does not intend to take part in a comprehensive self-management approach to manage the effects of their pain condition
- Funding will be provided for a maximum of 10 treatments provided there is ongoing evidence of consistent and effective relief from symptoms allowing patients to undertake further self-management techniques and approaches

### 11.3 Hyperbaric Oxygen Therapy

**Intro**

Despite the increasing use of Hyperbaric Oxygen Therapy (HBOT) in a range of conditions there is very little evidence from clinical trials regarding its clinical effectiveness or cost effectiveness. In line with findings from the review of HBOT by NHS Quality Improvement Scotland, The CCG will fund its use for conditions where there is a theoretical basis for its effectiveness, sufficient empirical evidence and clinical consensus.

**Criteria**

Unless one or more of the criteria below are met Hyperbaric Oxygen Therapy is not routinely funded:

- Acute decompression sickness OR
- Acute carbon monoxide poisoning OR Acute gas embolism OR
- Radiation Proctitis

**N.B.** In the case of decompression sickness due to diving accidents, the cost of Hyperbaric Oxygen Therapy should, where possible, be funded from any relevant insurance held by the patient
### Appendix 1 – Changes log prior to version 30

<table>
<thead>
<tr>
<th>Version</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1 – October 2011</td>
<td>Drafted from Hereford policy papers following agreement to proceed from Clinical Advisory Panel and Joint Committee on Priorities and Policies.</td>
</tr>
<tr>
<td>February 2012</td>
<td>Final comments received from Shrewsbury and Telford Hospital (SaTH).</td>
</tr>
<tr>
<td>V2 – February 2012</td>
<td>Amended with received comments and included current policies.</td>
</tr>
<tr>
<td>V3 – March 2012</td>
<td>Amended to include current aesthetics policies. Removed Initial Draft from Watermark and replaced with Final Draft. Submitted for Clinical Advisory Panel meeting on March 14th 2012.</td>
</tr>
<tr>
<td>V4 – 6th March 2012</td>
<td>Amended to include comments received from dental adviser’s changes to dental implants and formatting of the policy.</td>
</tr>
<tr>
<td>V5 – 6th March 2012</td>
<td>Amended per Su Green comments.</td>
</tr>
<tr>
<td>V6 – 7th March 2012</td>
<td>Amended per Su Green further amendments (v3).</td>
</tr>
<tr>
<td>V7 – 7th March 2012</td>
<td>Final amendments to layout.</td>
</tr>
<tr>
<td>V8 – 26th March 2012</td>
<td>Comments from Clinical Advisory Panel inserted and amendments following comments from Robert Jones and Agnes Hunt Hospital.</td>
</tr>
<tr>
<td>V9 – 17th April 2012</td>
<td>Adopted by CCG Board Meeting 4th April 2012 subject to HoSC meeting to be held on 28th May 2012.</td>
</tr>
<tr>
<td>V10 – 26th April 2012</td>
<td>Amendments made following Dr Povey meeting with Mr Fox (SaTH). Formatting changed to Vcontrol sheet and text within in section 9.</td>
</tr>
<tr>
<td>V10a – 30th April 2012</td>
<td>Amendments following Dr Povey review Dr to Mr on Vcontrol sheet and addition on page 14.</td>
</tr>
<tr>
<td>V10b – 9th May 2012</td>
<td>Amendments to Section 4.8 as per RAH letter dated 19th April 2012.</td>
</tr>
<tr>
<td>V12 – 20th September 2012</td>
<td>Blepharoplasty Surgery – Text added in “Documented clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow. Formatting of table of contents re-numbering of section 9 and page numbers.</td>
</tr>
<tr>
<td>V14 – 22nd October 2012</td>
<td>Abbreviations added for ease of reference and referring headings changed within the document.</td>
</tr>
<tr>
<td>V15 – 3rd December 2012</td>
<td>Amendments made as per e-mails from Su Green &amp; Dr J Povey November/December 2012.</td>
</tr>
<tr>
<td>V16 – 10th January 2014</td>
<td>Inserted CCG logo and updated IFR policy web link to: <a href="http://www.shropshireccg.nhs.uk/policies">www.shropshireccg.nhs.uk/policies</a> replaced wording from Shropshire County PCT to Shropshire Clinical Commissioning Group and Shropshire PCT to SCCG.</td>
</tr>
<tr>
<td>V17 – 11th July 2014</td>
<td>Whole document review post further evidence and comparison between current policy and NHS England policies for Armed Forces Commissioning, and discussion at JCPAC Meetings. Author I Culliss.</td>
</tr>
<tr>
<td>V18 – 6th August 2014</td>
<td>Policy as agreed by CAP with exclusions and inclusions.</td>
</tr>
<tr>
<td>V19 – 14th August 2014</td>
<td>Final amendments to layout – I Culliss</td>
</tr>
<tr>
<td>V20 – 29th December 2014</td>
<td>TWCCG logo added to joint CCG policy. Policy updated as per meeting with Carol McInnes and S Clennell</td>
</tr>
<tr>
<td>V21 – 5th March 2015</td>
<td>Latest updates added throughout inc. changes from Wendy Southall, Carol McInnes, Sharon Clennell and Claire Roberts</td>
</tr>
<tr>
<td>V22 – 13th March 2015</td>
<td>Updates to sections and Intro’s from Sharon Clennell, Wendy Southall and Darren Francis</td>
</tr>
<tr>
<td>V23 – 16th March 2015</td>
<td>Updates to Cataract and Ear Wax Section, amended Shropshire Clinical Commissioning Group and Telford &amp; Wrekin Clinical Commissioning Group to the CCGs.</td>
</tr>
<tr>
<td>V24 – 18th March 2015</td>
<td>Aligned Shropshire and Telford wording around cataracts and ear wax to one joint “criteria” for each. Amended wording on Bariatric Surgery.</td>
</tr>
<tr>
<td>V25 – 1st April 2015</td>
<td>Amendment within Hip Resurfacing – Read: As per NICE guidance prosthesis should only be used if the evidence shows they require revision at a rate of less than 1 in 5% in 10 years – NOW reads 1 in 5 (20%) Amendment Ear Wax – duplicate line removed regarding irrigation</td>
</tr>
<tr>
<td>V26 – 7th May 2015</td>
<td>Approved at CAP.</td>
</tr>
<tr>
<td>V27 – 21st August 2015</td>
<td>Approved at SCCG Board. Circulated. I Culliss.</td>
</tr>
<tr>
<td>V28 – 18th September 2015</td>
<td>Changes to 4.1 Hip and Knee Replacement Surgery – from J.Povey/I.Culliss – Shropshire CCG only</td>
</tr>
<tr>
<td>V29 – 14th April 2016</td>
<td>Section 11.2 ‘Complementary Medicines/Therapies’ has updated acupuncture guidance (agreed by CAP February 2016)</td>
</tr>
</tbody>
</table>