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Health and Wellbeing Scrutiny Committee

Agenda

Date:	**Thursday, 13th February, 2014**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 1 - 4)

   To approve the minutes of the meeting held on 5 December 2013

3. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

4. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the agenda

5. **Public Speaking Time/Open Session**

For any apologies or requests for further information, or to give notice of a question to be asked by a member of the public

Contact: James Morley
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A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake any background research, it would be helpful if members of the public notified the Scrutiny officer listed at the foot of the agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **Cheshire East Health Overview and Scrutiny Protocol** (Pages 5 - 16)

To consider the latest draft of the Protocol

7. **Protocol for Joint Health Scrutiny Arrangements for Cheshire and Merseyside** (Pages 17 - 22)

To consider the draft protocol and submit comments to the Constitution Committee

8. **Clatterbridge Cancer Centre - Briefing on Substantial Development and Variation to Services** (Pages 23 - 32)

To receive a short briefing on proposed service developments from Clatterbridge Cancer Centre

9. **South Cheshire CCG Connecting Care initiaitive**

To consider a presentation from South Cheshire Clinical Commissioning Group about its Connecting Care initiative

10. **CCGs' Commissioning Policies consultation** (Pages 33 - 96)

To consider and comment on the Commissioning Policy of the Clinical Commissioning Groups presented by Cheshire and Merseyside Commissioning Support Unit

11. **Integrated Health and Local Care**

To receive a briefing from the Director of Strategic Commissioning

12. **Committee Health "Champions"**

To discuss the use of “Champions” in the work of the Committee

13. **Work Programme**

To review the development of the Committee’s Work Programme

Agenda Item 2

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Scrutiny Committee** held on Thursday, 5th December, 2013 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor H Gaddum (Chairman)
Councillor L Jeuda (Vice-Chairman)

Councillors R Domleo, I Faseyi, W Livesley, A Moran, J Saunders, M J Weatherill and S Jones

Apologies

Councillor D Hough

ALSO PRESENT

Councillor J Clowes – Health and Adult Social Care Portfolio Holder
Jacki Wilkes – Eastern Cheshire Clinical Commissioning Group
Matthew Cunningham – Eastern Cheshire Clinical Commissioning Group
Jo Vitta – South Cheshire Clinical Commissioning Group
Stephen Cross – East Cheshire NHS Trust

OFFICERS PRESENT

Lorraine Butcher – Director of Strategic Commissioning
Dr Heather Grimbaldeston – Director of Public Health
James Morley – Scrutiny Officer

157 MINUTES OF PREVIOUS MEETING

RESOLVED – That the minutes of the meeting held on 14 November 2013 be approved as a correct record and signed by the Chairman.

158 DECLARATIONS OF INTEREST

There were no declarations of interest

159 DECLARATION OF PARTY WHIP

There were no declarations of party whip

160 PUBLIC SPEAKING TIME/OPEN SESSION

There were no members of the public present who wished to speak

161 **THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH**

The Committee examined the Annual Report of the Director of Public Health. Dr Heather Grimbaldeston provided a brief recap of the Report which had been submitted to the Committee at the previous meeting. The main focus of the report was preventing early deaths which were any death of someone under the age of 75. In tackling early deaths in the Borough, Public Health would prioritise action to reduce the effects of the four main causes of early deaths: cancer; heart disease and stroke; lung disease; and liver disease.

Cheshire East was performing well compared to the national average but was not performing particularly well relative to comparable authorities with similar characteristics. Many areas of the Borough had very good life expectancy and quality of life however the Borough's average was brought down considerable by poor statistics for large parts of Crewe and some parts of Macclesfield. These health inequalities were a major issue for the Council to address.

The following points were made during discussion:

- It was just as important to focus on ensuring people live good quality lives as it was to ensure people lived longer.
- People had to take responsibility for their own health to live well and longer. It was very difficult to change people attitudes towards their health however lifestyle change was essential for some people to live longer.
- To affect behaviours public health needed to target young people early through their schools by encouraging healthy lifestyles that they would continue throughout their lives.
- The quality of housing had a significant influence on people's health. The Council needed to ensure it had a good quality housing supply in all areas.
- Many of the Council's services that were not health related still had an impact on the health of service users (e.g. transport). The Council needed to examine what could be done to increase the positive impact on peoples' health of these services as well as health services.

RESOLVED – That the Annual Report of the Director of Public Health be noted.

162 **WORK PROGRAMME**

The Committee considered whether to include an item in the work programme on changes to stroke services at Macclesfield General Hospital. Stroke services were being reorganised by East Cheshire NHS Trust with hyper acute services being transferred to Stockport and Salford. This was going to affect residents in the north of the Borough, residents in Congleton, Holmes Chapel and southern areas of the Borough were linked to the services provided in North Staffordshire.

Members were concerned about the future of Macclesfield General Hospital as services provided there were gradually being reduced. Jacki Wilkes informed the

Committee that stroke recovery phase services would still be provided with patients transferring to Macclesfield after hyper acute phase of strokes.

Members also raised issues for the families of patients who would have to travel further with patients. East Cheshire NHS Trust was focused on the best outcomes for patients however the effects on family and friends would be taken into consideration when making decisions about services.

Members stated that it was important that NHS service providers kept them informed of service changes so that they were able to communicate with the press and public when questions were raised.

The Committee considered the rest of the Work Programme.

RESOLVED – That the next meeting of the Committee on 9 January 2014 be held as an informal meeting.

The meeting commenced at 10.00 am and concluded at 11.45 am

Councillor H Gaddum (Chairman)

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Wellbeing Scrutiny Committee

Date of Meeting: 13 February 2014
Report of: Democratic Services
Subject/Title: Cheshire East Health Scrutiny Protocol
Portfolio Holder: Councillor Janet Clowes

1.0 Report Summary

1.1 This is a covering report to present the latest draft of the Cheshire East Health Scrutiny Protocol.

2.0 Recommendation

2.1 That the Committee consider the latest draft and approve a version to be agreed with partners.

3.0 Reasons for Recommendation

3.1 The Committee previously had a protocol in place with the Primary Care Trust. Since the changes to health services brought about by the Health and Social Care Act 2012, new bodies have replaced the old PCT's requiring the Committee to agree a new protocol with its new partners.

4.0 Background

4.1 The latest draft of the protocol has been developed based on feedback from the Committee and partners at an informal meeting in January. Some amendments to this latest draft have been suggested by partners; these will be raised at the meeting.

5.0 Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

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CHESHIRE EAST HEALTH OVERVIEW AND SCRUTINY PROTOCOL

1 Introduction

1.1 The Health and Social Care Act 2012 and associated regulations give local authorities the power to review and scrutinise health services. This complements their existing power to promote the social, economic and environmental well-being of local areas. The role of local authorities is to contribute to health improvement and reducing health inequalities in their local area. Health services are to be viewed in their widest sense and will include Adult Social Care and other services provided by the local authority and in partnership with the NHS. Local authorities will be channels for the views of local people.

1.2 Health scrutiny is the democratic element of the new system for patient and public involvement. This includes Healthwatch, Independent Complaints and Advocacy Services (ICAS) and Patient Advice and Liaison Services (PALS). In addition, the NHS is required to make arrangements to consult with and involve the public in the planning of service provision, the development of changes and in decisions about changes to the operation of services.

1.3 The two main elements of health overview and scrutiny are:

- Formal consultation on substantial developments or variations to services.
- A planned programme of reviews with capacity to respond to issues referred by Cheshire East Healthwatch and other referrers.

1.4 The functional responsibility for the overview and scrutiny of health provision and services in Cheshire East lies with the Health and Wellbeing Scrutiny Committee of the Council ("the Committee"). The main points of contact for NHS scrutiny are the South Cheshire Clinical Commissioning Group, the Eastern Cheshire Clinical Commissioning Group ("the CCGs"), Cheshire East Council (the Local Authority) through its Public Health responsibilities and NHS England as commissioners of services and in a system leadership role which reflects the NHS responsibilities for commissioning and leading health services in the area. The responsibility to respond to scrutiny is not limited to those mention above and through this document they will be referred to jointly as "responsible commissioners".

2 Policy Statement

Members of the Committee, the Local Authority, the CCGs, NHS England, other responsible commissioners and organisations for patient and public involvement, will work together to ensure that health scrutiny improves the provision of health services and the health of local people.

3 Aims of Health Scrutiny

- To improve the health of local people by scrutinising the range of health services.
- To secure continuous improvement in the provision of local health services and services that impact on health.
- To contribute to the reduction of health inequalities in the local area.
- To ensure the views of patients and users are taken into account within a strategic approach to health care provision.

4 Principles

4.1 Overview and scrutiny of health services is based on a partnership approach.

4.2 Overview and scrutiny is independent of the NHS and the Health and Wellbeing Board.

4.3 The views and priorities of local people are central to overview and scrutiny, and patients and their organisations will be actively involved.

4.4 The overview and scrutiny approach is open, constructive, collaborative and non confrontational. It is based on asking challenging questions and considering evidence. Recommendations are based on evidence.

4.5 Overview and scrutiny will consider wider determinants of health and use wider local authority powers to make recommendations to other local agencies as well as the NHS.

4.6 Overview and scrutiny recognises that there will be tensions between people's priorities and what is affordable or clinically effective, and that local health provision takes place within a national framework of policies and standards.

4.7 The impact and effectiveness of health overview and scrutiny will be evaluated by means of an annual report to Council. Development of the annual report will include consultation with partners and Healthwatch.

5 The Role of the Committee

5.1 In the course of a review or scrutiny the Committee will raise local concerns, consider a range of evidence, challenge the rationale for decisions and propose alternative solutions as appropriate. It will need to balance different perspectives, such as differences between clinical experts and the public. All views should be considered before finalising recommendations.

5.2 The Committee will not duplicate the role of advocates for individual patients, the role of performance management of the NHS or the role of inspecting the NHS.

5.3 The Committee has no power to make decisions or to require that others act on their proposals. The responsible commissioners must respond within 28

days to recommendations of the Committee and give reasons if they decide not to follow these.

6 Organisations to which Health Scrutiny Applies

6.1 NHS bodies subject to overview and scrutiny include commissioners and any organisation that provides, arranges or performance manages the provision of publicly funded services. The Committee's main focus will be on services commissioned by CCGs, the Local Authority, NHS England and partner agencies.

6.2 The Local Government and Public Involvement in Health Act 2007 introduced "the Councillor Call for Action (CCfA)" which provides elected Ward Members with a formal means to escalate matters of local concern to an Overview and Scrutiny Committee. Although this is seen as a measure of "last resort" it can lead to recommendations being made to the Council concerned and/or other agencies. The CCfA is one of a number of measures designed to provide Overview and Scrutiny Committees with greater powers to work more closely with Partners and across organisational boundaries. It is likely that any CCfA which is concerned with NHS services will be referred to the Committee in the first instance.

6.3 The Council also has a local Petition Scheme which sets out how petitions will be handled. Should either a CCfA or a formal Petition be received which relates to health services, the Secretary of the Committee will liaise in the first instance with the relevant commissioner or service provider, to assist the Chairman and Vice Chairman of the Committee to determine how to proceed.

7 Matters that can be Reviewed and Scrutinised According to Regulations

7.1 Overview and scrutiny powers cover any matter relating to the planning, provision and operation of health services. Health services are as defined in the Health and Social Care Act 2012 and cover health promotion, prevention of ill health and treatment.

7.2 Issues that can be scrutinised include but are not limited to the following (more detail about what commissioners are responsible for can be found in NHS England summary fact sheets on commissioning responsibilities):

- Arrangements made by local NHS bodies to secure hospital and community health services and the services that are provided
- Arrangements made by the Local Authority for public health, health promotion and health improvement including addressing health inequalities.
- Planning of health services by local NHS bodies, including plans made in co-operation with local authorities setting out a strategy for improving both the health of the local population and the provision of health care to that population.
- The arrangements made by local NHS bodies for consulting and involving patients and the public.
- Any matter referred to the committee by a Healthwatch.

- Any appropriate matter raised by a Councillor Call for Action or a Petition.

8 Substantial Developments or Variations in Services

8.1 The responsible commissioner will consult the Committee on any proposals it may have under consideration for any substantial development of the health service or any proposal to make any substantial variation in the provision of such services. The responsible commissioner will give the Committee sufficient notice to make arrangements to consider the proposals and make a formal response.

8.2 This is additional to discussions between the responsible commissioner and the appropriate local authorities on service developments. It is also additional to the NHS duty to consult patients and the public. Guidance indicates that solely focusing on consultation with the Committee would not constitute good practice.

8.3 The Committee has the responsibility to comment on

- Whether as a statutory body the Committee has been properly consulted within the public consultation process
- The adequacy of the consultation undertaken with patients and the public
- Whether the proposal is in the interests of health services in the area

Arrangements relating to responsible commissioners

8.4 As the responsible commissioners lead the commissioning process they will usually be responsible for undertaking formal consultations for services which they commission. Where services are commissioned by more than one body, those bodies may agree a process of joint consultation or delegate one or more of those bodies to act on behalf of all those bodies.

8.5 Where the proposal impacts across the NHS Commissioning Board, local areas teams, and/or Public Health England the relevant CCGs with lead commissioning responsibilities may wish to invite these bodies to coordinate the consultation.

Substantial developments or variations ("SDV's") – explanation

8.6 Substantial developments or variations are not defined. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

- Changes in accessibility of services such as reductions, increases, relocations or withdrawals of service
- Impact on the wider community and other services such as transport and regeneration and economic impact

- Impact on patients – the extent to which groups of patients are affected by a proposed change
- Methods of service delivery – altering the way a service is delivered. The views of patients and Healthwatch are essential in such cases.

8.7 The first stage is for the Committee (acting initially through its Chairman and Vice Chairman) to decide whether or not the proposal is substantial. This initial assessment is conducted at three levels:

Level One

When the proposed change is minor in nature, eg. a change in clinic times, the skill mix of particular teams, or small changes in operational policies.

At level one, the Committee would not become involved directly, but would be notified that the Healthwatch is being consulted.

Level Two

Where the proposed change has moderate impact or consultation has already taken place on a national basis. Examples could include a draft Local Delivery Plan, proposals to rationalise or reconfigure Community Health Teams, or policies that will have a direct impact on service users and carers, such as the "smoke free" policy. Such proposals will involve consultation with patients, carers, staff and the Healthwatch, but will not involve

- Reduction in service
- Change to local access to service
- Large numbers of patients being affected

The Committee will wish to be notified of these proposals at an early stage, but would be unlikely to require them to be dealt with formally as an SDV. A briefing may be required for the full Committee or through the Chairman and Vice Chairman, and the Local Ward Councillors concerned will be informed of the proposal by the Secretary. The Committee will wish to ensure that the Healthwatch and other appropriate Organisations have been notified by the responsible commissioner or service provider concerned.

Level Three

Where the proposal has significant impact and is likely to lead to –

- Reduction or cessation of service
- Relocation of service
- Changes in accessibility criteria
- Local debate and concern

Examples would include a major Review of service delivery, reconfiguration of GP Practices, or the closure of a particular unit.

The Committee will normally regard Level Three proposals as an SDV, and would expect to be notified at as early a stage as possible. In these cases the Committee will advise on the process of consultation, which in accordance with the Government Guidelines would run for a minimum 12 weeks period. The Trust will make it clear when the consultation period is to end. The Local Ward Councillors concerned will be informed of the proposal by the Secretary. The Committee would consider the proposal formally at one of their meetings, in order to comment and to satisfy the requirement for the Overview and Scrutiny Committee to be consulted in these circumstances.

8.8 Officers of the responsible commissioners and service providers will work closely with the Committee during the formal consultation period to help all parties reach agreement.

8.9 The Committee will respond within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

Exemptions

8.10 The Committee will only be consulted on proposals to establish or dissolve a NHS trust or CCG if this represents a substantial development or variation to the provision of health services.

8.11 The Committee does not need to be consulted on proposals for pilot schemes within the meaning of section 4 of the NHS (Primary Care) Act 1997 as these are the subject of separate legislation.

8.12 A responsible commissioner will not have to consult the Committee if it believes that a decision has to be taken immediately because of a risk to the safety or welfare of patients or staff. These circumstances should be exceptional. The Committee will be notified immediately of the decision taken and the reason why no consultation has taken place. The notification will include information about how patients and carers have been informed about the change and what alternative arrangements have been put in place to meet the needs of patients and carers

Report to Secretary of State for Health

8.13 The Committee may report to the Secretary of State (SoS) for Health or, as appropriate, to Monitor for their consideration when it is not satisfied with the consultation or the proposals.

Referral to the Secretary of State may only be made in circumstances where the responsible commissioner and the Committee have attempted, but failed to resolve any disagreements or where the responsible commissioner has failed to attempt to resolve disagreements within a reasonable period of time. Likewise, referrals should not be made if the Committee has failed to respond to consultations by the date provided by the NHS Body.

8.14 Specific areas of challenge include:

- The content of the consultation or that insufficient time has been allowed;
- The reasons given for not carrying out consultation are inadequate; or
- Where the Committee considers that the proposal is not in the interests of the health service in its area.

NB 'inadequate consultation' in the context of referral to the SoS means only consultation with the Committee, not consultation with patients and the public.

8.15 In response to a referral the SoS may:

- Require the local responsible commissioner to carry out further consultation with the Committee.
- Make a final decision on the proposal and require the responsible commissioner to carry out the decision.
- Ask the Independent Review Panel to advise him/her on the matter.

9 Developing a Programme of Reviews

9.1 The Committee will produce an annual overview and scrutiny plan in consultation with the Commissioners and the Healthwatch.

9.2 The plan will consider the range of health services including those provided by the local authority and partnership arrangements with the NHS.

9.3 The plan will be based on the views and priorities of local people.

9.4 The plan will have the capacity to take into account issues that may be raised through the work of Healthwatch.

9.5 The plan will be realistic, based on the capacity of the Committee and the Committee's partners to undertake meaningful reviews.

9.6 The following factors should be taken into account when planning a programme:

- It is a local priority that can make a difference.
- The topic is timely, relevant and not under review elsewhere.
- If the topic has been subject to a national review it should be clear how further local scrutiny can make a difference.
- There is likely to be a balance between;
  - Health improvement and health services,
  - NHS and joint services,
  - Acute services and primary/ community services.
- It may be thematic, e.g. public health, homelessness or services for older people that might impact on the health of local people, or a service oriented priority.

- It should contribute to policy development on matters affecting the health and well being of communities.

9.7 There are a number of methods for scrutiny, including formal reports to the Committee or Reviews conducted by smaller "Task and Finish" Review Panels appointed by the Committee with specific terms of reference.

Sections 10 to 14 apply to both consultation on substantial developments or variations and reviews or scrutiny.

10 Provision of Information

10.1 The responsible commissioner will provide the Committee with such information about the planning, provision and operation of health services as it may reasonably require in order to discharge its health scrutiny functions. Reasonable notice of requests for information or reports will be given.

10.2 Confidential information that relates to and identifies an individual or information that is prohibited by any enactment will not be provided.

10.3 Information relating to an individual can be disclosed, provided the individual or their advocate instigates and agrees to the disclosure.

10.4 The local authority may require the person holding information to anonymise it in order for it to be disclosed. The Committee must be able to explain why this information is necessary.

10.5 The responsible commissioners will provide regular briefings for Committee Members on key issues.

10.6 In the case of a refusal to provide information that is not prohibited by regulation, the Committee may contact the relevant NHS performance management organisation, which should attempt to negotiate a speedy resolution.

11 Attendance at Meetings

11.1 The Committee may require any officer of the responsible commissioners to attend meetings to answer questions on the review or scrutiny.

11.2 Requests for attendance will be made through the Chief Executive body concerned.

11.3 The Committee will give reasonable notice of its request and the date of attendance. The Committee will provide the officer with a briefing on the areas about which they require information no later than one week prior to the attendance.

11.4 If the scrutiny process needs to consider health care provided by the independent sector on behalf of the NHS, it will consider the issue through

the lead commissioning body. The NHS will build into its contracts with independent sector providers a requirement to attend a review or scrutiny or provide information at no cost to the Committee.

11.5 The Chairman or Directors of the responsible commissioners cannot be required to attend before the Committee. They may, however, wish to do so if requested.

11.6 Local independent practitioners such as GPs, dentists, pharmacists and opticians may be willing to attend the Committee but cannot be required to do so. Local independent practitioners may be willing to attend at the request of the responsible commissioners. An alternative source of information may be the Local Medical Committee or appropriate professional organisations.

12 Reporting

12.1 In their reports the Committee will include:

- An explanation of the issues addressed
- A summary of the information considered
- A list of participants involved in the review or scrutiny
- Any recommendations on the matters considered
- Evidence on which the recommendations are based.
- Where appropriate, recognition of the achievements of the responsible commissioners/providers concerned.

12.2 The Committee will send draft reports to the responsible commissioners and other bodies that have been the subject of review to check for factual accuracy.

12.3 The report is made on behalf of the Committee and there is no requirement for the Cabinet or the full Council to endorse it. However the report will be sent to the Cabinet, Health and Wellbeing Board and full Council and, if required, a briefing will be arranged to identify the main implications.

12.4 If the Committee request a response from the responsible commissioners/providers this will be provided within 28 days. If a comprehensive response cannot be provided in this time, the Body(s) concerned will negotiate with the Committee to provide an interim report, which will include details of when the final report will be produced.

12.5 The response will include:

- The views on the recommendations
- Proposed action in response to the recommendations
- Reasons for decisions not to implement recommendations

12.6 Copies of the final report and the response will be widely circulated and made publicly available.

13 Conflict of Interest

13.1 The Committee must take steps to avoid any potential conflicts of interest arising from Members' involvement in the bodies or decisions they are scrutinising.

13.2 Conflict of interest may arise if councillors or their close relatives are:

- An employee of an NHS body, or
- A non-executive director of an NHS body, or
- An executive member of another local authority
- An employee or board member of an organisation commissioned by an NHS body to provide goods or services.

13.2 These councillors are not excluded from membership of overview and scrutiny committees but must follow the Council's Code of Conduct for Members regarding participation and as necessary seek advice from the Monitoring Officer of the Council where there is a risk of conflict of interest.

13.3 Executive (Cabinet) Members and Cabinet Assistant Members of Cheshire East Council are excluded from serving on the Committee in any capacity.

14 Liaison between the Committee and Healthwatch

14.1 The Committee will develop an appropriate working relationship with Cheshire East Healthwatch.

- Healthwatch may refer issues to the Committee, which must take these into account. If issues are not urgent they may be considered when planning future work programmes.
- The Committee will, where appropriate, advise Healthwatch of actions taken and the rationale for these actions.
- The outline and process of a scrutiny review will be discussed with members of Healthwatch.

15 Conclusion

15.1 This Protocol was considered and adopted by the Committee on (date) and is endorsed by the responsible commissioners.

CHESHIRE EAST COUNCIL

Health and Wellbeing Scrutiny Committee

Date of Meeting:	Thursday 13 February 2014
Report of:	Head of Governance and Democratic Services
Subject/Title:	Cheshire/Wirral/Merseyside – Joint Scrutiny Arrangements

1.0 Report Summary

1.1 The purpose of this report is to seek the committee's views on proposals to set up a protocol for joint scrutiny arrangements across Cheshire, Wirral and Merseyside authorities to deal with formal consultations regarding Substantial Developments or Variations (SDVs) that affect more than one local authority.

2.0 Recommendation

2.1 That the views of the Committee on the draft joint scrutiny protocol be referred to the Constitution Committee for consideration.

3.0 Reasons for Recommendations

3.1 The Constitution committee is responsible for recommending changes to the Constitution to Full Council.

4.0 Wards Affected

4.1 All.

5.0 Local Ward Members

5.1 Not applicable.

6.0 Policy Implications

6.1 Not applicable at this stage.

7.0 Financial Implications

7.1 None for the local authority.

8.0 Legal Implications

8.1 The Health and Social Care Act 2012 has introduced new arrangements requiring joint scrutiny committees to be established whenever proposals made by NHS bodies are deemed to be substantial developments or variation in service, by more than one local authority.

9.0 Risk Management

9.1 There are no identifiable risks

10.0 Background

10.1 The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations introduced new arrangements to require a joint scrutiny committee to be established for the purposes of considering consultations by a relevant NHS body or provider of NHS funded Services where such proposals impact on more than one local authority area and where more than one authority agrees that the proposal is an SDV.

10.2 In anticipation of substantial changes in the provision of cancer services at the Clatterbridge centre in Wirral, Knowsley Borough Council, as lead authority on behalf of the Merseyside authorities has developed a draft protocol (attached) which proposes a framework for the operation of joint scrutiny across Cheshire/Merseyside/Wirral. The protocol will initially be utilised for the purposes of setting up a joint committee in relation to the anticipated Clatterbridge consultation and also for any subsequent consultations regarding SDVs.

10.3 Cheshire, Wirral and Merseyside authorities have been invited to consider and adopt the protocol in order for it to be in place before the formal consultation regarding the Clatterbridge centre begins in June 2014. This committee will, as part of the formal Clatterbridge consultation, be asked to consider whether the proposals are considered to be an SDV insofar as Cheshire East is concerned. A map of the Cheshire CCG and local authority areas is attached together with a map showing North of England Area teams for NHS England.

10.4 The protocol puts in place arrangements to formally convene a joint health overview and scrutiny committee to be made up of each of the constituent local authorities that deem a proposal to be an SDV.
In dealing with substantial development/variations, the joint health overview and scrutiny committee can:

- make comments on the subject proposal
- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations
- report to the Secretary of State in writing where it:

- is not satisfied that consultation with the relevant health scrutiny arrangements on any proposal has been adequate
- is not satisfied that reasons for an 'emergency' decision that removes the need for formal consultation with health scrutiny are adequate
- does not consider that the proposal would be in the interests of the health service in its area

10.5 In practical terms, when a consultation is received by a local authority, each local Health Scrutiny Committee will need to determine whether the proposal is considered to be an SDV in its own area, (this Council has a separate protocol which provides guidance on SDVs). If it does consider the matter to be an SDV and at least one other authority also does, then a joint committee has to be established. If the authority does not consider it to be an SDV, then the authority will not be involved in the formal consultation. Once a joint committee has been established, only the joint committee may formally respond to the consultation.

10.6 The membership of the joint committee is not fixed and will be determined on each occasion depending on the number of participating authorities. Each authority will be required to submit nominations that reflect its own political balance. The numbers of nominations per authority will depend upon the number of participating authorities. Nominated substitutes will also be permitted. For this reason, the make up of the committee is likely to change on each occasion and the protocol provides some theoretical examples to illustrate how this would work.

10.7 The existence of joint health overview and scrutiny committee is time-limited to the course of the specified consultation and it may not otherwise carry out any other activity.

10.8 The draft protocol also sets out a framework for the operation of joint scrutiny activity which may be carried out on a discretionary basis into then planning, provision and operation of the health service.

10.9 The draft protocol proposes 2 options on political balance:

Option 1
The joint committee is made up of Councillors to reflect the political balance of each of the constituent local authorities.

Option 2
The joint committee is made up of Councillors to reflect the political balance of each individual authority and efforts will be made to ensure the joint committee is proportionately representative of the populations of the local authorities participating in the arrangement.

10.10 It is clear that option 1 is the simplest and most straightforward to administer and the informal view of the Chairman of this committee and Portfolio holder is that the Council should support option 1.

11.0 Approval procedure

11.1 As the adoption of the protocol will necessitate changes to the constitution, the protocol will be subject to consideration by the Constitution committee on 20 March 2014 prior to it being submitted to Council in April 2014.

11.0 Access to Information

The background papers relating to this report can be inspected by contacting the presenting officer:

Name: Mark Nedderman
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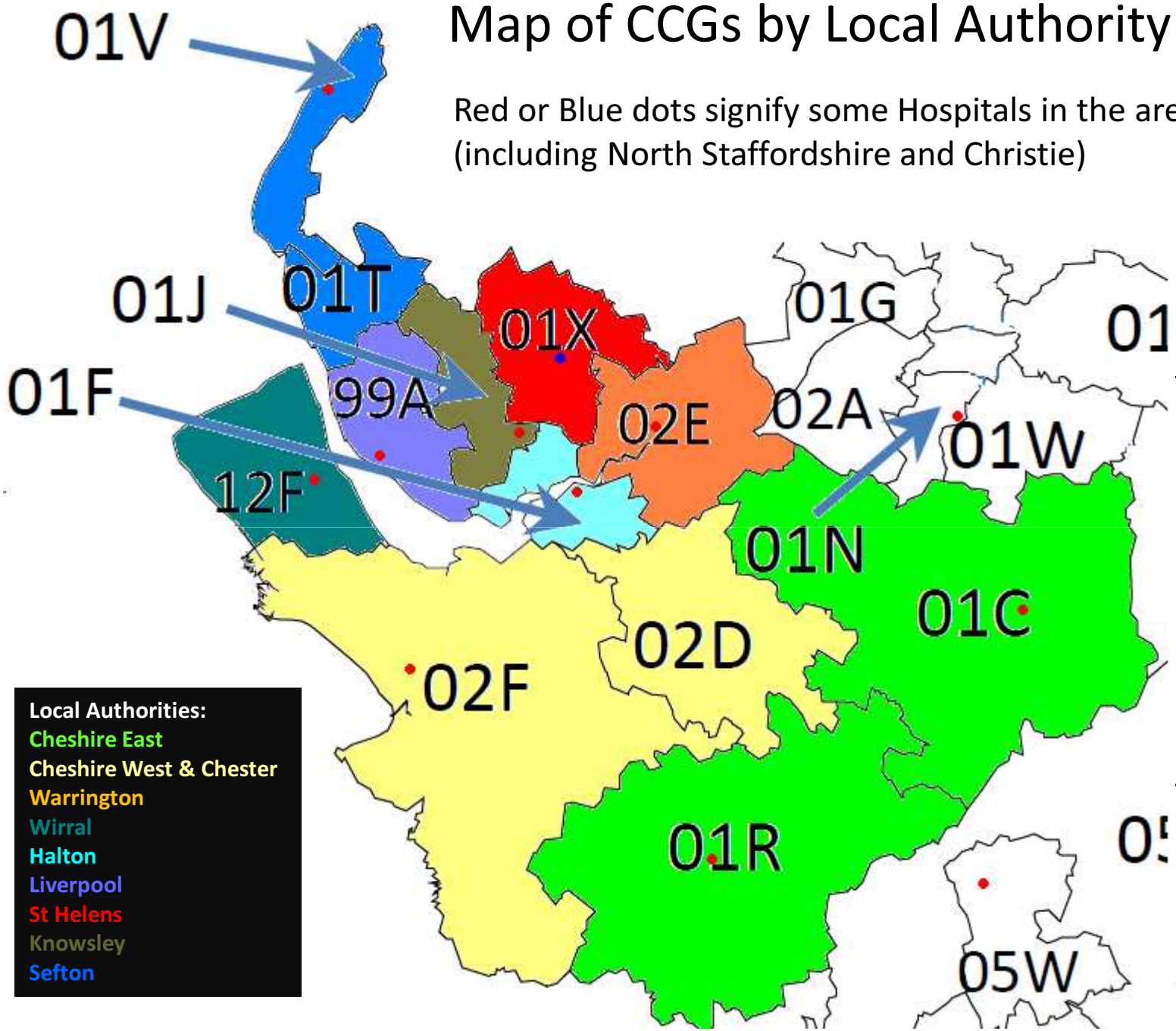
NHS England
North of England Area Teams

Map of CCGs by Local Authority

Red or Blue dots signify some Hospitals in the area
(including North Staffordshire and Christie)



Local Authorities:
Cheshire East
Cheshire West & Chester
Warrington
Wirral
Halton
Liverpool
St Helens
Knowsley
Sefton

CCGs:
01R – South Cheshire
01C – Eastern Cheshire
02D - Vale Royal
02F – West Cheshire
02E – Warrington
01F – Halton
01X – St Helens
01J – Knowsley
99A – Liverpool
01T – South Sefton
01V – Southport and Formby

Other CCGs:
01N – South Manchester
01W – Stockport
02A – Trafford
05W – Stoke on Trent
05V – Stafford and Surrounds

Transforming Cancer Care Update Jan 2014

Introduction

An independent review of cancer care across the region (the Baker Cannon Report 2008) commissioned by the Merseyside and Cheshire Cancer Network (MCCN) developed a series of recommendations to ensure that cancer services were delivered in the best way to improve outcomes for patients across the region.

Following the review PCTs in Cheshire and Merseyside supported:

- The establishment of six additional Consultant Oncology posts across the region, seven new nurse specialist appointments and two tumour specialist Cancer nurses at The Clatterbridge Cancer Centre (CCC)
- The enhancement of clinical services at The Clatterbridge Cancer Centre to improve care for acutely ill patients
- The opening of a CCC satellite radiotherapy unit on the Aintree Hospital site
- Appointment of a Chair in Medical Oncology by the University of Liverpool
- Opening of a CRUK research centre in Liverpool adjacent to the Royal Liverpool Hospital (RLBUHT) site

The report also concluded that big benefits could be gained for patients and their families by expanding the services provided by The Clatterbridge Cancer Centre.

The proposal

The proposal would see Clatterbridge Cancer Centre services expanded with the building of a new cancer centre for Cheshire and Merseyside next to the new Royal Liverpool University Hospital.

Inpatient services will move from Wirral to the Liverpool site and additional outpatient services will also be provided.

Only those Wirral based patients, who need more complex treatment, or an overnight hospital stay, will need to travel to the new centre in Liverpool, as outpatient radiotherapy, chemotherapy and proton therapy services for the more common cancers – such as breast or prostate – **will continue to be provided at the Wirral site.**

The benefits

The new centre in Liverpool means that for the first time Cheshire and Merseyside Cancer patients will have access to expert clinical services, surgery, in-patient care, radiotherapy, chemotherapy, critical care, outpatient clinics and enhanced research and development with clinical trials all on one site.

Developing a new Clatterbridge Cancer Centre on a thriving biomedical campus, alongside the new Royal Liverpool Hospital and Liverpool University is a once in a generation opportunity to make cancer services in this region the very best than can possibly be.

Being co-located with the Royal Liverpool Hospital and the University of Liverpool will allow The Clatterbridge Cancer Centre to:

- Have physical links to an acute teaching hospital where patients can have rapid access to critical care services when they are required.
- Develop its research programme further, giving patients access to a broader portfolio of clinical trials and leading edge treatments as soon as they are developed.
- Be located at the centre of the population we serve. Around 70% of our patients currently travel to the Wirral site from north of the River Mersey.

How cancer affects our region

- More than 5,500 people die each year from cancer in Cheshire and Merseyside.
- The burden of cancer for people in Merseyside and Cheshire is greater than anywhere else in England.
- Our mortality rate from all cancer is 20% higher than England as a whole – the worst in the country.
- The number of new cancer cases in the region is higher than the national average and expected to rise significantly in the next few years.
- New cases of lung cancer in Merseyside and Cheshire are 15% higher than the national average for men and 23% higher for women.

Progress achieved to date

All Primary Care Trusts (PCTs) in the Merseyside and Cheshire Cancer Network received and approved two papers relating to non-surgical oncology services and The Clatterbridge Cancer Centre.

The first paper (March/April 2008) sought PCT boards' support for an expansion of radiotherapy services through the development of two satellite services: one adjacent to the Walton Centre and one adjacent to the Royal Liverpool University Hospital.

The second paper (June/July 2009) presented the recommendations from the Baker Cannon report. That paper noted that expansion of CCC into Liverpool, whilst desirable, would take several years to plan and deliver, and so a series of interim measures were proposed which included endorsing Liverpool PCT to lead on the procurement of radiotherapy facilities on the Royal Liverpool site through an open competitive tender.

Work to take forward the procurement of satellite radiotherapy facilities at the Royal Liverpool

Hospital site was initiated and involved detailed analyses of clinical models of care, informed by a number of clinical experts from both within the network across England.

Following detailed consideration the cancer network and the radiotherapy procurement team led by Liverpool PCT agreed that the benefits to patients that could be derived from a satellite facility at the Royal would be outweighed by the cost of delivery and confirmed that a larger-scale relocation of CCC, as per the central recommendation of the Baker Cannon report and within an earlier timescale, would offer greater benefits to all patients Cheshire and Merseyside and would represent greater value for money.

Liverpool PCT and the Cancer Network agreed the need to support the development of proposals for the establishment of a new Clatterbridge Cancer Centre on the Royal Liverpool Hospital site in tandem with plans to rebuild the new Royal Liverpool Hospital.

A high level affordability study was undertaken to review the cost and affordability of building a new comprehensive Cancer Centre co-located with a redeveloped Royal Liverpool hospital.

Following this study senior colleagues from CCC, RLBUHT, the University of Liverpool and the Cancer Network worked together to produce a strong, collective agreement on a joint vision for the future provision of Cancer Services:

*"**The creation of a World Class Comprehensive Cancer Centre, co-located on the new RLBUH site for the Merseyside and Cheshire Network, which brings together in partnership for the first time specialist NHS cancer services with the University of Liverpool and other research partners on a single acute campus."***

At this point the total cost of proposals had been estimated at £94.5m.

At the September 2011 meeting the NHS Merseyside Board approved funding to meet the project costs to deliver an Outline Business Case and one-off investment of up to £20m for the new Centre.

In addition further on-going revenue support of £6.5m will be required from 2012/13 onwards to enable the scheme to proceed.

Given the significant benefits that would accrue to Merseyside residents of the proposals, and the high levels of cancer morbidity and mortality in Merseyside, it was proposed that the NHS Merseyside Cluster included, in the Cluster's Commissioning Intentions for 2012/13 onwards, the requirement for an additional £6.5m.

This intention was confirmed by the NHS Merseyside Cluster Board at the March 2012 meeting when the Commissioning Plan was approved.

Transforming Cancer Care

CCC has continued to develop the proposal to build a new centre, next to the redeveloped Royal Liverpool Hospital and the University of Liverpool.

The development of the Strategic Outline Case completed in March 2012 followed the support

given by The Merseyside and Chester, Warrington & Wirral PCT Clusters to this investment.

The current project timescale is as follows:

- Outline Business case approved by Q3 2014
- Contractor appointed by Q2 2014
- Full business case approved by Q2 2016
- Construction work starts Q2 2016
- New hospital opens Q3 2018
- Work complete on Wirral site Q3 2019

Work has included a programme of public engagement to share the real and continuing benefits for patients that these plans are designed to bring with a wide range of stakeholders. This has ensured that people are informed about the reasons for the proposed changes and that they have an opportunity to comment on and influence these plans.

Getting public feedback

We need to get the views of patients, families and the wider public if we are to develop services that fully meet their needs.

We wanted to know what the public think about our proposals so we used a variety of different ways to give people the opportunity to share their views with us.
From August 2012 to March 2013 members of the public attended events, completed an online survey or visited our customised 'Action on Cancer Trailer' which we took to busy shopping centres across Cheshire and Merseyside for 38, three day roadshow events.

Voting boxes were also placed in hospitals and a variety of community venues, cancer support groups and charities across both regions.

Our staff spoke to members of the public about the proposals, distributed information leaflets and showed a short DVD before asking people:

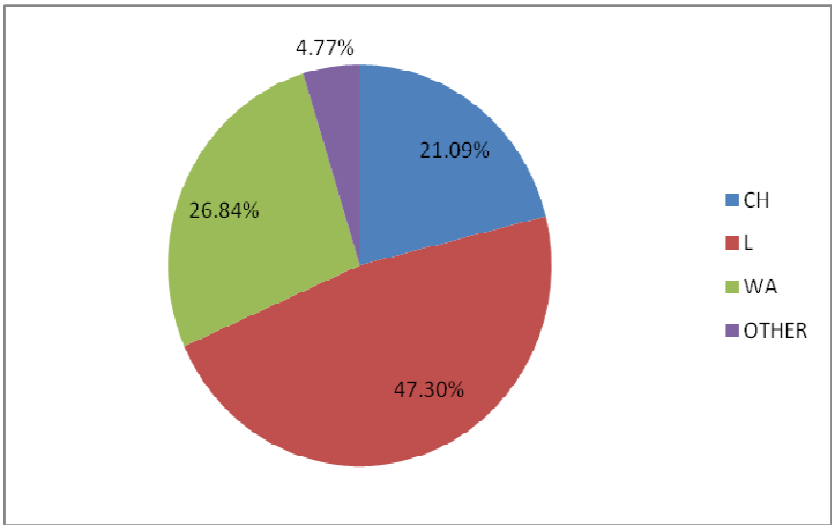
'Having heard about the proposals do you think they are a good idea?'

Who responded?

We reached approximately 90,000 people; with 14,000 people accessing the Action on Cancer trailer and a total of 4,164 responses returned.

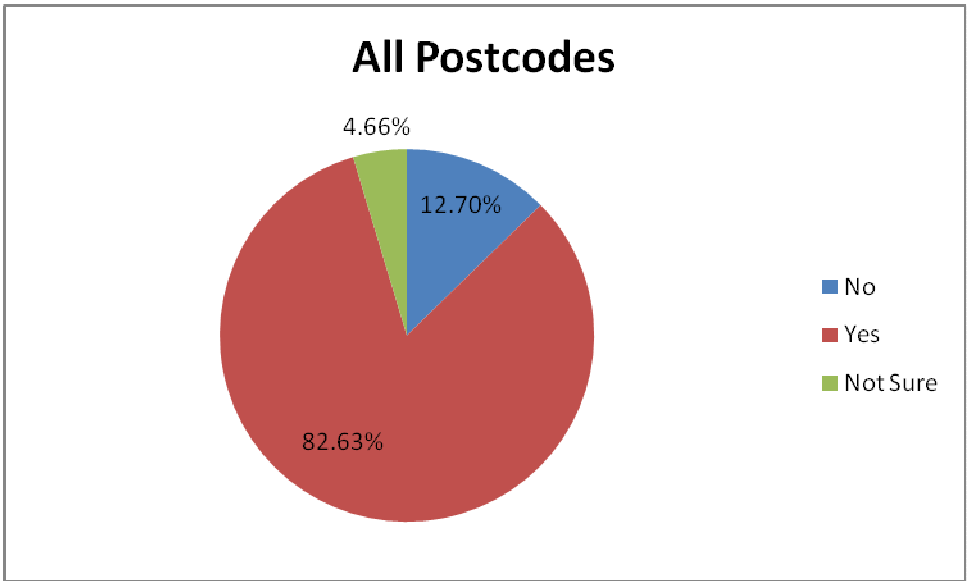
96 visits were made to 53 unique groups across Cheshire and Merseyside to speak to patients and members of the public.

Analysis of the questionnaires returned showed that respondents came from the following postcode areas:

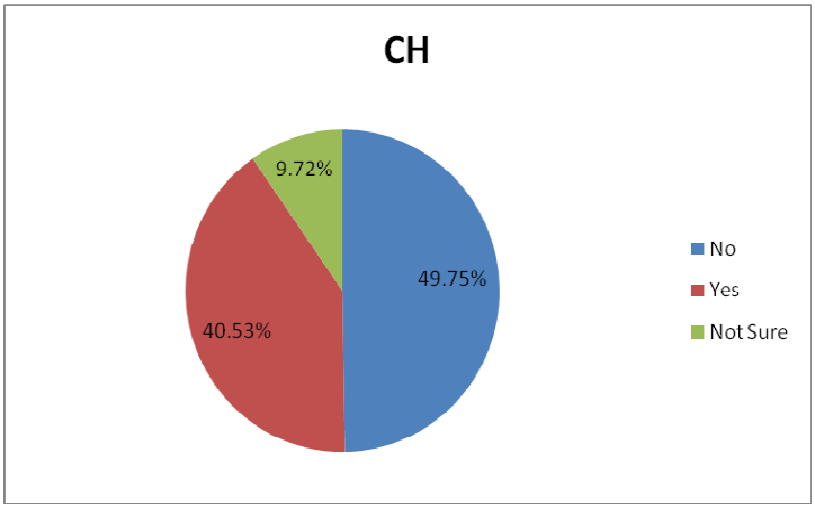


What they told us

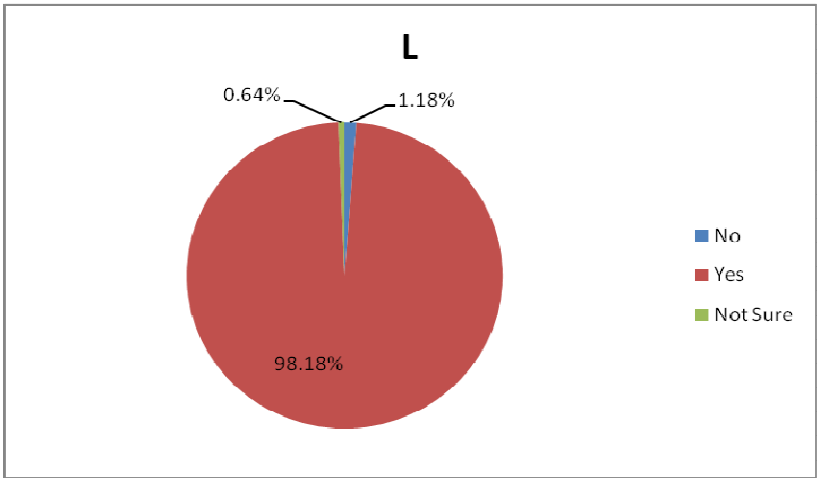
'Having heard about the proposals do you think they are a good idea?'



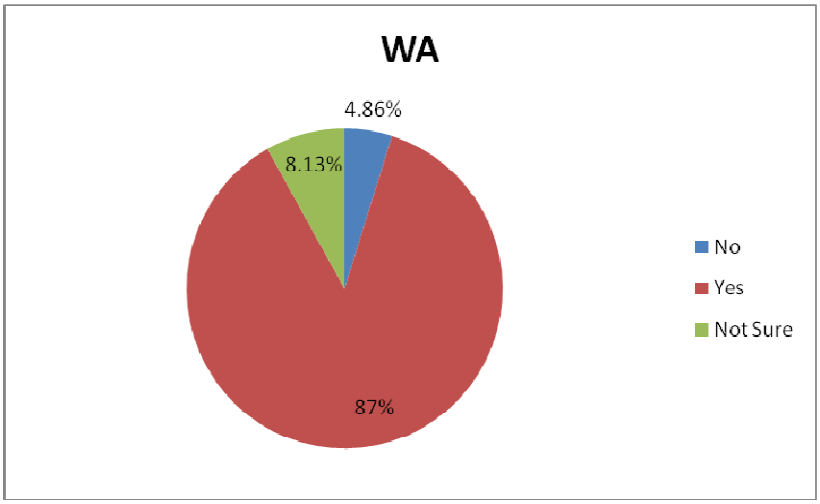
Responses broken down by Postcode Area



CH –includes Wirral, Flintshire, Cheshire West and Chester



L – includes Liverpool, Sefton (including PR8 and PR9 postcodes) and Knowsley



WA – Warrington, Widnes, Runcorn and St Helens

Main themes

The emerging themes identified were:

- Travel
- Accessibility
- Cost
- Good Current Services
- Ill health
- Loss of Services

Travel

Travel is a key emerging theme. The majority of comments relating to travel came from respondents in support of the proposals and reflect the opinion that the existing Cancer Centre is 'too far' from where they live and the new centre will be beneficial in terms of distance, time and money saved.

"My family have been affected by cancer and the travel to Clatterbridge took a lot out of them when they were unwell. It was too far."

Costs, parking and tunnel were also key words mentioned by South Mersey residents many of whom stated that they were happy with the current service provision at The Clatterbridge Cancer Centre.

Accessibility

The accessibility theme covers issues of transport and travel and also includes references to the availability of public and private transport, parking and congestion.

Those respondents in support of the plans felt that accessibility would be improved because of the transport infrastructure in Liverpool.

"I live in Wallasey but I am sure it would be easier for me to use public transport to get to Liverpool rather than Clatterbridge."

In general, those people who don't think the proposals are a good idea felt that the new centre would reduce accessibility for them. They consider The Clatterbridge Cancer Centre Wirral to be accessible as it is close to the motorway and that Liverpool would be inaccessible due to parking and congestion.

"Clatterbridge should stay as main hospital. It has the space for development. The Royal is congested by area and accessibility."

Cost

The majority of the cost references were in respect of the additional costs of travel, such as parking, taxis and tunnel fares.

"A lot of cancer patients are quite elderly and cannot travel to Clatterbridge and cannot afford taxis."

Comments on cost were balanced by Liverpool postcode residents who considered it to be positive as they would save money on tunnel fares. 'Yes' voters believed that a better transport infrastructure would reduce the amount of taxi journeys required to the new site.

Good Current Health Services

Respondents acknowledged the benefits of the re-location and the establishment of a new cancer centre, linked to state of the art research and treatment facilities and the development of a world class health campus.

Many respondents also spoke of excellent services and a preference to keep services in Clatterbridge.

"No problems with CCC so why change?"

Ill Health

Respondents who have had personal experience of cancer treatment reported on the difficulties of travelling when feeling unwell.

"A new centre will provide easier access for patients at a time when they would prefer to be nearer to home. Travelling can be stressful especially when someone is ill."

Loss of Services

The loss of services was a concern for a particular minority of voters. In some cases people felt that

the proposals might lead to the ultimate closure of services and loss of jobs at Clatterbridge.

"Provided the service currently available at the existing Clatterbridge site is not diminished in any way then the new proposal is an excellent idea otherwise not so."

Next steps

We want to make sure that everyone in Cheshire and Merseyside can access the right cancer services, at the right time and in the right place.

We plan to launch a formal twelve week consultation period in Summer 2014 which will enable us to explore the main themes identified in the pre consultation engagement work in more detail.

We anticipate making a formal request to form a Joint Overview and Scrutiny Committee to be held in June 2014 to explore your views and take advice before we seek approval to proceed with a formal public consultation.

This feedback will then be used as we develop our Outline Business Case which we anticipate will be completed in the Autumn of 2014.

In the meantime if you would like us to attend a forthcoming meeting to provide an update on the project and present the findings of engagement work so far please Transforming Cancer Care Project office on 0151 552 1823.

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CHESHIRE & MERSEYSIDE
Commissioning Policy

CRITERIA

Version	Date	Author	Status	Comments
1.0	23.01.11	CISSU, Champs & Cheshire and Mersey PCTs	Review date 2012	This policy superseded all individual PCT
Draft version 1.2	Oct 2013	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Draft Policy following review of evidence. Supporting documentation produced outlining changes and impact
Draft Version 1.3	19th Dec 13	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Botox section added (19.1) Duplicates numbers 18.8 same as 18.14 & 18.9 same as 18.15 removed Childlessness definition amended in Infertility policy.
Draft Version 1.4	6th Jan 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Minor wording changes made following legal advise

Introduction

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

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

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

The NHS standard contract specifies that the Co-ordinating Commissioner will agree with the Provider the circumstances where the Provider will need to seek prior approval (PA) to confirm the appropriateness of a proposed intervention or course of treatment. It is expected that such schemes focus on procedures of limited/low clinical effectiveness, or infrequent high cost and/or complex procedures. In designing and implementing PA schemes, individual patient needs must remain paramount. (Reference Guidance on the Standard NHS contract for Acute Hospital Services, community and Mental Health & Learning Disabilities.

Ideally the Co-ordinating Commissioner will agree a single set of PA requirements with which each Provider is expected to comply. However, there may be exceptional circumstances in which an Associate CCG needs to specify its own PA requirements. Agreeing a Cheshire and Merseyside Prior Approval Policy will improve equity of access to services, value for money and clinical effectiveness across the network.

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

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

Core Clinical Eligibility

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

- All NICE Technology Appraisals will be implemented.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. Leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- Any patient who needs urgent treatment will always be treated.
- No treatment is completely ruled out if an individual patient's circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patients responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.
- Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

Referral and Approval Process

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

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

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

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

- Have been prior approved by the CCG.
  OR
- Clearly state how the patient meets the criteria.
  OR
- Be for a clinical opinion to obtain further information to assess the patient's eligibility.

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

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

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

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

Exceptionality

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

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

Further details on exceptionality can be found at this link:

http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20managing%20individual%20funding%20requests.pdf

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

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

Psychological Distress

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

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

Personal Data (including Photographs)

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently

disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

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

- Clearly label the envelope to a named individual i.e. first name & surname, and job title.
- Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.
- Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Medicines Management

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

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

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

NOTE: For all cancer drugs (haematology and oncology) a revised process and prioritised list has been developed.

In 3rd quarter of each year, specialists will be asked to nominate drugs which they would like to be considered within the prioritisation process. The Northwest Cancer Prioritisation Steering group (attended by representatives from the three cancer networks, specialised commissioning and CCG representatives) co-ordinate the requests and create a single list. This list is reviewed and scored at two prioritisation meetings which are held across the region. Prioritisation will be

completed in the 4th quarter of each year prior to being submitted to the commissioning process, with recommendations rated as red (not for routine IFRs or funding), amber (IFRs may be submitted in certain circumstances or green (for routine funding). Any drug requested outside of this prioritisation process will not routinely be funded by any CCG in-year.

Conditions & Interventions

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

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

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

For the purposes of engagement process only, this policy includes under the comments the following key to assist readers in understanding the proposed change.

Key	Description
Red	Important change
Amber	Criteria changes.
Green	Minor word or no changes made.
New Statement	New -Important change
New Statement	New – Moderate Change
New Statement	New - No Significant Impact

]

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
1.	***Bariatric***			
1.1	Bariatric Surgery for Weight Management.	Please see local policies and pathways for criteria.	IPG432: Laparoscopic gastric plication for the treatment of severe obesity NICE (2012). Treatment of Obesity The Cochrane Library (2012). Surgery for obesity – Cochrane Metabolic and Endocrine Disorders Group (2009). Commissioning Guide: Weight Assessment and Management Clinics Royal College of Surgeons (2013).	All CCG local primary care pathways differ. After completion of local pathway patients will be referred for surgery if appropriate without needing prior approval. Surgery is then commissioned by NHS England at designated providers and sits outside of this policy. In exceptional circumstances where it is thought the usual process should not be followed an IFR request should be made to NHS England. In the case of revisional bariatric surgery beyond the usual follow-up period this should be discussed with the IFR team.

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
2.	***Complementary Therapies***			
2.1	Complementary Therapies including Homeopathy	Not routinely commissioned unless recommended by NICE guidance.	***Complementary and alternative medicine*** – NHS Choices 2012.	
3.	***Dermatology***			
3.1	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: Severe scarring following: • acne once the active disease is controlled. • chicken pox. Or • trauma (including post-surgical). Procedures will only be performed on the head and neck area..	Modernisation Agency's Action on Plastic Surgery 2005. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. www.evidence.nhs.uk	
3.2	Surgical or Laser Therapy treatments for Minor Skin Lesions.	Will be commissioned in any of the following circumstances: • Symptomatic e.g. ongoing pain or functional impairment.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the	Uncomplicated benign skin

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
	E.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, corn/callous dermatofibromas, comedones, molluscum contagiosum chalazion	• Risk of infection. • Significant facial disfigurement. • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins.	existing evidence-base - London Health Observatory 2010. Modernisation Agency's Action on Plastic Surgery 2005. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	lesions should NOT be referred. Send suspected malignancy on appropriate pathway. Consider if benefit out weighs risk associated with surgery. Consider Primary Care or community service.
	Surgical treatment for removal of Lipoma in Secondary Care..	Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position. Lipomas that are under 5cms should be observed only unless the above applies.	Noninvasive lipoma size reduction using high-intensity focused ultrasound – Dermatologic Surgery 2013 Oct;39(10):1446-51.	Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which have also shown rapid growth and are painful should be referred to an appropriate skin cancer clinic. There is argument to remove lipomas when they are smaller as this is easier and could be done in a community setting.
3.3 NEW	Treatments for Hypo-pigmentation	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red	No guidance found. http://www.changingfaces.org.uk/Skin-Camouflage	Initially the recommended NHS suitable treatment for hypo –

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
		Cross		pigmentation is biopsy of suspicious lesions only. Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage.
3.4	Surgical Laser therapy for Viral Warts (excluding Genital Warts) from secondary care providers.	Will be commissioned in any of the following circumstances: • Severe Pain substantially interfering with functional abilities. • Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. Or • Extensive warts (particularly in the immune-suppressed patient). • Facial warts. Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae	Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care
4	***Diabetes***			
4.1 NEW	Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus.	Evidence to support the use of Continuous Glucose Monitors (CGM) is limited. CGM will not be routinely commissioned.	Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012. Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials.	There is some evidence that CGM may be beneficial for a narrow group of young children on insulin pump therapy who despite optimal conventional monitoring are difficult to control and experience severe hypoglycaemic

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			– European Journal of Endocrinology. 2012 Apr; 166(4):567-74. Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805. Continuous Glucose Monitoring for Patients with Diabetes – Ontario: Health Quality Ontario, 2011. Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British Society for Paediatric Endocrinology and Diabetes, 2009.	episodes, that they do not have awareness of and severely interfere with daily routines and activities. The situation is less clear in adults. There is on-going public health review in this area.

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
5	***ENT***			
5.1 NEW	Adenoidectomy	Commissioned only in either of the following clinical situations. In Children For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy. In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. Adenoidectomy is not commissioned as an isolated procedure.	Tonsillectomy and Adenoidectomy in Children with Sleep Related Breathing Disorders – The Royal College of Anaesthetists - July 2010. Adenoidectomy for recurrent or chronic nasal symptoms in children The Cochrane Library 2010. Adenoidectomy for otitis media in children The Cochrane Library 2010. Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract) Centre for Reviews and Dissemination 2013. NICE "Do not do" recommendation: "Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms."	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
5.2	Pinnaplasty – for Correction of Prominent Ears	May be commissioned in the following circumstances: • The patient should be between 5 and 19 years of age. • Patient assessed by plastic or ENT surgeon who has the option to refer, when appropriate to a specialist paediatric psychologist. If there is evidence of psychological distress likely to be alleviated by surgery, prior approval is not required . Incisionless otoplasty is not commissioned.	Pinnaplasty Department of Health (2007). Local PCT consensus - review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. IPG 422: Incisionless otoplasty NICE 2012. Commissioning Guide: Pinnaplasty Royal College of Surgeons (2013).	Children under the age of five are usually oblivious and referrals may reflect concerns expressed by the parents rather than the child. Ear prominence is very common and can lead to low self-esteem, bullying and significant psychological morbidity particularly in childhood and adolescence.

5.3	Insertion of grommets for Glue Ear (Otitis media with effusion)	The CCG will commission treatment with grommets / Myringotomy for children with otitis media with effusion (OME) where: There is also a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year. Or There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon). AND • OME persists after three months AND • the child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse confirmed over 3 months. OR Persistent bilateral OME with hearing loss Less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child's developmental, social or educational status. Children with Downs Syndrome are normally fitted with Hearing Aids. Management of children with cleft palate is under specialist supervision. Do Not perform adenoidectomy at the same time unless evidence of significane upper respiratory tract symptoms see Section 5.1 Adenoidectomy.	Commissioning Guide: Otitis Media with Effusion Royal College of Surgeons (2013). NICE Pathway – Surgical management of Otitis Media with effusion in children (2012). CG60 Surgical management of children with otitis media with effusion (OME) (February 2008). The advice in the NICE guideline covers: •the surgical management of OME in children younger than 12 years. •guidance for managing OME in children with Down's syndrome and in children with all types of cleft palate. It does not specifically look at the management of OME in: •children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease). •children with multiple complex needs. *Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children* - Cochrane Ear, Nose and Throat Disorders Group 2010. http://pathways.nice.org.uk/pathways/surgical-management-of-otitis-media-with-effusion-in-children - path=view%3A/pathways/surgical-management-of-otitis-media-with-effusion-in-children/assessment-and-treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions	

5.4	Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) adults and children	Sore throats are due to acute tonsillitis. The episodes of sore throat are disabling and prevent normal function. 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	Scottish intercollegiate guidelines network. Management of sore throat and indications for tonsillectomy (April 2010) Guideline 117. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis - Cochrane Ear, Nose and Throat Disorders Group (2008). Evidence note 23: Tonsillectomy for recurrent bacterial tonsillitis – Health Improvement Scotland (2008). Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009. Commissioning Guide: Tonsillectomy Royal College of Surgeons guidance.	Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats. .
5.5	Surgical Remodelling of External Ear Lobe.	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

5.6 NEW	Use of Sinus X-ray	X-rays of sinuses are not routinely commissioned.	BSACI guidelines for the management of rhinosinusitis and nasal polyposis Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007. NHS Choices Sinusitis Commissioning Guide: Rhinosinusitis Royal College of Surgeons (2013).	
5.7	Rhinoplasty - Surgery to Reshape the Nose.	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate.		Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment.
5.8 NEW	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Nuances in the management of rhinophyma Facial Plastic Surgery, 2012 Apr;28(2):231-7. http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm Information for Commissioners of Plastic Surgery Services:Referrals and Guidelines in Plastic Surgery NHS Modernisation Agency 2009 (page 17).	The first-line treatment of this condition of the nasal skin is medical. However response is poor. Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances.

6	***Equipment***			
6.1 NEW	Use of Lycra Suits	Lycra Suits are not normally commissioned for postural management of cerebral palsy.	What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013.  Lycra splints TSC May 2013.pdf Do lycra garments improve function and movement in children with cerebral palsy? BestBets, 2010.	Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames.
7	***Fertility***			
7.1	Infertility treatment For Sub fertility e.g medicines, surgical procedures and assisted conception. This also includes Reversal of Vasectomy or Female Sterilisation	Draft Cheshire & Merseyside policy.  Cheshire Mersey Infertility Draft Policy New Draft policy out for engagement.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab	Proposed new Draft policy subject to CCG approval.
8	***Gastroenterology***			
8.1	Gastro-electrical Stimulation	NHS England Guidance is that this procedure is NOT commissioned.	Gastroelectrical stimulation for gastroparesis NICE IPG 103 – December 2004. EndoStim LES Stimulation System for severe gastro-oesophageal reflux – NIHR (2013). Commissioning Guide: Gastro-oesophageal reflux disease (GORD) Royal College of Surgeons (2013). NHS England Guidance NHSCB/B11/PS/a	

9	***General Surgery***			
9.1	Haemorrhoidectomy - Rectal Surgery: & Removal of Haemorrhoidal Skin Tags	Surgery commissioned for symptomatic : • Grade III and IV haemorrhoids. • Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments – - Diet modification to relieve constipation. - Topical applications. - Stool softeners and laxatives. - Rubber band ligation. - Sclerosant injections. - Infrared coagulation. Surgical treatment options include: • Surgical excision (haemorrhoidectomy). • Stapled haemorrhoidopexy. • Haemorrhoidal artery ligation. Removal of Skin tags should not ordinarily be performed.	Haemorrhoidal artery ligation NICE 2010. TAG128: Stapled haemorrhoidopexy for the treatment of haemorrhoids NICE 2007. BMJ2008. Clinical Review: Management of Haemorrhoids. Austin G Acheson, John H Scholefield, BMJ 2008; 336:380. Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008. Long-term Outcomes of Stapled Hemorrhoidopexy vs Conventional HemorrhoidectomyA Meta-analysis of Randomized Controlled Trials – JAMA Surgery March 16, 2009, Vol 144, No. 3. Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US. Management of haemorrhoids BMJ 2008;336:380. Haemorrhoids NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab Commissioning Guide: Rectal bleeding Royal College of Surgeons (2013).	There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure. Short term efficacy and cost effectiveness is similar.

9.2	Surgery for treatment of Asymptomatic Incisional and Ventral Hernias. Surgical correction of Diastasis of the Recti	Surgery: not commissioned if no symptoms, easily reducible (i.e. can be 'pushed back in') and not at significant risk of complications. Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect.	Commissioning Policy For Procedures Of Limited Clinical Value NHS Derby City and NHS Derbyshire County (April 2011). A systematic review on the outcomes of correction of diastasis of the recti Hernia ,December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.	
9.3 NEW	Surgery for Asymptomatic Gallstones Lithotripsy for Gallstones	This procedure is not routinely commissioned. Lithotripsy not routinely commissioned.	Commissioning Guide: Gallstone disease Royal College of Surgeons (2013).	This procedure is considered a Low clinical priority for asymptomatic gallstones. Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for some unrelated reasons. Lithotripsy rarely performed as rate recurrence high.
10	***Gynaecology***			
10.1	Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this	CG44 Heavy menstrual bleeding: full guideline NICE 2007. QS47 Heavy Menstrual Bleeding	

		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).	*NICE 2013.*	
	D&C (Dilatation and curettage)	Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure.		
11	***Mental Health***			
11.1 NEW	Counselling Services for Hearing Impaired Adults with Mental Health Problems.	Patients with hearing problems (who use sign language) and who need specialist counselling and support will be considered on a case by case basis. Some CCGs commission the service from non NHS providers.	Specialised Mental Health Services for the deaf NHS England. Mental Health and Deafness: Towards Equity and Access Department of Health 2005. Mental Health of Deaf People Lancet 2012; 379: 1037–44.	CCGs commission primary care based psychological services such as IAPT (Improving Access to Psychological Therapies), which are accessible by Deaf patients either via providing appropriate interpreting services and technology (to implement their Equality Duty (Equality Act 2010) or via commissioning services specifically designed for Deaf patients.
11.2 NEW	Inpatient Care for treatment of Chronic Fatigue Syndrome (CFS).	In patient care for Chronic Fatigue Syndrome is not routinely commissioned. If in-patient treatment is recommended an IFR referral will be required.	*Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53. *Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008.	Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission.

			Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis - . PLoS ONE 7(8): e40808. doi:10.137. *Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012, 12:264.	However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital.
11.3	Treatment of Gender Dysphoria	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at Charring Cross. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	NHS England interim protocol – NHS England (2013) Pages 13 & 14 describe non -core NHS England & CCG commissioning responsibilities.	Where the provision of ''non-core surgery'' is appropriate the GIC should apply for treatment funding through the CCG.
11.4 NEW	Non-NHS Drug and Alcohol Rehabilitation (Non-NHS commissioned services)	These treatments will only be funded on the advice of the Community Alcohol and Drugs Teams of the Cheshire and Wirral Partnership Foundation Trust.	Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007) Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
11.5	Private Mental Health	This will not normally be funded.	Veterans' post traumatic stress disorder	

NEW	(MH) Care - Non-NHS commissioned services including Psychotherapy Adult Eating Disorders General In-patient Care Post-Traumatic Stress Adolescent Mental Health	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.	programme (Adult) Service Specification NHS England Specialised Commissioning 2013. Post –traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care NICE Clinical Guideline 26 (2005). Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification NHS England Specialised Commissioning (2013) The use of motivational interviewing in eating disorders: a systematic review. Psychiatry Research, 2012 Nov 30;200(1):1-11. Depression in children and young people: Identification and management in primary, community and secondary care. NICE Clinical Guideline 2005. Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013.	
12	***Neurology***			
12.1 NEW	Bobath Therapy	Bobath Therapy is not routinely commissioned by the NHS. The evidence base is poor for both children and adults.	The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme Physiotherapy Research International Volume 16, Issue 2, pages 69–80, June 2011.	

			Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15. Bobath Therapy for Cerebral palsy Cambridge CCG (2013). A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy National Public Health Service for Wales (2008).	
12.2 NEW	Trophic Electrical Stimulation for Facial/Bells Palsy	Not routinely commissioned.	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).	

12.3 NEW	Functional Electrical Stimulation (FES)	Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease.	Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10. Functional electrical stimulation for drop foot of central neurological origin NICE, 2009. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.	
13	***Ophthalmology***			
13.1	Upper Lid Blepharoplasty - Surgery on the Upper Eyelid.	Only commissioned in the following circumstances: • Eyelid function interferes with visual field.	*Eyelid Surgery* *The British Association of Aesthetic Plastic Surgeons 2011.* Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.

13.2	Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	*Eyelid Surgery* The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus –review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.
13.3	Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids).	Only commissioned for: larger legions which satisfy all of the following: 1. not responded to treatment for underlying familial lipoprotein lipase deficiency 2. failed topical treatment 3. Causing significant disfigurement 4. Causing functional impairment. Topical treatments may be available in a Primary care or Community setting.	Local PCT consensus – review conducted 2007. DermNet NZ information resources updated Jan 2013. Commissioning Criteria – Plastic Surgery Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). http://www.patient.co.uk/doctor/xanthelasma	The following treatments should be considered for patients with xanthelasma: Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or cryotherapy. Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist. Patients with xanthelasma should always have their lipid profile checked before referral to a specialist. Investigation for underlying lipid abnormalities should be undertaken in the first instance. Lesions are harmless. Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or cryotherapy.

13.4 NEW	Surgery or Laser Treatment for Short Sightedness (Myopia) or long sightedness (hypermetropia)	Surgery or Laser Treatment for Short Sightedness or long sightedness is not commissioned. Glasses are lower risk and more cost effective.		
13.5 NEW	Cataract Surgery	CCGs currently have agreed clinical pathways with Optometrists.	Thresholds for cataract surgery – Shropshire and Telford Hospital NHS Trust, 2012. Shropshire CCG POLICY ON LOW PRIORITY TREATMENTS Version 13 – June 2013 Based on OPCS 4.6 and ICD 10 8.2 Cataract surgery pg38. Cataract surgery Hull CCG, 2012. NHS Atlas of Variation, (cataract spend, cataract admissions) Don't turn back the clock: Cataract surgery - the need for patient centred care. RNIB / Royal College of Ophthalmologists (2011). Cataract surgery guidelines The Royal College of Ophthalmologists (RCOphth) 2010. Action on cataracts good practice guidance Department of Health (2000). Cataract care pathway Map of Medicine (2013). NHS UK - http://www.nhs.uk/conditions/Cataracts-age related/Pages/Introduction.aspx	*Further public health work in this area is being undertaken.*

13.6 NEW	Coloured (Irlens) Filters for treatment of Dyslexia	There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.	Coloured filters for reading disability:A systematic review WMHTAC 2008	
13.7 NEW	Intra ocular telescope for advanced age-related macular degeneration	This is not routinely commissioned as there is limited published evidence of effectiveness.	Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012).	
13.8	Surgical removal of Chalazion or Meibomian Cysts	Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND Causes blurring or interference with vision. OR Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk.	Guidance for the management of referrals for Meibomian Cysts NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013).	
14	***Oral Surgery***			
14.1	Extraction of impacted Wisdom Teeth.	Commissioned by NHS England in accordance with their policy document.	TA1 Guidance on the Extraction of Wisdom Teeth NICE (2000). Procedures of Limited Clinical Effectiveness	Impacted Wisdom teeth free from disease should not be operated on.

			Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010. Removal of impacted teeth Centre for Review and Dissemination 2010. *Surgical removal versus retention for the management of asymptomatic impacted wisdom teeth* Cochrane Oral Health Group (2012). NHS England Removal of Third molars NHS England 2013	
14.2 NEW	Surgical Replacement of the Temporomandibular Joint Temporo-mandibular Joint Dysfunction Syndrome & Joint Replacement	Only commissioned in the following circumstances: Any or a combination of the following symptoms are present: - Restricted mouth opening <35mm). - Dietary score of< 5/10 (liquid scores 0, full diet scores 10). - Occlusal collapse (anterior open bite or retrusion). - Excessive condylar resorption and loss of height of vertical ramus. - Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). - Other significant quality of life issues. AND	Surgical Replacement of the Temporomandibular Joint: Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests .  TMJ replacement guidance 20130806.c Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes	

		Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.		
14.3	Orthodontics	NHS orthodontic care is available to children under 18 if there is clinical need. NHS orthodontic care is not usually available for adults but may be approved on a case-by-case basis if it is needed for health reasons. Commissioned by NHS England.	Orthodontics - NHS Choices	.
15	***Paediatrics***			
15.1 NEW	Cranial Banding for Positional Plagiocephaly	Not routinely commissioned.	Nonsurgical treatment of deformational plagiocephaly: a systematic review Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27. What is the role of helmet therapy in positional plagiocephaly? BestBETS 2008.	This treatment is considered low priority. Most children's head shapes will improve naturally in their own time.
16	***Plastic & Cosmetic Surgery***			
16.1	Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: Musculo-skeletal symptoms are not due to other causes. And	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010. Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/	Best not performed on young teenagers and delayed until any planned family is complete. Unilateral reduction is preferable to unilateral augmentation.

		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 There is a proposed reduction of at least 500g per side. 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.	Procedures not usually available on the National Health Service Health Commission Wales (2008). Modernisation Agency's Action on Plastic Surgery 2005. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. *British Journal of Plastic Surgery*, *56*(3), 230–236. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. *Chiropractic & Osteopathy*, *16*(1), 1–7. An investigation into the relationship between breast size, bra size and mechanical back pain British School of Osteopathy (2010).	

16.2	Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstance: The BMI is <25 and stable for at least twelve months. And any of the following: Unilateral breast enlargement is considered for breasts of three or more cup size difference as measured by a specialist. . Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.	Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 . Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050. Vale of Glamorgan Local Health Board, 2006, Policy on the commissioning of procedures of low priority or limited clinical effectiveness not normally funded, Annex A, 3.36. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and	Patients should be made aware that; 1 in 5 implants need replacing within 10yrs regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.

			repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005.	
16.3	Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention , such as: Capsule contraction causing significant deformity or Implant rupture. 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.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).	1 in 5 implants need replacing within 10yrs regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.
16.4	Mastopexy - Breast Lift	Not routinely commissioned May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/*	

			Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
16.5	Surgical Correction of Nipple Inversion	This is not routinely commissioned. .	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005.	Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule. This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months.
16.6	Male Breast Reduction Surgery for Gynaecomastia.	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: True gynaecomastia not just adipose tissue. AND Underlying endocrine or liver abnormality excluded. AND Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this. AND Not due to prescribed drug use.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf	Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer.

		AND Has not responded to medical management for at least three months. AND Post pubertal. AND BMI <25kg/m2 and stable for at least 12 months. AND Patient experiences pain. AND Experiences significant functional impairment.		
16.7	Hair Removal Treatments including Depilation Laser treatment or Electrolysis –for Hirsutism –	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey Score 3 or more per area to be treated.	Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70). Hirsutism - NICE: Clinical Knowledge Summaries 2010. Laser and photoepilation for unwanted hair growth – Cochrane Library 2009. Management of hirsutism – Koulouri et al BMJ 2009; 338:b847.	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy, electrolysis performed by a registered electrologist, or laser centre.

		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. dermatologist or endocrinologist). Photographs will also be required to allow the PCTs to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005. NHS North West London CCGs policy.  NWLHairDepilationfor Hirsutism-v3.pdf	
16.8 NEW	Surgical treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds.	IPG310 Minimally invasive placement of pectus bar: guidance NICE (2009).	
16.9	Surgical revision of Scars.	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	
16.10	Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • 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.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	

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

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

		• 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.		
16.13	Treatments to correct Hair Loss for Alopecia.	Only commissioned in either of the following circumstances: • Result of previous surgery • Result of trauma, including burns Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy.	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 Interventions for alopecia areata – Cochrane Library 2008. Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. Alopecia areata – NICE Clinical Knowledge Summaries 2008. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service	

			Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005.	
16.14	Hair Transplantation	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction.	*A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005.	
16.15	Treatments to correct Male Pattern Baldness	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	
16.16	Labial Reduction Surgery	This is not routinely commissioned.	Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499. Department for Education and Skills. (2004). *Local Authority Social Services Letter. LASSAL (2004)4,* London, DfES.	

			Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159.* Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature. *BJOG: An International Journal of Obstetrics & Gynaecology; Volume 117: 20-25.* *Labiaplasty for labia minora hypertrophy* - *Centre for Reviews and Dissemination 2013.* Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. Hymenoplasty and Labial Surgery (RCOG Statement 6).	
16.17	Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophias or non-excisable clinical significant lipomata. An individual funding request will be required.	Liposuction for chronic lymphoedema NICE 2008. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
16.18	Rhytidectomy - Face	This procedure is not available under the NHS on	Modernisation Agency's Action on Plastic	Changes to the face and brow

	or Brow Lift	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.	Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	result due to normal ageing; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function.
17	***Respiratory***			
17.1	Treatments for Obstructive Sleep apnoea/hypopnoea syndrome in Adults (OSAHS)	Weight loss, stopping smoking and reducing alcohol should be encouraged prior to referral to secondary care for mild cases of sleep apnoea. For patients with moderate to severe symptoms, attempts at weight loss should not delay the initiation of further treatment. Dental devices, are commissioned in either of the following circumstances : • Mild to Moderate OSAHs. • For severe OSAHS where CPAP cannot be tolerated. Continuous positive Airway Pressure is commissioned for adults in either of the following circumstances: • With moderate or severe OSAHS(defined as Apnoea/hypnoea index 1 ≥15. • Patients with mild OSAHS(AHI 5-14) if symptoms affect their quality of life and ability to go about daily activities and advice about lifestyle and other relevant treatment options have been unsuccessful or are considered inappropriate. Drug therapy – not routinely commissioned.	Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome – NICE (2008)TA139 Obstructive sleep apnoea/hypopnoea: suspected - Map of Medicine (2013) Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003). Oral appliances for obstructive sleep apnoea Cochrane Database of Systematic Reviews (2009). Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005). Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36.	There is a lack of RCT evidence on lifestyle modification specific to the treatment of sleep apnoea. However, there is NICE Guidance on management of obesity, smoking cessation, physical activity and preventing harmful drinking. NB: 20-30% of symptomatic OSAHS are not overweight. The efficacy of dental devices has been established in clinical trials but as a treatment option for mild and moderate symptoms and for those unable to tolerate CPAP. Weight loss, stopping smoking and reducing alcohol should be encouraged as an adjunct to CPAP. Pharmacological therapy should not be used as a first line therapy for OSAHS.

		Surgery – not routinely commissioned. Bi-PAP may be commissioned if clinically appropriate as assessed by a specialist service.		There is currently insufficient evidence to recommend use of drug therapy. Palatal surgery, such as Uvelopalatopharyngoplasty (UPPP) and Laser-assisted uvulopalatoplasty (LAUP) is not recommended by SIGN (2003) and it may compromise the patient's subsequent ability to use nasal CPAP, although the extent of this risk is not known. Current evidence on soft-palate implants for obstructive sleep apnoea (OSA) raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist. Studies assembled for the Cochrane Review do not provide evidence to support the use of surgery for sleep apnoea as overall benefits have not been demonstrated.
17.2	Treatments for Snoring. Soft Palate Implants and Radiofrequency Ablation of the Soft Palate	Not Routinely Commissioned.	Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007). Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005).	NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and

	Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty' Uvulopalatoplasty and Uvulopalatopharyngoplasy		Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003). Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005). Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs – Health Technology Assessment (2009). Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36. The British Snoring & Sleep Apnoea Association	research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient's subsequent ability to use nasal CPAP. Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as 'Snoreplasty' is not well recognised in the UK as an effective method of treating snoring. This method has.
18	***Trauma & Orthopaedics***			

18.1 NEW	Diagnostic, Interventions and treatments for Early Management of Back Pain Persistent *non-specific* low back pain of duration 6 weeks to 12 months. Excluding spinal pathology, radiculopathy, and children.	X Rays and MRI scans should not be offered unless in a context of referral for surgery. Management should consist of a structured exercise programme, manual therapy or acupuncture. 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.	CG88 Low back pain: full guideline NICE 2009. Review of Clinical Guideline (CG88) – Low back pain: early management of persistent non-specific low back pain NICE 2012.	RCS commissioning guidance on LBP due out November. Gives guidance and tools. Will also give guidance on facet joints. https://www.boa.ac.uk/LIB/LIBPUB/Documents/CCG_Low%20Back%20pain_draft.pdf
	Radiofrequency facet joint denervation Intra Discal Electro Thermal Annuloplasty (IDET Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), TAMARS (Technology	The following referrals 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), Not routinely commissioned.	IPG 319: Percutaneous intradiscal electrothermal therapy for low back pain NICE 2009. IPG83: Percutaneous intradiscal radiofrequency thermocoagulation NICE 2004. http://tamars.co.uk/wp/wp-	

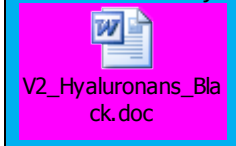
	Assisted Micromobilisation and Reflex Stimulation) Fusion	There is limited data on effectiveness and no data on superiority over other treatments. Fusion not commissioned unless the patient has completed an optimal package of care, including a combined physical and psychological treatment programme; over a period likely to be more than 12 months. And • Still has severe non-specific low back pain for which they would consider surgery.	content/uploads/2012/10/21stCenturyBackCare.pdf Final_TAMARS_report[1].pdf	
18.2	Facet Joint and Epidural Injection	Referral to a pain intervention service may be appropriate for consideration of therapeutic injection of facet joints or epidural injection in patients with non-specific back pain of over 12 months duration or radicular pain failing to respond to conservative treatment as per the policy attached.	Pathways for patients with Low Bac	
18.3	Endoscopic Laser Foraminoplasty	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence of the safety and efficacy of endoscopic laser foraminoplasty does not appear adequate to support the use of this procedure without special arrangements for consent and for audit or research.	IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011.	
18.4 NEW	Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of peripheral nerve-	IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013	

		field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device.		
18.5 NEW	Endoscopic Lumbar Decompression	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of percutaneous endoscopic laser lumbar discectomy is inadequate in quantity and quality.	IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009	
18.6 NEW	Percutaneous Disc Decompression using Coblation for Lower Back Pain.	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence suggests that there are no major safety concerns associated with the use of percutaneous disc decompression using coblation for lower back pain. There is some evidence of short-term efficacy; however, this is not sufficient to support the use of this procedure without special arrangements for consent and for audit or research.	IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006	
18.7 NEW	Non-rigid Stabilisation Techniques	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of non-rigid stabilisation techniques for the treatment of low back pain shows that these procedures are efficacious for a proportion of patients with intractable back pain.	IPG 366: Non-rigid stabilisation techniques NICE 2010	

18.8 NEW	Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	IPG 321: Lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. NICE 2009.	
18.9 NEW	Percutaneous Intradiscal Laser Ablation in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of percutaneous intradiscal laser ablation in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.	IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.	
18.10 NEW	Transaxial Interbody Lumbosacral Fusion	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of transaxial interbody lumbosacral fusion is limited in quantity but shows symptom relief in the short term in some patients. Evidence on safety shows that there is a risk of rectal perforation. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	IPG 387: Transaxial interbody lumbosacral fusion NICE 2011.	
18.11	Therapeutic	This procedure is NOT routinely commissioned.	IPG 333: Therapeutic endoscopic division of	

NEW	Endoscopic Division of Epidural Adhesions	Individual funding requests will need to be made for exceptional circumstances. Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	epidural adhesions NICE 2010	
18.12 NEW	Automated Percutaneous Mechanical Lumbar Discectomy.	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence suggests that there are no major safety concerns associated with automated percutaneous mechanical lumbar discectomy. There is limited evidence of efficacy based on uncontrolled case series of heterogeneous groups of patients, but evidence from small randomised controlled trials shows conflicting results. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and for audit or research.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	
18.13 NEW	Prosthetic Intervertebral Disc Replacement in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of prosthetic intervertebral disc replacement in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in	IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009. Commissioning Guide – Low Back Pain. Royal College of Surgeons (2013). Total disc replacement for chronic back pain in the presence of disc degeneration The Cochrane Database of Systematic	As effective as discectomy in the short term 2-3 yrs. but after that outcomes are similar. Long term follow-up data on efficacy and safety is lacking.

		place for clinical governance, consent and audit.	Reviews, Issue 9 (2012).	
18.14 NEW	Bone Morphogenetic Proteins Dibotermin alfa Eptotermin alpha	Dibotermin alfa is commissioned in the following situation: The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. Eptotermin alfa is commissioned in line with its licensed indication: Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
18.15	Surgery for trigger finger	Conservative management (including splinting, steroid injections, NSAIDS) is adequate in the majority of cases. Local steroid injections should be the first line treatment unless the patient is diabetic (where surgery preferred). Surgery not commissioned unless conservative treatments, (including at least 2 corticosteroid injections) have failed or are contraindicated AND Fixed flexion deformity that cannot be corrected	Nimigan AS, Ross DC, Bing SG. Steroid injections in the management of trigger fingers. American Journal of Physical Medicine and Rehabilitation 2006; 85(1):36-43. BMJ review: Akhtar S, Bradley MJ, Quinton DN, Burke FD. Management and referral for trigger finder/thumb. BMJ 2005; 331(7507):30-33. NHS Oxfordshire, Interim Treatment Threshold Statement: Surgery for trigger finger (stenosing tenovaginosis) Corticosteroid injection for trigger finger in	

		easily is present.	adults Cochrane Database of Systematic Reviews (2008). Trigger Finger Assessment Map of Medicine (2012) – for North Mersey Surgery versus ultrasound-guided steroid injections for trigger finger disease: protocol of a randomized controlled trial Danish Medical Journal 2013;60(5):A4633.	
18.16 NEW	Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain Secondary care administered steroid joint injections.	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection. Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre	Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012.	See Pan Mersey Statement.  V2_Hyaluronans_Black.doc
18.17 NEW	Palmar Fasciectomy /Needle Faciotomy For Dupuytren's Disease.	Requests for treatment will be considered when: • Metacarpophalangeal joint contracture of 30o or more, (inability to place hand flat on table OR • Any degree of proximal interphalangeal joint contracture, OR • Patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 100 or more.	IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004. Dupuytrens disease NICE Clinical Knowledge Summaries (2010). British society hand surgeons New guidelines awaited. NHS North West London commissioning policy	

		There should be significant functional impairment	– Dupuytren's Disease April 2013.  NWLDupuytren'sDisease-Contracture-v3.p Common Hand Conditions NHS Dorset Clinical Commissioning Group (2011).	
	Radiotherapy Collagenase injections	These procedures are not commissioned.	IPG368: Radiation therapy for early Dupuytren's disease NICE 2010.	
18.18	Hip and Knee Replacement Surgery & Hip Resurfacing	Referral is based on local referral pathways.	NHS North West London commissioning policy – Hip Replacement (Total) April 2013.  NWLHipReplacement v3.pdf NHS North West London commissioning policy – Knee Replacement (Total) April 2013.  NWL KneeReplacementv3. Clinical thresholds knee replacement York & Humber Health Intelligence (2011). Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013).	A hip and knee score threshold can form part of a demand management approach. NICE ID 540 (in development – expected publication date Feb 2014). Suggests the following; 1 Appraisal Committee's preliminary recommendations. 1.1 Total hip replacement and resurfacing arthroplasty prostheses are recommended as treatment options for people with end-stage arthritis of the hip only if the prosthesis has a rate (or projected rate) of revision of less than 5% at 10 years. 1.2 If more than one type of

				prosthesis meeting the above criteria is suitable for a patient, the prosthesis with the lowest acquisition costs should be chosen.
18.19	Diagnostic Arthroscopy for arthritis of the knee	Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate. However it is not routinely commissioned for any of the following indications: • Investigation of knee pain. • Treatment of Osteo-Arthritis including Arthroscopic washout. • If there is diagnostic uncertainty despite a competent examination or if there are ''red flag'' symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.	CG59 Osteoarthritis. Section 3.1 NICE 2008 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007. Knee replacement: A guide to good practice British Orthopaedic Association, 2000. Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013).	
	Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee -	Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).		
	Patient Specific Unicompartmental Knee Replacement Patient Specific Total Knee Replacement	This is not commissioned.	IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009	Referral should be made to specialist centres only.

			EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates ECRI Institute (2012) IPG 345: Mini-incision surgery for total knee replacement NICE 2010	
18.20	Surgical treatment for Carpal Tunnel Syndrome	Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases. Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied: • Patients have not responded to 3 months of conservative treatments, including: ➢ >8 weeks of night-time use of wrist splints. ➢ Corticosteroid injection in appropriate patients. • Conservative treatments contraindicated. Severe cases: Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment. The following treatments are not commissioned for carpal tunnel syndrome: • Diuretics. • NSAIDS. • Vitamin B6. • Activity modification. • Heat treatment. • Botulinum toxin.	Local corticosteroid injection for carpal tunnel syndrome Cochrane Database of Systematic Reviews, 2007. Clinical practice guideline on treatment of Carpal Tunnel Syndrome American Academy of Orthopaedic Surgeons, 2008. Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome NHS Oxfordshire, 2009. Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome - Cochrane Database of Systematic Reviews 2002. Surgical treatment options for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2007. Surgical versus non-surgical treatment for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2008. Is surgical intervention more effective than	Mild cases often resolve spontaneously after 6 months.

			non-surgical treatment for carpal tunnel syndrome? a systematic review Journal of Orthopaedic Surgery & Research 2011, 6:17. Median Nerve Lesions and Carpal Tunnel Syndrome Patient.co.uk. Commissioning Guide: Painful tingling fingers Royal College of Surgeons (2013).	
18.21	Surgical Removal of Ganglion & Mucoid Cysts at Distal Inter Phalangeal Joint (DIP).	Only commissioned for mucoid cycsts under the following circumstance: Failure of conservative treatments including watchful waiting. AND any of the following • Nail growth disturbed • Discharging, ulcerated or infected. • Size interferes with normal hand function. Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned.. Reassurance that no treatment is required should be given to the patient.	Digital Mucous Cyst Overview of condition – Medscape. South Central Priorities Committee Policy statement 152: Wrist ganglions Berkshire PCT, 2009. Ganglions of the hand and wrist: determinants of treatment choice – Journal of Hand Surgery 2013 Feb. v.38(2) p151-7.	50% may resolve. High risk of recurrence after any treatment. More radical surgery carries higher risks of complications.
18.22 NEW	Hip Arthroscopy for Femoro–Acetabular Impingement.	CCGs routinely commissions hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: A definite diagnosis of hip impingement syndrome /	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. Hip Arthroscopy for the treatment of symptomatic hip impingement syndrome in adults NHS Hull Clinical Commissioning Group 2012.	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are

		femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7). Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.
18.23 NEW	Surgical Removal of Bunions/ Surgery for Lesser Toe Deformity	Requests for the removal of bunions will only be considered where; conservative methods of management* have failed. AND the patient suffers significant functional impairment** as a result of the bunions. AND radiographic evidence of joint damage (at point of referral). *Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non	Bunions NICE Clinical Knowledge Summaries (2012) IPG 332: Surgical correction of hallux valgus using minimal access techniques NICE (2010) Commissioning Guide: Painful deformed great toe in adults Royal College of Surgeons (2013)	

		surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate. **Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living. Treatment will not be commissioned for cosmetic appearance only.		
18.24 NEW	Surgical Treatment of Morton's Neuroma	Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway. 1. The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads. 2. Been referred to an orthotist for an assessment. 3. Had a trial of local corticosteroid injection.	Therapeutic massage provides pain relief to a client with Morton's Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012. Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9. Morton's neuroma NICE Clinical Knowledge Summaries (2010).	
18.25 NEW	Surgical treatment of Plantar Fasciitis	Surgical Treatment is not routinely commissioned unless the following pathway has been followed: 1. patient has documented evidence that they are not responding to conservative treatments 2. patient is experiencing significant pain or it is having a serious impact on their daily life and has	Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.	

		completed the following 3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss. 4. Been referred to a podiatrist or physiotherapist. 5. Been offered up to 3 corticosteroid injections 6 weeks apart.	Plantar fasciitis NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.	
18.26 NEW	Treatment of Tendinopathies Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection.	These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.	IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis NICE 2009. IPG 312: Extracorporeal shockwave therapy for refractory Achilles NICE 2009. IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow NICE 2009. IPG 437: Autologous blood injection for plantar fasciitis NICE 2013. IPG 438: Autologous blood injection for tendinopathy NICE 2013.	
19	***Urology***			
19.1 NEW	Circumcision	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies. Indicated for the following condition;	Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2002.	Race /cultural implications.

		➢ balantis xerotica obliterans. ➢ traumatic foreskin injury/scarring where it cannot be salvaged. ➢ 3 or more episodes of balanitis/balanoposthis. ➢ Pathological phimosis. ➢ Irreducible paraphimosis. ➢ Recurrent proven Urinary Tract Infections (UTIs) with an abnormal urinary tract.	2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis NICE Clinical Knowledge Summaries 2009. I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. Commissioning Guide: Foreskin conditions Royal College of Surgeons guidance (2013).	
19.2	Penile Implant: A surgical procedure to implant a devise into the penis .	Not routinely commissioned. 59 PenileImplants.pdf See attached sheet.	1. Penile implants NHS NWL policy 2012. 2. Telford and Wrekin CCG Penile Implants 2012. 3. Guidelines Male Sexual Dysfunction European Association Urology (2010). 4. Guidelines on the Management of ED British Society for Sexual Medicine(2007). 5. CG58: Prostate Cancer NICE 2008.	*See attached discussion document re wording of policy.* Penile Implants Review.doc
19.3 NEW	Reversal of Male Sterilisation	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.		Cross reference to fertility policy.

19.4 NEW	ESWT (Extracorporeal Shockwave Therapy) for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited clinical evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
19.5 NEW	Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome.	This is not commissioned as there is limited evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
19.6 NEW	Surgery for Prostatism	Only commissioned where there are sound clinical reasons and after failure of conservative treatments and in any of the following circumstances: ➢ International prostate symptom score >7; ➢ dysuria; ➢ post voided residual volume >150ml; ➢ recurrent proven Urinary Tract Infections (UTI); ➢ deranged renal function; ➢ Prostate-specific antigen (PSA) > age adjusted normal values.	CG97: Lower urinary tract symptoms: The management of lower urinary tract symptoms in men NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). Commissioning Guide: LUTS Royal College of Surgeons (2013).	No references to treatment thresholds found.
20	***Vascular***			
20.1 NEW	Surgery for Extreme Sweating Hyperhydrosis – All areas Surgical Resection Endoscopic Thoracic Sympathectomy	Treatment is medical. Treatment of hyperhidrosis with surgery is not commissioned. Risk of compensatory hyperhidrosis elsewhere is very high.	Hyperhidrosis – NICE Clinical Knowledge Summaries (2013). Hyperhidrosis Patient.co.uk.	
20.2	Chelation Therapy for	This is not commissioned.	Diagnosis and management of Peripheral	A recent trial has been published

NEW	Vascular Occlusions		arterial disease: A national clinical guideline - SIGN, 2006. Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.	showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.
20.3	Interventional treatments e.g. endothermal ablation, foam sclerotherapy and surgery for Varicose Veins.	Treatment is in line with NICE CG168. For patients with symptomatic varicose veins having a significant impact on their activities of daily living the following pathway applies. Refer people to a vascular service[1] if they have any of the following. • Symptomatic[2] primary or symptomatic recurrent varicose veins. • Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. • Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. • A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). • A healed venous leg ulcer. 1. A team of healthcare professionals who have the skills to undertake a full clinical and duplex	CG168: Varicose Veins in the legs NICE 2013. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. A systematic review and meta-analysis of treatments for varicose veins – Centre for Reviews and Dissemination 2011 Ultrasound-guided foam sclerotherapy for varicose veins – NICE IPG 440 2013 A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein – Centre for Review and Dissemination 2013 CG 168: Varicose veins NICE 2013	See below for discussion of issues. Varicose veins.doc Currently there is no consensus amongst CCGs. There is on-going work to facilitate this process and understand the potential impact if adopted. This section is subject to changes.

		ultrasound assessment and provide a full range of treatment. 2. Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching). Compression hosiery is not recommended unless patients are not willing or are unfit for surgery.	Commissioning Guide: Varicose veins Royal College of Surgeons (2013)	
21.1	Botulinum toxin A Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane.	Not routinely commissioned for the following conditions: ▪ Hyperhidrosis ▪ Chronic anal fissure ▪ Sphincter of Oddi dysfunction ▪ Carpal tunnel syndrome ▪ Cosmetic surgery procedures e.g. Glabellar lines/wrinkles ▪ Chronic migraine - only commissioned in accordance with NICE TA260 June 2012 – Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 ▪ Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections.	NICE TA260 June 2012 –Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections. **Diagnosis and management of hyperhidrosis** British Medical Journal	

Appendix One - IFR Panel Contact Details

Details to be added on completion of final draft.