NHS
Doncaster
Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group

Commissioning for Value – Decision Making and Prioritisation Framework

April 2015
Revised November 2011
Revised April 2017

Content

1. Executive Summary

Now more than ever due to the current challenging financial climate, it is important for NHS Doncaster CCG to demonstrate that it is making the most effective use of public monies to maximise the health and wellbeing of the people of Doncaster. To achieve this, we need to ensure that our resources are used wisely and we maximise the impact of the services we commission to improve health, reduce health inequalities and ensure our population receives appropriate high quality evidenced clinical care.

We seek to ensure that our commissioning decisions are fully informed and based on the best evidence available and provide best value for money through available benchmarking.

To ensure that our finite resources are consistently directed to the highest priority areas, NHS Doncaster CCG is proposing a commissioning decision making and prioritisation framework that sets out our approach and governance arrangements to ensure as far as possible that our decisions are robust, rational and can be justified to stakeholders and our local population.

This proposed framework should ensure that resources are invested in the highest priority areas and robust processes are in place to identify services which can no longer be prioritised on the basis of clinical evidence, outcomes and value for money. Where approval has been given to reprioritise and realign our commissioning intentions, a clearly defined process will be followed, with clear lines of accountability and responsibility and NHS Doncaster CCG recognises that a number of steps will be required prior to a final decision being taken, including clinical engagement to inform that decision.

2. Introduction

The purpose of this Policy is to establish a system for transparent and coherent prioritisation for the commissioning of health and wellbeing services. It provides a framework for making decisions about relative priorities at a strategic and planning/commissioning level and facilitates rational and reasonable decisions about which services are commissioned in accordance with our agreed strategy.

The proposed framework applies to all commissioning decisions made by NHS Doncaster CCG and should be applied when they can no longer be prioritised on the basis of clinical evidence, outcomes and value for money.

This policy links with our strategic plan and commissioning intentions available at http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/11/Combined-papers-for-Governing-Body-17th-November-2016.pdf

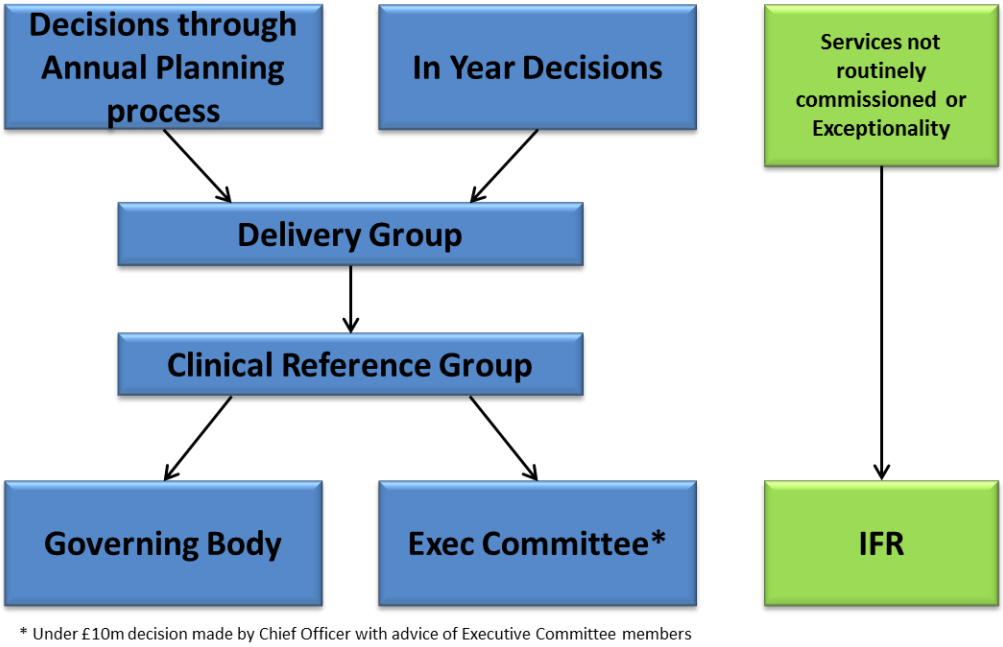
3. Decision Making and Prioritisation Approach

NHS Doncaster CCG is required to make decisions relating to varying situations as outlined below:

- Decisions about strategic and operational priorities for annual resource allocation through business cases for investment and services or value for money reviews and performance monitoring in services or specific treatments where they no longer provide evidenced clinical value, outcomes and best value for money or are a lower priority than services we need to fund within our affordability envelope (including proposal for new Individual Funding Request (IFR) policies)

- Decisions outside of our planning process, decisions on funding outside existing commissioned services and decisions on exceptionality for individual cases. This may apply in the following circumstances where a decision is required:
    - A new intervention is made available that is of significant importance
    - A new treatment or service is made available that provides such significant health or financial benefits
    - A proposal submitted by an external body that provides benefits

Figure 1 Decision Prioritisation Approach



* Under £10m decision made by Chief Officer with advice of Executive Committee members

Informed by:

- Patient Engagement
- Procurement Rules
- Alignment with DCCGs strategic objectives or national mandatory priorities
- Benefits and outcomes are identified and evidenced/measureable
- Compliance with any legal and clinical frameworks or guidance
- Response to a need that has been assessed
- Clinical effectiveness, outcomes including assessment by NICE or other evidence based review
- Impact on health inequalities and protected characteristics
- Will improve patient safety and experience
- Accessibility to service users
- Affordability and value for money

4. Priorities for Annual Resource Allocation

NHS Doncaster CCG will prioritise existing resources, reconsider commissioned services that are not considered to be delivering the expected health benefit, and consider any new services or business cases to ensure that we are utilising our resources effectively. Local needs and national benchmarking information, where appropriate, will guide NHS Doncaster

CCG in this prioritisation of expenditure at a local level between commissioning programmes. The following criteria will be used for consideration:

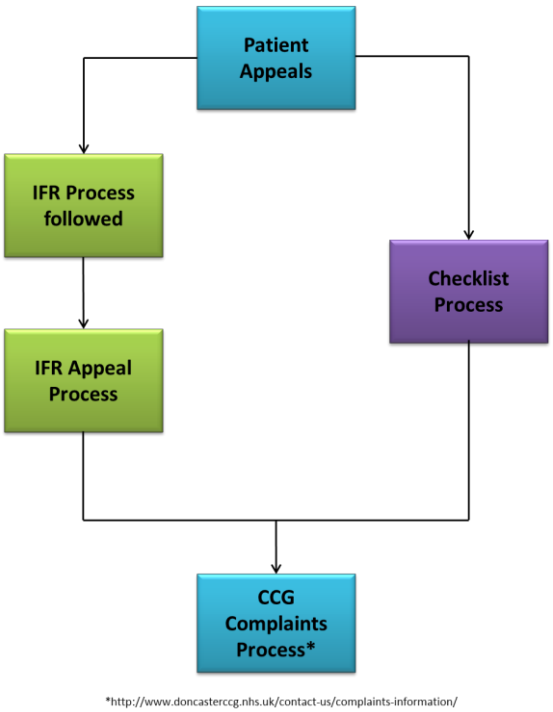
- Alignment with NHS Doncaster CCG's strategic objectives or national mandatory priorities
- Benefits and outcomes are identified and evidenced/measurable
- Compliance with any legal and clinical frameworks or guidance and procurement processes
- Response to a need that has been assessed
- Clinical effectiveness, outcomes including assessment by NICE or other evidence-based review
- Impact on health inequalities and protected characteristics
- Will improve patient safety and experience
- Accessibility to service users
- Affordability and value for money

5. Appeals

NHS Doncaster CCG recognises that there may be times when members of the public are dissatisfied with its decisions. We are committed to undertaking engagement and consultation work that, at a minimum meets national expectations of best practice, and believe that doing so will help ensure our decisions are in the interests of the public of Doncaster.

Any patient/carer who feels that a decision is not justified may register a complaint or appeal, as per the below process. Ultimately, the CCG's decisions may be the subject to legal challenge from individuals or groups.

Figure 2- Patient Appeals Process



6. Procedures of Limited Clinical Value and Clinical Thresholds

NHS Doncaster CCG have set a number of clinical criteria as per Appendix 1 and the process for ensuring the clinical criteria are adhered to, is as below.

7. Process for operating the schedule

Please see Appendix 1 for the Clinical Thresholds and IFR Panel Referral Process.

Where prior approval is required to demonstrate exceptionality, all requests should be sent to Individual Funding Requests, 722 Prince of Wales Road, Sheffield, S9 4EU, or sent electronically to sheccg.sybifr@nhs.net (safehaven) or by safehaven fax to 0114 305 1370 adhering to confidentiality procedures. Request by letter or proforma will be accepted. Clinicians should include relevant information against exception criteria to enable decisions to be made on funding request.

SC 29.25 of the contract makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat. The IFR policy allows the IFR team 13 days to process the requests through the panel and request further information from the GP where required.

The CCG reserves the right to audit providers to ensure that prior approval criteria are adhered to and will expect evidence from providers to that effect.

8. Exceptionality

The CCG commissions according to the policy criteria. Requests for individual funding can be made only where exceptional circumstances exist and can be made through NHS Doncaster's Individual Funding Request (IFR) procedure.

Responsibility for demonstrating exceptionality rests with the referring clinician (potentially supported by the patient).

In order to demonstrate exceptionality the patient:

- Must be *significantly different* to the population of interest (i.e. patients with pulmonary hypertension and/or the subpopulation)

AND

- Be more likely to benefit from this intervention than might be expected than other patients with the condition

The fact that the treatment might be efficacious for the patient is not, in itself, grounds for exceptionality.

If a patient's clinical condition matches the 'accepted' indications for a treatment or situation which falls outside the commissioning policy the patient is, by definition, not exceptional.

9. Service Developments

The CCG will not introduce new drugs/technologies on an ad hoc basis through the mechanism of individual case funding. To do so risks inequity, since the treatment will not be offered openly and equally to all with equal need. There is also the risk that diversion of resources in this way will de-stabilise other areas of health care which have been identified as priorities by the CCG.

The CCG expects consideration of new drugs/technologies to take place within the established planning frameworks of the NHS. This will enable clear prioritisation against other calls for funding and the development of implementation plans which will allow access for all patients with equal need.

The CCG is required to achieve financial balance each year and therefore has a default policy of not funding a treatment where no specific policy exists to approve funding for the treatment. If the CCG has not previously been asked to fund an intervention that has the potential to affect a number of patients, the applications should be made by clinicians for the CCG to consider the intervention through its general commissioning policy and not by way of an IFR application.

Interventional Procedure Guidance issued by NICE will be deemed by the CCG as a Service Development and will not be routinely funded by the CCG unless agreed in advance.

10. Definitions

Definition of Procedures of Limited Clinical Value
Procedures of limited clinical value are those that deliver a relatively poor output/outcome to the population. This schedule sets out those procedures of limited clinical value that are not routinely commissioned or only commissioned when certain criteria are met.

Definition of Clinical Thresholds
Clinical thresholds are a predetermined set of criteria that must be met before some procedures are considered. The threshold may be such that medication would deal with the problem. Surgery should be a last resort for a number of conditions and should not take place before considering and trying other non-surgical, reasonable options.

Definition of Commissioning
Assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

Definition of Individual Funding Request
An individual funding request is where prior approval for a patient's treatment is required due to that treatment or symptom criteria being outside of our approved commissioning policies and in such cases exceptionality will need to be proven.

Definition of Exceptionality
In order to demonstrate exceptionality the patient

- Must be significantly different to the population of interest (i.e. patients with pulmonary hypertension and/or the subpopulation), and,
- Be more likely to benefit from this intervention than might be expected than other patients with the condition

For further information regarding Individual Funding Requests please see the following link: http://www.doncasterccg.nhs.uk/about-us/public-information/policies-and-procedures/clinical-policies/

11. Monitoring and Payment

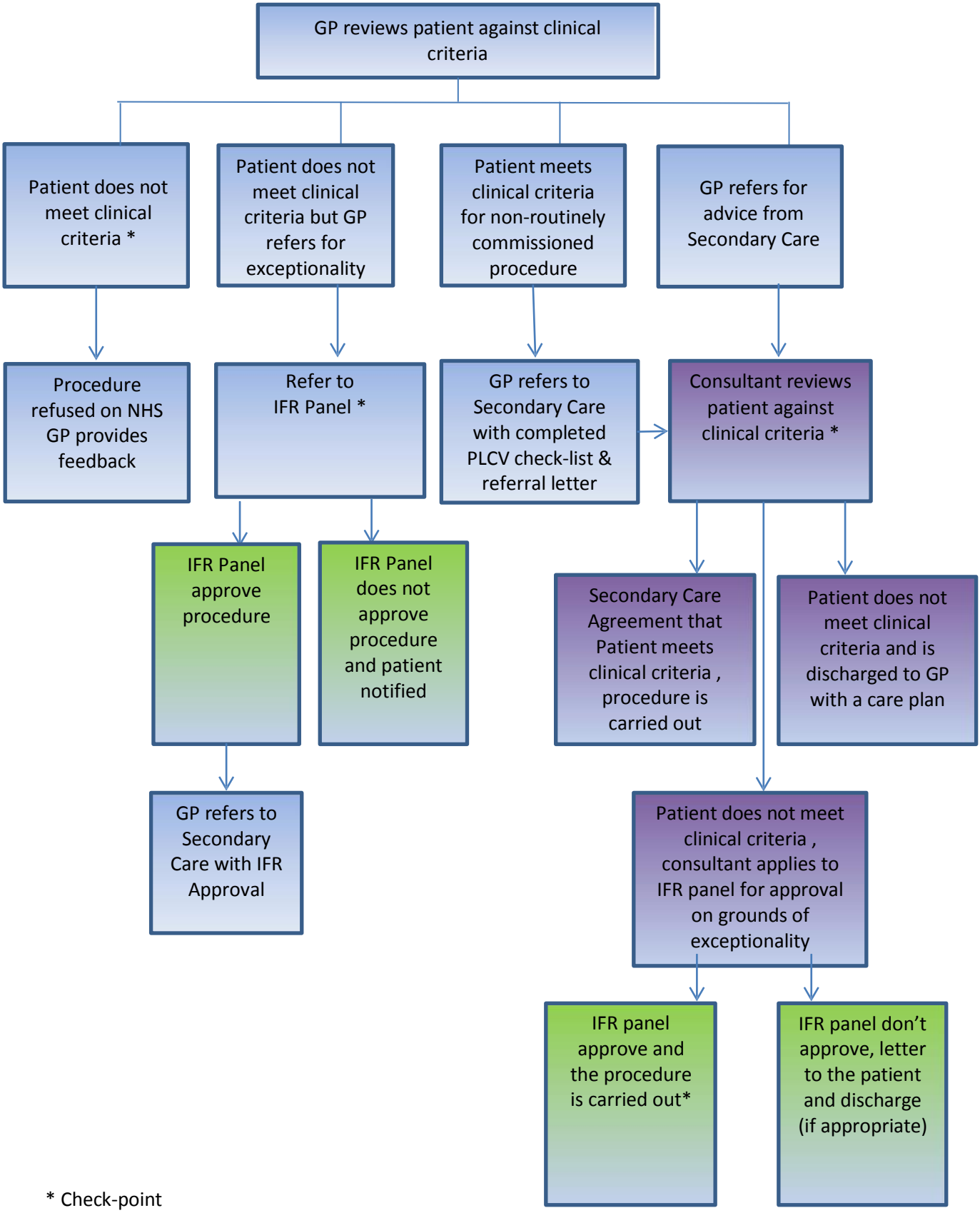
The CCG will audit adherence to the clinical thresholds policy. Where there is no evidence that the patient meets the clinical threshold, the CCG will not pay for the patient's treatment. The NHS Standard Contract Service Conditions 29.22 makes clear that the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed prior approval schemes. 5

The CCG will monitor activity and finance levels on a monthly basis through the Contract Finance, Performance and Information Group. A baseline will be established and activity monitored against the following OPCS codes listed in the table below

12. Commissioner Exceptional Treatment Request/Appeal Contact Points

Address:	722 Prince of Wales Road, Sheffield	
Named Lead:	Allison Ball	
Job Title:	Head of IFR	
Phone:	0114 305 1099	
E mail:	sheccg.sybifr@nhs.net	(safehaven)
Patient information:	sheccg.sybifr@nhs.net	(safehaven)
Safe haven fax:	0114 305 1370	

Appendix 1- Clinical Thresholds and IFR Panel Referral Process



* Check-point

Appendix 2 List of Treatments and Services (pre February 2017)

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
	Homeopathy			Various procedures	**Not Routinely Commissioned**	Insufficient high quality evidence on the clinical effectiveness, cost effectiveness and safety of homeopathic medicines.	
	AntiTNF's			AntiTNF's (Cytokine Inhibitors) – outside NICE Guidance	**Prior Approval Required** for those patients not meeting the NICE Guidance. Doncaster CCG does not routinely commission outside of NICE Guidance	NICE TAG's TA126, TA104 TA141,TA125 TA130,TA35, TA134,TA146 TA103,TA140 TA163,TA40 TA163	Contract monitoring and clinical audit
	Cardiology	K62		Open P.V.A. (Pulmonary Vein Ablation)	**Routinely Commissioned** for patients meeting criteria.	North Trent Cardiac Network commissioning position	Contract monitoring SLAM
	Cardiology	K62		Percutaneous P.V.A. (Pulmonary Vein Ablation)	**Prior Approval Required**	North Trent Cardiac Network commissioning position	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
	Custom Made Prosthetic Limbs			Custom Made Prosthesis Limbs	**Routinely Commissioned NHS Products** The CCG will only fund prosthetic limbs which are available on the NHS.		
	Dental	F08 F11.5	CZ02 S CZ02 T CZ02 W CZ02 Y	Dental Implants	**Not Routinely Commissioned** (orthodontics and oral surgery)		Contract monitoring SLAM
	Dental	F09.1 F09.3		Wisdom Teeth Removal	**Routinely Commissioned** for patients meeting the NICE criteria.	NICE TAG001	Routine contract monitoring
Updated Nov 2011	ENT	D15		Myringotomy /Grommets	**Routinely Commissioned meeting Criteria** Funding for grommets for children with persistent otitis media with effusion will be considered for the following indications: Otitis media with effusion has persisted for a three month period of watchful waiting after diagnosis in primary care and the child suffers from one of the following: -at least five recurrences of acute otitis media requiring medical assessment and/or treatment in the previous year. - hearing loss of at least 25dB, particularly in the lower tones with either delay in speech development or educational/behavioural problems attributable to the hearing loss. -a second significant health problem or		Contract monitoring SLAM But diagnosis code not E081, E201, E291, F34 or D191

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					disability, for example learning difficulties, developmental delay or autism, with tympanometric evidence of middle ear effusions and where a reliable hearing test has not been achieved after three attempts. -severe retraction of the tympanic membrane with risk of developing cholesteatoma or erosion of the ossicular chain. -suspected underlying sensorineural hearing loss, as demonstrated by a single hearing test with hearing loss of at least 50dB on pure tone audiometry or at least 65dB on free field testing and flat tympanograms. If the patient does not fully meet these criteria the clinician may still submit an application if exceptionality can be demonstrated. National supporting evidence- NICE CG 60 Surgical management of otitis media with effusion February 2008 http://www.nice.org.uk/nicemedia/live/11928/39564/39564.pdf NHS England Interim Commissioning Policy Grommets November 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf **Adults** Funding for grommets for adults will be considered for any of the following indications:		

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					- a middle ear effusion causing measured conductive hearing loss of at least 25 Db, persisting for at least three months and causing disability. - persistent Eustachian tube dysfunction resulting in pain. - as treatment for Meniere's disease. - severe retraction of the tympanic membrane with risk of developing cholesteatoma or erosion of the ossicular chain. If the patient does not fully meet these criteria the clinician may still submit an application if exceptionality can be demonstrated. National supporting evidence- NHS England Interim Commissioning Policy Grommets November 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf		
Updated Nov 2011	ENT	E201 E208 E209 F341 F342 F344 F345 F346 F348 F349 F361 F368 F369	CZ05 S CZ05 T CZ05 V CZ05 Y C57 C58	Tonsillectomy	**Routinely Commissioned meeting Criteria** If the indication for surgery is suspected malignancy or acute upper airways obstruction then prior approval is not required. Funding for tonsillectomy for both adults and children will be considered for the following indications: - sore throats are due to acute tonsillitis and - episodes of sore throat are	SIGN Guidance No. 117	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					disabling and prevent normal functioning as evidenced by three of the following criteria: tonsillar exudates, tender anterior cervical lymph nodes, history of fever, absence of cough and - seven or more well documented such episodes in the preceding year or - five or more such episodes in each of the preceding two years or - three or more such episodes in each of the preceding three years or - two documented episodes of quinsy or - severe halitosis secondary to tonsillar crypt debris. Funding for tonsillectomy for children will in addition be considered for the following indications: - failure to thrive due to difficulty eating solid foods If the patient does not fully meet these criteria the clinician may still submit an application if exceptionality can be demonstrated. National supporting evidence- SIGN Guidance No 117 April 2010 Management of sore throat and indications for tonsillectomy http://www.sign.ac.uk/guidelines/fulltext/117/index.html NHS England Interim Clinical Commissioning policy for tonsillectomy		

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					November 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC033.pdf •		
	Gastroenterology	G802	FZ15Z FZ07 B FZ07 A	Wireless Capsule Enteroscopy for Investigation of the Small Bowel	**Not Routinely Commissioned from DBHFT** This investigation is commissioned by the CCG at STHT.	NICE IPG 101	Contract monitoring SLAM
Updated Nov 2011	General Surgery	L84 L85 L86 L87 L88		Varicose Veins	**Routinely Commissioned meeting Criteria** Patients with bleeding varicose veins do not need prior approval and can be referred to a vascular service immediately. Conservative management should be the first line of treatment and applications will not normally be accepted for patients whose BMI is over 30. Interventional treatment of varicose veins will only be commissioned for patients aged 18 and over when any of the following criteria apply: • skin changes secondary to chronic venous insufficiency, for example pigmentation or venous eczema. • at least two episodes of superficial thrombophlebitis. • active or healed venous leg ulcers. • a previous episode of bleeding from the varicosity. • symptomatic varicose veins (veins associated with troublesome		Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					symptoms, typically pain, swelling, heaviness and aching). If the patient does not fully meet these criteria, the clinician may still submit an application if exceptionality can be demonstrated. National supporting evidence: NICE CG168 The diagnosis and management of varicose veins July 2013 http://publications.nice.org.uk/varicose-veins-in-the-legs-cg168 NHS England Interim clinical commissioning policy for varicose veins November 2013 http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC035.pdf		
	Neurology	S53.2		Botulinum Toxin – Neurology/Spines /Neurorehabilitation. Urology/Ophthalmology	**Routinely commissioned** for patients meeting criteria Use of Botox described in BNF section 4.9.3. will continue	CCG policy	Contract monitoring SLAM
	Obstetrics & Gynaecology	Q29 Q37		Reversal of Female Sterilisation	**Not Routinely Commissioned**		Contract monitoring SLAM
	Obstetrics & Gynaecology	Y96		In-vitro fertilisation (IVF)/ Assisted conception	IVF is approved in accordance with Policy. Prior Approval if referred via primary care	NHS Doncaster Commissioning Policy for IVF/ICSI Has the new policy been through your Governing Body	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
	Ophthalmology	C46.1		Laser surgery for Short Sight	**Not Routinely Commissioned**		Contract monitoring SLAM
	Orthodontics	F14 F15		Orthodontic treatment	**Routinely Commissioned** for patients meeting criteria. An Index of Orthodontic Treatment Need of 3.6 or above. Only patients under the age of 18 years are eligible for routine NHS orthodontic treatment. These criteria may be waived where the consultant clinician considers that there are exceptional or mitigating circumstances and prior approval has been sought from the CCG		Contract monitoring SLAM
	Paediatrics			Cranial banding for positional plageocephaly	**Not Routinely Commissioned.** Cranial Banding will not be routinely commissioned. The available evidence does not show cranial banding as a treatment for brachycephaly and positional plagiocephaly to be effective.		
Updated July 2015	Plastic and Cosmetic surgery	S01		Facelift Browlift	**Facelift procedures and Botulinum toxin will not be routinely commissioned by the NHS for cosmetic reasons** Cases may be considered on an exceptional basis, for example in the presence of an anatomical abnormality or a pathological feature which significantly affects appearance.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
Updated July 2015	Plastic and Cosmetic surgery	S02		Abdominoplasty/ apronectomy (tummy tuck)	**Abdominoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Abdominoplasty may rarely be considered on an exceptional basis, for example where the patient: • has lost a significant amount of weight (moved down two levels of the BMI SIGN guidance) and has a stable BMI, which would normally be below 27 for a minimum of 2 years, **and** • is experiencing severe difficulties with daily living, for example ambulatory or urological restrictions. Other factors may be considered: • recurrent severe infection or ulceration beneath the skin fold • significant abdominal wall deformity due to surgical scarring or trauma	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	S03		Buttock, thigh and Arm lift surgery	**Not Routinely Commissioned** Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					exceptional basis, for example where the patient: • has an underlying skin condition, for example cutis laxa or • has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living **and** • has a normal BMI in the range18.5 - 25 for a minimum of 2 years		
	Plastic and Cosmetic surgery	S010.3 S011.3		Resurfacing procedures e.g. Chemical peels to face	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	B30 B31.2		Breast Augmentation	**Breast augmentation will not be routinely commissioned by the NHS for cosmetic reasons, for example for small normal breasts or for breast tissue involution (including post-partum changes).** Breast augmentation may rarely be considered on an exceptional basis, for example where the patient: • has a complete absence of breast tissue either unilaterally or bilaterally or • has suffered trauma to the breast during or after development and	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					• has a BMI within the range 18.5 - 25 and • has completed puberty as surgery is not routinely commissioned for individuals who are below 19 years of age Patients who have received feminising hormones for an adequate length of time as part of a recognised treatment programme for gender dysphoria will only be considered when they meet the above criteria. Revision surgery will only be commissioned for implant failure or for other physical symptoms, for example capsule contracture associated with pain, and not for aesthetic indications. Implant replacement will only be considered if the original procedure was performed by the NHS. If the criteria above are met then the patient will be referred to Nottingham for a breast scan, for objective information regarding this request. 3 breast scans will be undertaken. These are: • BMI • Breast Volume • Breast : Torso Ratio The patient must pass BMI test and one other test to be eligible for funding		

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
Updated July 2015	Plastic and Cosmetic surgery	B31		Breast Reduction	**Not Routinely Commissioned** Breast reduction will not routinely be commissioned by the NHS for cosmetic reasons. Breast reduction may rarely be considered on an exceptional basis, for example where the patient: • has a breast measurement of cup size G or larger **and** • has a BMI in the range 18.5 - 25 **and** • is 19 years of age or over **and** • has significant musculo-skeletal pain causing functional impairment which in the opinion of the referrer is likely to be corrected or significantly improved by surgery **and** • has tried and failed with all other advice and support, including a professional bra fitting and assessment by a physiotherapist where relevant If the criteria above are met then the patient will be referred to Nottingham for a breast scan, for objective information regarding this request. 3 breast scans will be undertaken. These are:	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					• BMI • Breast Volume • Breast : Torso Ratio The patient must pass all 3 tests to be eligible for funding **National supporting evidence** NHS England Interim Commissioning Polic http://www.england.nhs.uk/wp-content/uplo		
Updated July 2015	Plastic and Cosmetic surgery	B31		Breast Reduction for male gynaecomasti a	**Not Routinely Commissioned** Surgery to correct gynaecomastia will not routinely be commissioned by the NHS for cosmetic reasons. Surgery may be considered on an exceptional basis, for example where the patient: • has more than 100g of sub areolar gland and ductal tissue (not fat) **and** • has a BMI in the range 18.5 - 25 **and** • has been screened prior to referral to exclude endocrinological and drug related causes ○ if drugs have been a factor then a period of one year since last use should have elapsed **and**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					not routinely commissioned below the age of 19 years **and** • has been monitored for at least 1 year to allow for natural resolution if aged 25 or younger **National supporting evidence** NHS England Interim Commissioning Polic http://www.england.nhs.uk/wp-content/uplo		
Updated July 2015	Plastic and Cosmetic surgery			Breast Asymmetry	**Not Routinely Commissioned** Surgery to correct breast asymmetry will not routinely be commissioned by the NHS for cosmetic reasons. Surgery may rarely be considered on an exceptional basis, for example where the patient: • has a difference of at least 2 cup sizes and • has a BMI in the range 18.5-25 and • has tried and failed with all other advice and treatment, including a professional bra fitting and • has completed puberty - surgery is not normally commissioned below the age of 19 years If the criteria above are met then the patient will be referred to Nottingham for a breast scan, for objective information	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					regarding this request. 5 breast scans will be undertaken. These are: • BMI • Volume • Nipple to Fold • Areola Diameter • Notch to Nipple The patient must pass BMI test and one other test to be eligible for funding National supporting evidence NHS England Interim Commissioning Polic http://www.england.nhs.uk/wp-content/uplo		
Updated July 2015	Plastic and Cosmetic surgery	B31.3		Breast lift mastopexy	**Not Routinely Commissioned** Mastopexy will not be routinely commissioned by the NHS for cosmetic reasons, for example post lactation or age related ptosis but may be included as part of the treatment to correct breast asymmetry.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	B35		Correction of Nipple inversion	**Not Routinely Commissioned** Surgical correction of benign nipple inversion will not be routinely commissioned by the NHS for cosmetic reasons.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic	s60.		Hair removal ICD 10 I68.0	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
	surgery				Hair removal will not be routinely commissioned by the NHS for cosmetic reasons. Hair removal may be considered on an exceptional basis, for example where the patient: • has had reconstructive surgery resulting in abnormally located hair bearing skin or • has a pilonidal sinus resistant to conventional treatment in order to reduce recurrence risk		SLAM
Updated July 2015	Plastic and Cosmetic surgery	S33 S34		Hair transplantation	**Not Routinely Commissioned** Hair transplantation will not be routinely commissioned by the NHS for cosmetic reasons, regardless of gender. Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is needed following cancer or trauma.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	S60.1, s60.4 S60.2		Acne scarring ICD10 L70	**Procedures to treat facial acne scarring will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					treatments.		
Updated July 2015	Plastic and Cosmetic surgery	C13		Blepharoplasty	**Blepharoplasty will not be routinely commissioned by the NHS for cosmetic reasons.** Cases may be considered on an exceptional basis when there is excess skin or ptosis of the upper eyelid which is confirmed to obscure vision.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
	Plastic and Cosmetic surgery	D06.2		Otoplasty Earlobe repair in the absence of traumatic injury	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	D03		Pinnaplasty	**Not Routinely Commissioned** Surgical correction of prominent ears will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern **and** • has very significant ear deformity or asymmetry **National supporting evidence** NHS England Interim Commissioning Polic	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC027.pdf		
Updated July 2015	Plastic and Cosmetic surgery	E02		Rhinoplasty	**Not Routinely Commissioned** Rhinoplasty will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example in the presence of severe functional problems. Post traumatic airway obstruction or septal deviation does not need funding approval.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery			Rhinophyma	**Not Routinely Commissioned** Surgical/laser treatment of rhinophyma will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an individual basis, for example where the patient has functional problems and where conventional medical treatments have been ineffective.	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery			Revision of Surgical Scars	**Not Routinely Commissioned** Revision surgery for scars will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient:	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					• has significant deformity, severe functional problems, or needs surgery to restore normal function or • has a scar resulting in significant facial disfigurement.		
Updated July 2015	Plastic and Cosmetic surgery	S09.2		Congenital vascular abnormalities	**Not Routinely Commissioned** Procedures for congenital vascular abnormalities will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only. .	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	L86.1 (injection) S09.2 (laser) S09.1 (head)		Thread vein/telangectasia	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	S60.1 S60.2 S60.3		Tattoo removal ICD10 L81.8	**Tattoo removal will not be routinely commissioned by the NHS.** Cases may be considered on an exceptional basis, for example where the patient: • has suffered a significant allergic reaction to the dye and medical treatments have failed • has been given a tattoo against their will (rape tattoo)	Policy for specialist plastic surgery procedures	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
Updated July 2015	Plastic and Cosmetic surgery	P05.5 P05.6 P05.7		Reduction of labia minora (Labioplasty)	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
	Plastic and Cosmetic surgery	N29		Phallaplasty	**Not Routinely Commissioned**	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
Updated July 2015	Plastic and Cosmetic surgery	S62.1 (head and neck) S62.2 (other)		Liposuction	**Not Routinely Commissioned** Liposuction will not be routinely commissioned by the NHS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient has significant lipodystrophy. .	Policy for specialist plastic surgery procedures	Contract monitoring SLAM
	Pain Management	A70		SNS for pain	**Prior Approval Required.** SNS for Pain will be commissioned in accordance with the NICE TAG 159 and the European Consensus on Neuromodulation of pain1998.	NICE TAG 159 NHS Doncaster Commissioning policy	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
	Trauma & Orthopaedics			Hip Arthroscopy for hip impingement	**Not routinely commissioned** Arthroscopic femoro-acetabular surgery for hip impingement syndrome should only be used with "special arrangements for consent and for audit or research" There are no East Midlands Units currently offering this service and the arrangements for consent or research at Coventry, the sole provider are unclear at present. Current evidence on safety and efficacy does not appear adequate to recommend hip arthroscopy for other indications, treatments or diagnoses.	NICE Interventional Procedure Guidance 213	
	Trauma & Orthopaedics	X334	SA26 A SA26 B	Autologous Cartilage transplantation	**Not routinely commissioned** ACI is not recommended for treating knee problems caused by damaged articular cartilage, unless it is used in studies that are designed to produce good quality information about the results of the procedure. These results should include measuring any improvement in patients' quality of life and the benefits and risks of ACI over a long period of time,	NICE TAG89	Contract monitoring SLAM
Updated Nov 2011	Trauma & Orthopaedics	V25 V26 V33 V34 V382-4 V393-5 V433 V473		Lumbar Spine procedures	**Not Routinely Commissioned** Lumbar spine procedures are not routinely commissioned for non-specific lower back pain.		Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
		V485-6 V493					
	Urology	N181	LB34A LB34B LB34C	Reversal of Male Sterilisation	**Not routinely commissioned**		Contract monitoring SLAM
	Urology	N303 Z426	LB32A LB32B LB32C	Male Circumcision	**Not Routinely Commissioned** Circumcision will only be considered for a small number of therapeutic reasons in line with policy • True "pathological" Phimosis either primary or secondary to circumcision • True recurrent Balanoposthis (recurrent bacterial infection of the prepuce).		Contract monitoring SLAM
	Urology	A483 Z112	AB01Z	Sacral Nerve Stimulation for Faecal Incontinence	**Not Routinely Commissioned** In accordance with NICE CG 49 and NICE IPG64 treatment should also be offered to patients who meet the criteria outlined in the policy		Contract monitoring SLAM
	Urology	N17*	LB33Z	Vasectomy	**Not Routinely Commissioned in Secondary Care** Provision of vasectomy should only be undertaken in a primary care setting, it is not commissioned as a secondary care service. However it is noted that referral to secondary care may be required in some circumstances e.g. GA for Needle phobics		Contract monitoring SLAM

Appendix 3 List of Treatments and Services (post February 2017)

Benign Skin lesions
Cholecystectomy
Interventional treatment for Haemorrhoids
Hernia Repair (Inguinal, umbilical, para-umbilical, incisional)
Cataract Surgery
Hip/Knee Replacement for osteoarthritis
Carpal Tunnel Syndrome
Common Hand Conditions (Dupuytren's, Trigger Finger, Ganglion)
Acupuncture for Low Back pain and sciatica

Appendix 3 List of Treatments and Services (post February 2017)

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
Updated January 2017	Dermatology Adults & Children			Benign Skin lesions Minor surgery: Seborrhoeic warts Molluscum contagiosum Spider angiomas (thread veins) Cherry angiomas or Campbell de Morgan spots Skin Tags and papillomas Naevi (moles) and other benign haemangiomas Xanthelasma Lipomas Sebaceous Cysts Port Wine stains	DCCG will only offer funding if one or more of the eligibility criteria has been met. • Diagnostic uncertainty exists ***following Telederm report*** • The lesion is painful or impairs function and warrants removal, but it would be unsafe to do so in primary care/community setting, for example because of large size (>10mm), location (e.g. face or breast) or bleeding risk. Removal would not be purely cosmetic. • Viral warts in the immunosuppressed. • Patient scores >20 in Dermatology Life Quality Index administered during a consultation with the GP or other healthcare professional. ****NICE recommend GPs use the following checklist, with major features scoring 2 and minor features scoring 1. A score of 3 indicated high suspicion of malignancy. If there is a strong clinical suspicion, the patient may be referred on the basis of one feature alone.*** Major features Minor features Change in size Diameter > 7mm Irregular in shape Inflammation Irregular in colour	http://www.nice.org.uk/nicemedia/live/10968/29814/29814.pdf (p35) Kerr OA, Tidman MJ, Walker JJ *et al.* The profile of dermatological problems in primary care. *Clin Exp Dermatol*. 2010; (4):380-3 http://www.patient.co.uk/doctor/minor-surgery-in-primary-care George S, Pockney P, Primrose J *et al.* A prospective randomised comparison of minor surgery in primary and secondary care. The MiSTIC trial. *Health Technology Assessment* 2008;12(23):iiiiv, ix-38. Mazzotti E, Barbaranelli C, Picardi A *et al.* Psychometric properties of the Dermatology Life Quality Index (DLQI) in 900 Italian patients with psoriasis.Acta Derm Venereol 2005;85(5):409-13 http://www.dermatology.org.uk/quality/dlqi/quality-dlqi.html	Contract monitoring SLAM

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					Oozing Change in sensation		
Updated January 2017	General Surgery Adults only			Cholecystectomy	The CCG will **only** support the funding of cholecystectomy in incidental gallstones if **one or more** of the following criteria are met: • High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer). • Transplant recipient (pre or post transplant). • Diagnosis of chronic haemolytic syndrome by a secondary care specialist. • Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct, stones smaller	Sanders G, Kingsnorth AN. Gallstones. *BMJ*. 2007;335:295-9. Sakorafas GH, Milingos D, Peros G. Asymptomatic cholelithiasis: is cholecystectomy really needed? A critical reappraisal 15 years after the introduction of laparoscopic cholecystectomy. *Dig Dis Sci*. 2007;52:1313-25. http://www.rcseng.ac.uk/healthcare-	
Updated January 2017	General Surgery Adults only			Interventional treatment for Haemorrhoids	Interventional treatment for Haemorrhoids will be considered only if one of the following criteria are met: • Symptomatic 3rd and 4th degree haemorrhoids • Recurrent 2nd degree haemorrhoids with failed conservative treatment • Persistent pain or bleeding *Conservative measures = high fibre diet, exercise, weight loss and topical preparations, followed by non-surgical ablative/fixative interventions and rubber band ligation. Documentation of dates and	1.Davies RJ. Haemorrhoids. BMJ Clinical Evidence. April 2006. Available at: http://www.clinicalevidence.com/ceweb/conditions/dsd/0415/0415.jsp 2.Brisinda G. How to treat haemorrhoids. BMJ 2000; 321: 582-3	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					types of conservative measures required to be included with this form. Definition of degrees of haemorrhoids: • First grade: the haemorrhoids remain inside at all times • Second grade: the haemorrhoids extend out of the rectum during a bowel movement but return on their own • Third grade: the haemorrhoids extend out during a bowel movement but can be pushed back inside • Fourth grade: the haemorrhoid is always outside.		
Updated January 2017	General Surgery Adults only			Hernia Repair (Inguinal, femoral, Umbilical, para-umbilical, incisional)	*Inguinal:* Surgical treatment should only be offered when one of the following criteria is met: • Symptomatic i.e. symptoms are such that they interfere with work or activities of daily living **OR** • The hernia is difficult or impossible to reduce, **OR** • Inguino-scrotal hernia, **OR** • The hernia increases in size month on month *Femoral:* All suspected femoral hernias should be	National Institute for Health and Care Excellence (2004) laprascopic surgery for hernia repair. [TA83]. London: National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ta83 (Accessed 2016) Medscape: *Hernias.* Available from: http://emedicine.medscape.com/article/775630-overview#a0104 (accessed 2016) McIntosh A. Hutchinson A. Roberts A & Withers, H. Evidence-based	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					referred to secondary care due to the increased risk of incarceration/strangulation *Umbilical/Paraumbilical and midline ventral hernias:* Surgical treatment should only be offered when one of the following criteria is met: • pain/discomfort interfering with Activities of Daily Living **OR** • Increase in size month on month **OR** • to avoid incarceration or strangulation of bowel where hernia is > 2cm *Incisional:* Surgical treatment should only be offered when of the following criteria are met: Pain/discomfort interfering with Activities of Daily Living	management of groin hernia in primary care—a systematic review. Family Practice, 2000;17(5), 442-447. GP notebook: *Paraumbilical hernias*. Available from: http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1811546097&linkID=17862&cook=n (accessed 2016) Friedrich M. Müller Riemenschneider F. Roll S. Kulp W. Vauth C. Greiner W & von der Schulenburg JM. Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. *GMS health technology assessment*. 2008;*4*. Dabbas. Frequency of abdominal wall hernias: is classical teaching out of date. JRSM *Short Reports*: 2011;2/5. Fitzgibbons. Watchful waiting versus repair of inguial hernia in minimally symptomatic men, a randomised controlled trial. *JAMA*: 2006;295, 285-292 Purkayastha S. Chow A, Anthanasiou T, Tekkis P P & Darzi A. Ingunal hernias. *Clinical evidence, 2008;*0412, 1462-3846 Rosenberg J. Bisgaard T. Kehlet H. Wara P. Asmussen T. Juul P & Bay-	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
						Nielsen M. Danish Hernia Database recommendations for the management of inguinal and femoral hernia in adults. *Dan Med Bull*, 2011;*58*(2), C4243. Simons M P. Aufenacker T. Bay-Nielsen M. Bouillot J L. Campanelli G. Conze J & Miserez, M. European Hernia Society 14 guidelines on the treatment of inguinal hernia in adult patients. Hernia, 2009;13(4),343-403. Primatesta P & Goldacre MJ. Inguinal hernia repair: incidence of elective and emergency surgery, readmission and mortality. International journal of epidemiology, 1996;25(4), 835-839. Patient Care Committee, & Society for Surgery of the Alimentary Tract. Surgical repair of incisional hernias. SSAT patient care guidelines. Journal of gastrointestinal surgery: official journal of the Society for Surgery of the Alimentary Tract. 2004;8(3), 369. The Society for Surgery of the Alimentary Tract. Surgical Repair of Groin Hernias. Available from: http://www.ssat.com/cgi-bin/hernia6.cgi (accessed 2016)	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
Updated March 2017	Ophthalm-ology Adults only			Cataract Surgery	***For first eye surgery:*** All requests for the surgical removal of cataract in the first eye will **only** be supported by the CCG when the total assessment score is 7 or above as per the Cataract Assessment Checklist. ***For second eye surgery:*** If vision in the first operated eye is be 6/9 or better (0.20 logMAR) corrected postoperatively then the patient will need to have sufficient cataract to cause blurred or dim vision with a monocular distance acuity of 6/18 (0.40 logMAR) or worse in the second eye to qualify for cataract surgery. If vision in the first eye does not correct to 6/9 or better then second eye cataract surgery can be offered only if the binocular corrected vision is worse than 6/9 or the second eye vision is monocularly worse than 6/18 corrected.	Department of Health. National Eye Care Plan (2004) The Royal College of Ophthalmologists: Cataract Surgery guidelines (2004) NHS Executive. Action on Cataracts; Good Practice Guidance (2000). Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S. Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older people in the community. *Br J Ophthalmol* 2002; 86: 795- 800 NICE February 2014. Eye conditions pathway http://pathways.nice.org.uk/pathways/eye-conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209.February 2007. http://guidance.nice.org.uk/IPG209	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					Exceptions: The only exceptions to the above referral criteria are as follows: • Anisometropia (a large refractive difference between the two eyes, on average about dioptres) which would result in poor binocular vision or disabling diplopia which may increase falls. • Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma • Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management. • Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery • Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty) • Corneal or conjunctival disease where delays might increase the risk of complications (e.g.cicatrising conjunctivitis) • Other glaucoma's (including open-	800 NICE February 2014. Ey e conditions pat hway http://pathways.nice.org.u k/pathways/eye -conditions NICE guidance IPG 264. June 2008. https://www.nice.org.uk/guidance/ipg264 NICE guidance IPG 209. February 2007. http://guidance.nice.org.u k/IPG209	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					angle glaucoma), inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography • Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes) • Post Vitrectomy cataracts which hinder the retinal view or result in a rapidly progressing myopia. Cataracts progress fairly rapidly following vitrectomy and are age dependent. Patients over the age of 50, especially those over 60 can have a rapid increase in the density of a cataract.		
Updated January 2017	Orthopaedics Adults only			Hip/Knee Replacement for osteoarthritis	Doncaster CCG will only fund hip/knee replacement for osteoarthritis when conservative measures have failed (listed below) AND the following criteria have been met: Patient's clinical condition must be clearly documented during a clinical encounter prior to surgical decision and documentation must include dates and description of measures: (If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement	http://pathways.nice.org.uk/pathways/musculoskeletal-conditions (accessed 2016) National Institute of Health. Consensus development program. Dec 2003 https://consensus.nih.gov/2003/2003totalkneereplacement117html.htm (accessed 2016) The musculoskeletal services framework – A joint responsibility: doing it differently. Department of Health. 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digit	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request) • Referral to the Hip or Knee Pathway **AND** • Patient has a BMI of less than 35 (Patients with BMI>35 should have 6 months of documented weight loss attempt with dates and intervention types- if the patient fails to lose weight to a BMI less than 35 then may consider referral through the IFR process.) **AND** • Intense to severe persistent pain which leads to severe functional limitations, ***OR*** • Moderate to severe functional limitation affecting the patients quality of life despite 6 months of conservative measures including referral to the local hip pathway or its successor. ***Exceptions include:*** 1. Patients whose pain is so severe and/or mobility is compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this. 2. Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure. 3. Rapid onset of severe hip pain	alassets/@dh/@en/documents/digitalasset/dh_4138412.pdf Namba, R., Paxton, L., Fithian, D., and Stone, M. Obesity and perioperative morbidity in total hip and total knee arthroplasty patients. J Arthroplasty 20(7) Supplement 3 (2005), 46-50. Hawkeswood MD, J.,Reebye MD, R. Evidence-based guidelines for the nonpharmacological treatment of osteoarthritis of the hip and knee. Issue: BCMJ, Vol. 52, No. 8, October 2010, page(s) 399-403 Articles. College of General Practitioners. 'Guideline for the non-surgical management of hip and knee osteoarthritis. July 2009.InterQualR. Total Joint Replacement Hip Procedures criteria. 2013. NICE. TA44 Metal on Metal Hip Resurfacing. 04 January 2013. https://www.nice.org.uk/guidance/TA2/documents/appendix-b-proposal-paper-presented-to-the-institutes-guidance-executive2 NHS England. Interim Clinical Commissioning Policy: Hip Resurfacing. November 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC019.pdf Kandala NB, Connock M, Pulikottil-	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					Conservative measures: - Patient education such as elimination of damaging influence on hips/knees, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment. Documentation of this is required. **AND** - Physiotherapy or appropriate exercise undertaken **AND** - Oral analgesia. Opioid analgesics can be used effectively if paracetamol or NSAIDS are ineffective or poorly tolerated. Documentation of dates and medication types is required **AND** - Steroid injection, if appropriate	Jacob R, Sutcliffe P, Crowther MJ, Grove A,Mistry H Clarke A. Setting benchmark revision rates for total hip replacement: analysis of registry evidence. BMJ 2015;350:h756 doi: 10.1136/bmj.h756 (Published 9 March 2015)	
Updated January 2017	Orthopaedics Adults only			Carpal Tunnel Syndrome	Doncaster CCG will only fund Carpal Tunnel Surgery when either of the following criteria is met: • Severe symptoms at presentation CTS score 5 or more (including sensory blunting, muscle wasting, weakness on thenar abduction or symptoms significantly interfere with daily activities)*, OR • If there is no improvement in mild-moderate symptoms after 6 months conservative management which includes nocturnal splinting used for at least 8 weeks (documentation of dates and type(s) of conservative measures is required) • Steroid injection	Bickel, K. (2010). Carpal Tunnel Syndrome. *Journal of Hand Surgery*, 35 (1), pp. 147-151285-1295 Massy-Westropp. N, Grimmer.K and Bain. G, (2000). A systematic review of the clinical diagnostic tests for carpal tunnel syndrome, *J Hand Surgery,* 25A, pp. 120–127. Gerritsen. A, de Krom. M, Struijs. M, Scholten. R, de Vet.H, Bouter. L. (2002) Conservative treatment options for carpal tunnel syndrome: a systematic review of randomised control trials. *Journal Neurology*, 249, pp.272-80 Bland, J.(2007). Carpal Tunnel Syndrome. *BMJ*, 335:343-6	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					*This criterion includes all individuals whose symptoms are severe where six months conservative management would be detrimental to the management of the condition. Evidence should be provided to demonstrate severity of symptoms	Kruger. V, Kraft.G, Deitz.J, Ameis.A, Polissar.L. (1991). Carpal tunnel syndrome: objective measures and splint use. *Arch phys Med Rehabil*, 72, pp.517-20 Manente. G, Torrieri. F, Di Blasio. F, Staniscia. T, Romano. F, Uncina. A. (2001). An innovative hand brace for carpal tunnel syndrome: a randomised controlled trial. *Muscle Nerve*, 24, pp. 1020-5. Gerritsen, A.A., Uitdehaag, B.M., van Geldere, D. et al. (2001) Systematic review of randomized clinical trials of surgical treatment for carpal tunnel syndrome. *British Journal of Surgery,* 88(10), pp.1285-1295 Wong. S, Hui. A, Tang. A, Ho. P, Hung. L, Wong. K. (2001). Local vs systematic corticosteroids in the treatment of carpal tunnel syndrome. *Neurology*, 56, pp.1565-7. Marshall, S., Tardif, G. and Ashworth, N. (2007) *Local corticosteroid injection for carpal tunnel syndrome (Cochrane Review).* The Cochrane Library. Issue 2. John Wiley & Sons, Ltd. British Society for Surgery of the Hand. BSSH Evidence for Surgical Treatment (BEST) 1: Carpal Tunnel Syndrome. http://www.bssh.ac.uk/patients/conditi	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
						ons/21/carpal_tunnel_syndrome	
Updated January 2017	Orthopaedics Adults only			Common Hand Conditions (Dupuytren's, Trigger Finger, Ganglion)	*Dupuytren's Disease:* Referral should **only** be considered when the patient is having **at least one** of the following functional difficulties: • Moderate to severe form of the disease with notable functional impairment • Loss of extension in one or more joints exceeding 30 degrees at MCP joint (or 20 degrees or more at PIP joint) **OR** • Disease affecting 2 or more digits and loss of extension exceeding 20 degrees, in one digit *Ganglions:* Referral should only be undertaken when one of the following criteria are met: • Painful seed ganglia • Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) **OR** • If diagnosis is in doubt There is no indication for the routine excision of simple wrist ganglia and these should not be routinely referred. *Trigger Finger:* Referral should only be undertaken when	British Society for Surgery of the Hand. BSSH Evidence for Surgical Treatment (BEST) 1: Dupuytren's Disease. http://www.bssh.ac.uk/patients/conditions/25/dupuytrens_disease Davis, T. et al. Surgery for dupuytren's contractures of the fingers. Cochrane Musculoskeletal Group. Published online 17 Oct.2012. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010143/epdf NICE Clinical Knowledge Summaries. Dupuytren's disease. http://cks.nice.org.uk/dupuytrens-disease	

	Speciality	OPCS code	HRG	Procedure	Commissioning Position	Evidence Base	Monitoring
					the following criteria have been met including patient record documentation of conservative treatment interventions: • Fixed flexion or extension deformity that cannot be corrected • No improvement after conservative treatment of splinting and non-steroidal anti-inflammatory drugs **and** steroid injection (max 2 injections with a 10 week interval between each injection)		
Updated January 2017	Orthopaedics			Acupuncture for Low Back pain	In accordance with NICE NG59.	https://www.nice.org.uk/guidance/NG59/chapter/recommendations	

Appendix 4 Checklists for Treatments and Services (post February 2017)

Benign Skin lesions
Cholecystectomy
Interventional treatment for Haemorrhoids
Hernia Repair (Inguinal, umbilical, para-umbilical, incisional)
Cataract Surgery
Hip/Knee Replacement for osteoarthritis
Carpal Tunnel Syndrome
Common Hand Conditions (Dupuytren's, Trigger Finger, Ganglion)
Acupuncture for Low Back pain and sciatica