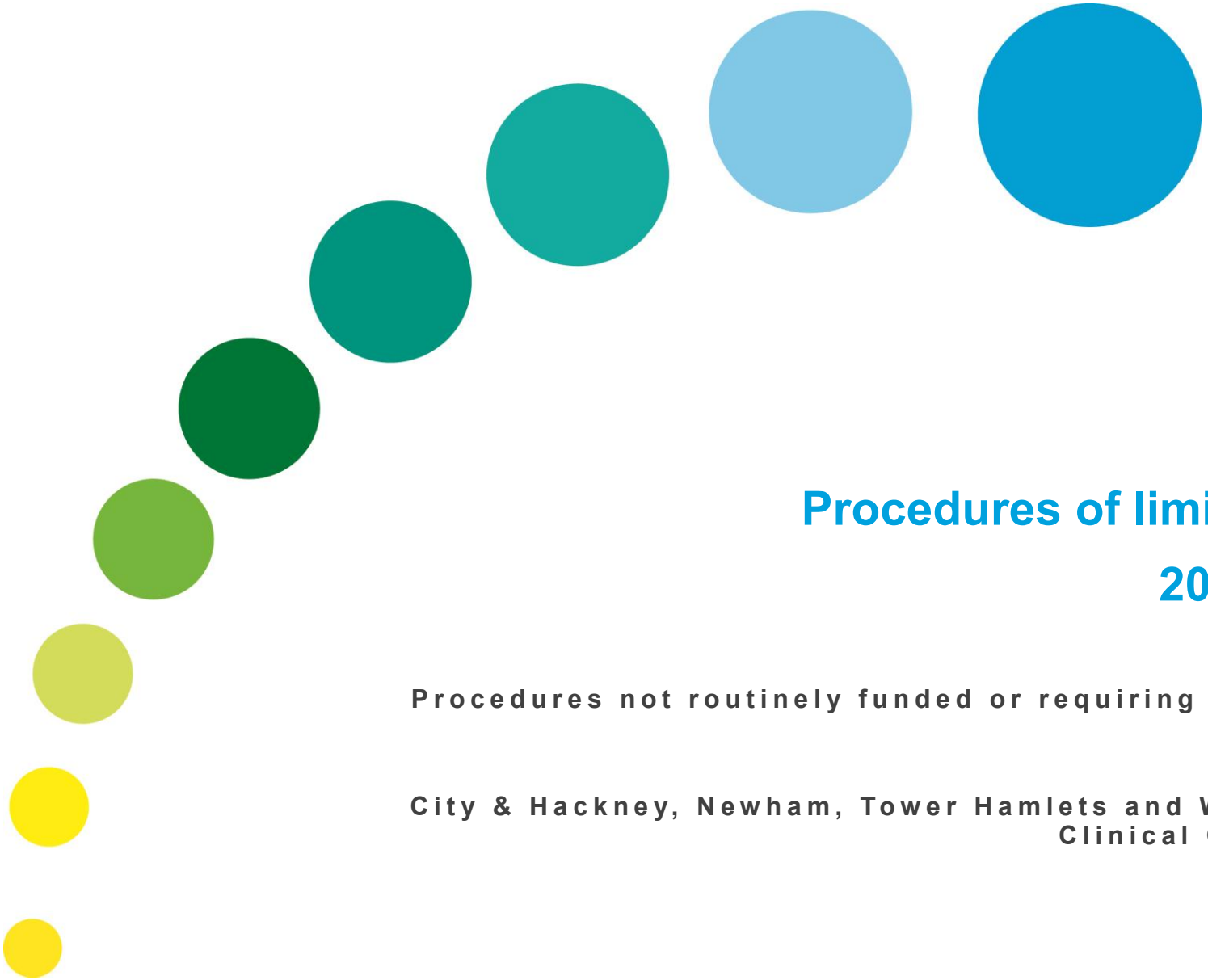

Procedures of limited clinical value

2014/2015 – 2015/16

Procedures not routinely funded or requiring prior funding approval

City & Hackney, Newham, Tower Hamlets and Waltham Forest (WELC) Clinical Commissioning Groups

Document revision history

Date	Version	Revision	Comment	Author / Editor
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Document approval

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General principles

1. City & Hackney, Newham, Tower Hamlets, and Waltham Forest (WELC) Clinical Commissioning Groups will commit NHS resources where there is clearly articulated need in terms of symptoms and/or clinical signs and the proposed intervention is demonstrably effective in relieving these. It follows from this that WELC CCGs will not fund procedures aiming to give a patient the body contour or appearance that they desire.

Treatment	Criteria for funding	Additional information
Female breast reduction, correction of breast asymmetry, and breast lift (mastopexy)	Bilateral breast reduction surgery is not routinely funded by WELC CCGs. In rare occasions and with prior approval funding may be considered if the criteria below are met and evidenced: 1. The patient's breast size is cup size H or larger **AND** 2. The breast reduction surgery should result in a reduction in breast size of at least three cup sizes **OR** 500gm per side **AND** 3. The patient has a BMI equal to or below 27 kg/m2 for at least two years (documented). **AND** 4. Evidence to be submitted to demonstrate patient is symptomatic – with at least TWO of the following for at least one year (documented evidence of GP visits for these problems): • Pain in the neck • Pain in the upper back • Pain in the shoulders • Painful kyphosis documented by X-rays • Pain / discomfort / ulceration from bra straps cutting into shoulders **AND**	WELC CCGs would not expect to receive applications for breast procedures for women younger than 18 years or men younger than 25 years unless exceptional circumstances apply.

Treatment	Criteria for funding	Additional information
	5. Evidence to be submitted to demonstrate pain symptoms persist as documented by the physician despite a 6 month trial of therapeutic measures including all of the following: • Supportive devices (e.g., proper bra/support bra fitted by a trained bra fitter, wide bra straps) • Analgesic / non-steroidal anti-inflammatory drugs (NSAIDs) interventions • Physical therapy / exercises / posturing manoeuvres **AND** 6. There are significant muskulo-skeletal pain or symptoms that are causing significant functional impairment which in the opinion of the referrer (in the opinion of an appropriate specialist) are likely to be corrected or significantly improved by surgery. Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless and the patient has failed to respond to 6 months of conservative treatment. **Correction of breast asymmetry** is not routinely funded by WELC CCGs. Unilateral breast reduction (NOT augmentation) will be funded only in the following circumstances: Where there is gross asymmetry (difference in size a minimum 3 cup* sizes) **AND**	

Treatment	Criteria for funding	Additional information
	Where there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra). **AND** The woman's breasts are fully developed i.e. there has been no change in the size of either breast over the previous 18 months. **AND** The woman is aged over 18 years * AA, A, B, C, D, DD, E, F, FF, G, GG, H, HH, J, JJ, K, L **Breast lift** surgery or 'Mastopexy' is not routinely funded by WELC CCGs either as a: • Component of breast reduction surgery **OR** • Stand-alone procedure **NICE guidance** http://www.nice.org.uk/guidance/ipg417/resources/guidance-breast-reconstruction-using-lipomodelling-after-breast-cancer-treatment-pdf	
Male breast reduction ***(No change)***	This procedure is not routinely funded by WELC CCGs. With prior approval it will be funded in the following circumstances: 1. The applicant demonstrates that they have screened for and excluded all treatable causes of gynaecomastia (drug related – particularly abuse of anabolic steroids, endocrine) AND 2. The patient is both post pubertal AND in the case of idiopathic gynaecomastia has had this for at least 18 months (to allow spontaneous resolution) AND	WELC CCGs would not expect to receive applications for breast procedures for women younger than 18 years or men younger than 25 years unless exceptional circumstances apply. Gynaecomastia is commonly seen during puberty and may correct once the post pubertal fat distribution is

Treatment	Criteria for funding	Additional information
	3. gynaecomastia is causing pain unrelieved by standard analgesia AND 4. the patient has a BMI of less than 27 kg/m^2 AND 5. A consultant surgeon has confirmed that the patient has grade III gynaecomastia (i.e. gross breast enlargement with skin redundancy and ptosis so as to simulate a pendulous female breast) AND the proposed reduction is greater than 100gm per side.	complete if the patient has a normal BMI. It may be unilateral or bilateral. Rarely, it may be caused by an underlying endocrine abnormality or a drug related cause including the abuse of anabolic steroids. It is important that male breast cancer is not mistaken for gynaecomastia and, if there is any doubt, an urgent consultation with an appropriate specialist should be obtained.
Breast augmentation	WELC CCGs will not routinely fund breast augmentation (augmentation mammoplasty). Reduction of the larger breast should be regarded as the first line treatment for patients seeking to correct breast asymmetry (see breast asymmetry policy). In rare situations and with prior approval, funding for breast augmentation may be considered if the criteria below are met and evidenced: 1. Developmental failure resulting in unilateral or bilateral absence of breast tissue or asymmetry ≥ 2 cup sizes (Congenital amastia) **OR**	WELC CCGs would not expect to receive applications for breast procedures for women younger than 18 years or men younger than 25 years unless exceptional circumstances apply.

Treatment	Criteria for funding	Additional information
	2. Breast asymmetry ≥ 2 cup sizes due to mastectomy, excision breast surgery for cancer/lumpectomy, prophylactic mastectomy for cancer prevention in high risk cases **OR** 3. For breast asymmetry ≥ 2 cup sizes due to trauma or burns, or endocrine abnormalities WELC CCGs do not provide breast augmentation for the following patient cohorts unless there are exceptional circumstances: • Patients that have reduced breast tissue following weight loss – (including after bariatric surgery) • Patients that have reduced breast tissue following pregnancy • Patients that perceive that they have small symmetrical breasts N.B: Evidence that pubertal growth of breasts has ceased must be documented, i.e. there has been no change in the size of either breast over the previous 18 months and the woman is over 18 years old.	
Revision of breast augmentation	WELC CCGs will commission the removal of breast implants for any of the following indications in patients who have undergone cosmetic augmentation mammoplasty: 1. Breast disease 2. Implants complicated by recurrent infections 3. Implants with capsule formation that is associated with severe pain 4. Implants with capsule formation that interferes with mammography 5. Intra or extra capsular rupture of silicon gel-filled implants	

Treatment	Criteria for funding	Additional information
	Reinsertion of new breast implants will only be commissioned if the original implant insertion was funded by the NHS and the patient would still be eligible for breast implant under WELC CCGs commissioning policies, for example post mastectomy or to correct asymmetry. WELC CCGs will not contribute funding to procedures funded privately, irrespective of whether part of that procedure involves removal of breast implants.	
Nipple inversion ***(No change)***	Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. Surgical correction of nipple inversion will be funded by WELC CCGs (with prior approval) only for functional reasons in a post-pubertal woman, if the inversion has not been corrected by correct use of a non-invasive suction device.	Idiopathic nipple inversion may be corrected by the application of sustained suction. Commercially available devices are available from major chemists or online without prescription. Best results are seen where this is used correctly for up to three months.
Liposuction ***(No change)***	This procedure is not routinely funded by WELC CCGs.	
Abdominoplasty and excess skin excision	**Abdominoplasty** and **other skin excision for body contouring** will not be routinely funded by WELC CCGs. Requests for funding will be considered with prior approval for patients who: 1. Following weight loss have a stable BMI of less than 27 Kg/m^2 for at least 24 months **AND**	

Treatment	Criteria for funding	Additional information
	2. in the case of bariatric surgery, had their surgery at least 2 years previously **AND** 3. have severe functional problems from excessive abdominal skin folds as defined below: • Severe difficulties with daily living (i.e. walking, dressing, toileting) which have been formally assessed, and for which abdominoplasty will provide a clear resolution. **OR** • Documented evidence of clinical pathology due to the excess of overlying skin e.g. recurrent infections or intertrigo which has led to ulceration requiring four or more courses of antibiotics in the 24 month period of stable weight. **OR** • Where overhanging skin makes it impossible to maintain care of stoma bags. WELC CCGs do not routinely commission surgery to correct **divarification (or diastasis) of the rectus abdominis** muscles irrespective of whether additional abdominoplasty is requested because there is no good evidence that this surgery is anything other than cosmetic.	
Excision of skin and subcutaneous lesions	These procedures are not routinely funded by WELC CCGs. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment. Benign skin lesions may occasionally be excised for a differential diagnosis. Clinically benign moles should not be referred for cosmetic reasons.	

Treatment	Criteria for funding	Additional information
	Suspicious pigmented lesions should always be subjected to excision biopsy and sent for histology, if referred to secondary care this should be to a pigmented lesions clinic. The following common, clinically benign skin lesions should not be excised for cosmetic reasons: 1. Skin tags including anal skin tags 2. Seborrhoeic keratoses 3. Hand or foot viral warts in adults 4. Comedones 5. Corn/callouses 6. Lipomas 7. Milia 8. Molluscum contagiosum 9. Sebaceous (epidermoid or pilar) cysts 10. Spider Naevus (telangiectasia) 11. Xanthelasma 12. Neurofibromata 13. Angioma Keratoma 14. Benign Naevi 15. Haemangiomas For benign skin lesions the CCG will only routinely fund surgery in patients meeting the following criteria: • The lesion is unavoidably and significantly traumatised on a regular basis **AND** • This results in significant infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year	

Treatment	Criteria for funding	Additional information
	OR • The lesion is obstructing an orifice OR impairing field vision **OR** • The lesion significantly impacts on function e.g. restricts joint movement by >20 degrees. **NICE Guidance** http://www.nice.org.uk/guidance/csgstim/evidence/skin-tumours-including-melanoma-evidence-update2 http://www.nice.org.uk/guidance/cg27/resources/guidance-referral-guidelines-for-suspected-cancer-pdf	
Keloid and other scar revision	**Scar Revision** WELC CCGs will not fund procedures to re-fashion scars for cosmetic purposes. Funding for surgery for revision of scars will be considered through the IFR route where the scar interferes with function or causes significant facial disfigurement. Applications on the basis of disfigurement should be supported by high quality clinical photography. **Keloid Scars** WELC CCGs will not fund procedures to re-fashion keloid scars for cosmetic purposes. Symptomatic keloid scars may be treated if the scar: • interferes with function **OR** • causes pain or itchiness which is persistent and unrelieved by standard medication for over one year	

Treatment	Criteria for funding	Additional information
	For keloid scars the first line treatment should be excision and steroid injection. Excision followed by radiotherapy may be considered as a second line treatment approach if excision/ steroid injection has not relieved symptoms. Applications for funding made on the basis of disfigurement should be supported by high quality clinical photography.	
Face lifts and brow lifts (rhytidectomy) **Surgery on the upper or lower eyelid (blepharoplasty)**	These procedures are not routinely funded by WELC CCGs. Procedures carried out for cosmetic purposes will not be funded. Funding will be approved without prior approval for: 1. Patients (including children) who present with severe upper eyelid ptosis (low eyelid margin position), severe upper eyelid dermatochalasis (excess upper eyelid skin), severe eyebrow ptosis or a combination of any of these such that the eyelid margin or lowest point of upper eyelid skin comes down to less than 1mm above the central corneal light reflex should access corrective surgery without prior funding approval being sought. Prior approval will be required for funding for: 2. Impairment of visual field(s) in the relaxed, non-compensated state where visual field test results are show that eyelids impinge on visual fields reducing them to 120^0 laterally and 40^0 vertically. 3. Patients who have severe headache as a result of frontalis muscle overaction when trying to overcome brow ptosis, upper eyelid ptosis or excess dermatochalasis should be allowed corrective surgery.	Providers may wish to treat patients with severe facial trauma or facial paralysis with these procedures to restore function. A full IFR application should be submitted in this case.

Treatment	Criteria for funding	Additional information
	These procedures should only be carried out in the ophthalmology department under the care of an oculoplastic surgeon. WELC CCGs will not fund ptosis repair, upper eyelid blepharoplasty and browlift for cosmetic reasons. This will include corrective surgery for patients who are dissatisfied with the cosmetic appearance post-surgery of any procedure carried out in paragraphs 1, 2 or 3 above.	
Rhinoplasty (surgery to reshape the nose) ***(No change)***	This procedure is not routinely funded by WELC CCGs. NHS funding may be considered for: 1. Demonstrable obstruction of the nasal airway AND 2. significant symptoms confirmed by an ENT consultant as resulting from nasal obstruction AND 3. symptoms that persist despite at least three months of conservative management with, where appropriate nasal steroids or immunotherapy.	Correction of complex congenital conditions e.g. cleft lip and palate is commissioned by NHS England.
Treatment for scarring and skin hyper- or hypo-pigmentation ***(No change)***	Interventions for these conditions including laser dermabrasion and chemical peels are not routinely funded by WELC CCGs. The IFR Panel will consider each case. For all patients a very clear statement of exceptionality would be required including the following: 1. a clear description of symptoms that the intervention is expected to improve AND 2. all previous interventions for this condition and their impact AND 3. the relevant evidence of clinical benefit for the proposed intervention in the underlying condition AND	

Treatment	Criteria for funding	Additional information
	4. if the application is based on facial disfigurement, high quality, colour clinical photographs.	
Treatment of vascular lesions	WELC CCGs will not routinely fund treatments for vascular lesions as most interventions are for cosmetic purposes and there is a limited evidence of effectiveness.	
Treatment for hair loss (alopecia) ***(No change)***	Treatment (hair grafting and flaps with/ without tissue expansion) is not routinely funded by WELC CCGs. Funding for treatment may be approved by the IFR Panel when the alopecia is a result of previous surgery or trauma including burns.	'Male pattern' baldness is a normal process for many men at whatever age it occurs.
Hair transplantation ***(No change)***	This procedure is not routinely funded by WELC CCGs. Funding may be approved by the IFR Panel as part of the treatment pathway for reconstruction following cancer or trauma.	
Hair epilation	This procedure is not routinely funded by WELC CCGs. Funding for hair epilation may be approved by the IFR Panel for patients who: 1. Have undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck or upper chest (areas not covered by normal clothing) OR 2. Are undergoing treatment for pilonidal sinuses to reduce recurrence For patients who do not meet these criteria, an IFR application will ONLY be considered (for facial, neck or upper chest areas not covered by normal clothing) on completion of the relevant section explaining for the benefit of the IFR Panel why the patient differs from	Patients undergoing gender reassignment procedures will be assessed in accordance with this policy as it applies to a natural born male or female. An IFR application would need to be submitted in this context explaining precisely why the transgender person is likely to gain significantly greater health benefit than other patients for whom the same procedures are not funded.

Treatment	Criteria for funding	Additional information
	the cohort of similarly hirsute patients such that they are likely to gain more health benefit from depilation which is not available to other similar patients. In the event that NHS funding is agreed it will be for a maximum of six treatments. Because WELC CCGs do not fund maintenance treatment for hirsuitism, it is not considered appropriate to commission an intervention whose effects are likely to be transitory and psychological distress would be likely to recur. Severe hirsuitism due to an endocrine disorder may be referred to an endocrinology department but this is not an indication for NHS funding of epilation. WELC CCGs will fund radiosurgery for the treatment of symptomatic trichiasis.	
Tattoo removal ***(No change)***	This procedure is not routinely funded by WELC CCGs.	
Cosmetic genital procedures (Labiaplasty) ***(No change)***	This procedure is not routinely funded by WELC CCGs.	Transgender surgery is funded by NHS England for patients on a recognised NHS care programme.
Reversal of female sterilisation and reversal of vasectomy ***(No change)***	Reversal of sterilisation and vasectomy are not routinely funded by WELC CCGs. The IFR Panel will NOT consider funding, irrespective of the merits of the individual case if:	The original decision on sterilisation is assumed to have been made by mature adults on the understanding that the procedure is an irreversible contraceptive choice and that each

Treatment	Criteria for funding	Additional information
	• sterilization used diathermy (female) or two widely separated clips because reversal is unlikely to be successful: written documentation of the original procedure should accompany any application OR • the female partner is not demonstrably ovulating (day 21 progesterone levels)	patient/couple has been fully counselled to this effect.
Dilatation and curettage for heavy menstrual bleeding in women aged under 40 years ***(No change)***	This is not normally funded. **NICE Guidance** http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf	This is an inappropriate procedure because targeted endometrial sampling is at least as accurate and has lower complication rates. It is not a reliable therapeutic procedure for dysfunctional uterine bleeding for which a range of effective medical interventions is available (mefenamic acid, norethisterone).
Hysterectomy for menorrhagia (heavy menstrual bleeding) ***(No change)***	1. Documented medical contra-indication to Mirena® coil insertion including large fibroids (uterine size >12 weeks) or distorted uterine cavity 2. Severe anaemia, unresponsive to transfusion or other treatment whilst a Mirena trial is in progress 3. Genital malignancy or active trophoblastic disease are rare causes of menorrhagia **NICE Guidance** http://www.nice.org.uk/guidance/cg44/resources/guidance-heavy-menstrual-bleeding-pdf	NICE clinical guidelines emphasise that: • The Mirena® device is effective in the treatment of menorrhagia and is considerably cheaper than a hysterectomy, even if required for many years (for contraception costs estimated at £207 including consultation; removal cost £26). • Other effective conservative treatments are available as second line treatment after failure of Mirena or where Mirena is contra-indicated • A Cochrane systemic review showed that the Mirena® coil

Treatment	Criteria for funding	Additional information
		improved the quality of life of women with menorrhagia as effectively as hysterectomy.
MRI guided ultrasound (MRgFUS) for uterine fibroids ***(No change)***	WELC CCGs do not routinely fund MRgFUS for uterine fibroids for: • fertility preservation because of lack of evidence of effectiveness • relief of symptoms because other, equally effective, better established interventions are available.	There is a routinely funded non-surgical option (uterine artery embolisation) for women with symptomatic fibroids who wish to avoid surgery.
Bartholin's cysts ***(No change)***	Significant infection and/or rapid growth causing significant pain that is unresolved by non-surgical treatment.	
Non-medical circumcision ***(No change)***	Non-medical circumcision is not routinely funded. A service for boys aged between 6 weeks and 5 months is available at a cost to the parent or guardian of the patient. Patients must be resident in either Tower Hamlets, City & Hackney or Newham and registered with a local GP. Please contact Religious & Cultural Male Circumcision Service at Mile End Hospital on 020 8223 8010 for further information. Female circumcision is prohibited by under the Prohibition of Female Circumcision Act 1995.	Circumcision is funded for medical indications, including: 1. phimosis seriously interfering with urine flow and/or associated with recurrent infection 2. some cases of paraphimosis 3. suspected cancer or balanitis obliterans 4. congenital urological abnormalities when skin is required for grafting and interference with normal sexual activity in adult males 5. recurrent, significantly troublesome episodes of infection beneath the foreskin. 6. To restore functional anatomy after female circumcision to facilitate childbirth where mutilation renders this hazardous.

Treatment	Criteria for funding	Additional information
Surgery for varicocoele ***(No change)***	Persistent discomfort or pain despite adequate conservative management.	There is no evidence that treating varicocoele can help male sub-fertility problems.
Non-core gender reassignment procedures ***(No change)***	Non-core procedures are likely to be confined to epilation. Applications will be assessed in accordance with this policy as it applies to a natural born male or female by the IFR Panel. IFR applications should explain precisely why the transgender person is likely to gain significantly greater health benefit than other patients for whom the same procedures are not funded.	Core procedures (assessment, psychological support, and core surgery – genital, breast and donor site hair removal) are funded by NHS England from April 2013.
Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary) ***(No change)***	Sympathectomy will only be funded if the following conditions are met: 1. significant focal hyperhidrosis and a 1–2 month trial of aluminium salts (under primary care supervision to ensure compliance) has been unsuccessful in controlling the condition OR 2. significant focal hyperhidrosis and intolerance of topical aluminium salts despite reduced frequency of application and use of topical 1% hydrocortisone AND all of the following conservative therapies have been tried and found to be unsuitable or unsuccessful: 3. treatment of underlying anxiety if it is an exacerbating factor 4. referral to a dermatologist for modified topical therapy 5. prescription of oral anticholinergics (which block the effect of the nerves that stimulate the sweat glands) 6. iontophoresis (for palmar or plantar hyperhidrosis) or botulinum toxin injections (for axillary hyperhidrosis).	Sympathectomy is an established intervention for this condition BUT should be considered only after all other non-invasive non-surgical treatment options have been tried and failed. Compensatory sweating following sympathectomy is common and can be worse than the original problem. Patients should be made aware of this risk.
Cholecystectomy for asymptomatic gall stones	Surgery for asymptomatic gallstones is not routinely funded as there is limited evidence that intervention under these circumstances is beneficial.	Approximately 10-20% of people in western countries have gallstones, and most (50-70%) are asymptomatic at

Treatment	Criteria for funding	Additional information
(No change)		the time of diagnosis. Asymptomatic disease has a benign natural course and progression to symptomatic disease is relatively low, ranging from 10-25%. The majority of patients do not develop gallstone-related complications without first having at least one episode of pain.[1]
Pinnaplasty/ Otoplasty	WELC CCGs will commission surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged 5 to 18 years at the time of referral **AND** 2. With very significant ear deformity or asymmetry demonstrated by clinical photography Patients not meeting these criteria should not be routinely referred for surgery.	
Repair of totally split ear lobes ***(No change)***	This procedure is not routinely funded by WELC CCGs.	
Open MRI	WELC CCGs will not routinely fund open MRIs for patients.	

[1] Gurusamy KS, Samraj K. Cholecystectomy for patients with silent gallstones. Cochrane Database of Systematic Reviews 2007, Issue 1. http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD006230/frame.html

Treatment	Criteria for funding	Additional information
	Claustrophobic patients Most patients with claustrophobia can be successfully scanned using a conventional MRI scanner. Applications for open MRI will only be accepted if the patient has failed to tolerate a conventional scan using feet first or oral sedation approaches as appropriate. Applications for open MRI should confirm that the patient has not tolerated a conventional scan using a feet first approach or following oral sedation if clinically appropriate, and, confirm that no other diagnostic tests are suitable. If more serious health problems preclude sedation, this will need to be detailed. **Obese patients** Patients who are too large to fit within a conventional MRI scanner should be referred by a secondary care clinician to the bariatric MRI service at Barts Health.	
Tonsillectomy	Tonsillectomy may be funded for: 1. Suspected malignancy **OR** 2. Significant impact on quality of life resulting from documented recurrent acute tonsillitis (patients or parents should keep a diary to verify this) comprising: 2.1. Five or more episodes of tonsillitis in the preceding year **OR**	The frequency of sore throats reduces with time whether or not tonsillectomy has been performed. The benefit in the year after operation is around 2.8 fewer days off school and this needs to be balanced against the risk of surgical complications. A revised Cochrane systematic review in 2008,concluded that Adeno-

Treatment	Criteria for funding	Additional information
	2.2. Four episodes/year in each of the preceding two years **OR** 2.3. Three episodes/year in the preceding three years **AND** 2.4. Documented evidence of absence from playgroup, school or work **OR** 2.5. Failure to thrive N.B. An eligible episode must have three of the following criteria - Tonsillar exudates/ Tender anterior cervical lymph nodes/ History of fever/ Absence of cough (Centor clinical prediction score, SIGN guidelines 117- management of sore throat). 3. Adults with proven recurrent group A streptococcal pharyngitis (GAHSP) **OR** 4. Documented evidence of 2 or more episodes of tonsillitis or quinsy requiring admission to hospital **OR** 5. Tonsillitis exacerbating existing disease such as febrile convulsions, guttate psoriasis, glomerulonephritis or rheumatic fever. 6. As treatment for sleep apnoea syndrome, tonsillectomy should only be considered for children with: 6.1. Witnessed episodes of apnoea exceeding 10 seconds **OR** choking episodes during sleep **AND**	/tonsillectomy is effective in reducing the number of episodes of sore throat and days with sore throats in children, the gain being more marked in those most severely affected. SIGN national guideline on management of sore throat and indications for tonsillectomy (2010) recommended watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.

Treatment	Criteria for funding	Additional information
	6.2. Daytime neuro-behavioural abnormalities or excessive sleepiness. **NICE Guidance** IPG186; IPG9; IPG178; IPG150	
Grommet (ventilation tube) insertion ***(No change)***	1. Children between the ages of 3 and 12 years who have documented, persistent, bilateral otitis media with effusion (OME) AND documented persistent hearing loss on two occasions at intervals of 3 months or more AND hearing in the better ear of 25-30 dBHL or less averaged at 0.5, 1, 2 and 4 kHz OR 2. Children between the ages of 3 and 12 years who have documented, persistent otitis media with effusion (OME) AND documented persistent hearing loss on two occasions at intervals of 3 months or more AND 3. hearing loss suggestive of additional sensori-neural deafness OR 4. evidenced delay in speech development OR significant educational, social or behavioural problems attributable to persistent hearing impairment AND a hearing level of 25-30 dBHL or less OR 5. a second disability (e.g. Down's syndrome) OR 6. the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma OR	See Current NICE Guidance[2] • Surgery may resolve glue ear in the short term but there is less certainty about longer term outcomes and large variation in effect between children • There is debate about how best to select children for intervention, given the high rate of resolution particularly in younger children • A period of watchful waiting is widely recognized as good practice because timing of surgery is not critical to medium term outcome Grommets and adenoidectomy represent a trade-off between benefits and harms; adenoidectomy on its own is of unknown effectiveness[3]

[2] http://www.nice.org.uk/media/A8F/DC/Referraladvice.pdf
[3] Clinical Evidence. Review of adenotonsillectomy. 2005

Treatment	Criteria for funding	Additional information
	7. 5 or more episodes of acute otitis media. Insertion of ventilation tubes for patients of any age may be indicated as a component of tympanic membrane repair or to preserve function. **NICE Guidance** CG60 Surgical management of otitis media with effusion in children	
Surgical treatment of chronic sinusitis ***(No change)***	ENT referral is appropriate for suspected: 1. complications, e.g. periorbital infection OR 2. suspected sinonasal tumour. Referral may be appropriate if there is: 3. recurrent or chronic sinusitis of uncertain cause AND 4. unremitting or progressive facial pain AND 5. a trial of intranasal corticosteroids for three months has been ineffective AND 6. a significant anatomical abnormality.	NHS Clinical Knowledge Summaries advise a trial of intranasal corticosteroids for 3 months for treatment in the first instance.[4] Sinus puncture and irrigation has a poor diagnostic yield, and carries the risk of secondary contamination.4 Only short-term benefit seen in patient refractory to medical management treated with balloon catheter dilation of sinus ostia.[5]
Interventions for varicose veins	Intervention, including open surgery (ligation and stripping), endovenous laser ablation, and radiofrequency ablation is appropriate only for significant and intractable symptoms and signs including:	

[4] http://www.cks.nhs.uk/sinusitis/management/quick_answers#-369973 (accessed 8 February 2010)
[5] NICE Balloon catheter dilation of paranasal sinus ostia for chronic sinusitis. IPG 273 NICE September 2008.

Treatment	Criteria for funding	Additional information
	• Symptomatic primary or symptomatic recurrent varicose veins, unresolved by at least 6 months conservative management (exercise, elevation) • 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. **NICE Guidance** http://www.nice.org.uk/guidance/qs67/resources/guidance-varicose-veins-in-the-legs-pdf	
Dupuytren's contracture	WELC CCG will fund surgical treatment when: • The patient has a 30 degree fixed flexion deformity at either the metacarpophalanageal joint or proximal interphalangeal joint **OR** • The patient cannot flatten their fingers or palm on a table **OR** • There has been rapid progression over a few months. **NICE Guidance** https://www.nice.org.uk/guidance/ipg43/resources/guidance-needle-fasciotomy-for-dupuytrens-contracture-pdf	
Trigger finger	WELC CCGs will only fund if the following conditions are met: • Patients diagnosed with trigger finger who fail to respond to conservative non-invasive treatment methods e.g. exercise/massage, rest from aggravating activities, splinting, NSAIDs; for over three months **AND**	

Treatment	Criteria for funding	Additional information
	• Who fail to respond to at least one corticosteroid injections **OR** • Who have a fixed flexion deformity that cannot be corrected by conservative measures **OR** • Where corticosteroid injection is contraindicated.	
Surgical treatment of carpal tunnel syndrome	1. Severe symptoms persisting after 3 months of conservative therapy with local corticosteroid injection and/or nocturnal splinting OR 2. Mild to moderate symptoms persisting after at least 4 months of conservative therapy with local corticosteroid injection and/or nocturnal splinting OR 3. Significant neurological deficit or median nerve denervation with sensory blunting, muscle wasting, or weakness of thenar abduction AND 4. Severe symptoms that significantly interfere with everyday living activities that have been formally assessed.	
Surgical excision of ganglia ***(No change)***	1. They are painful seed ganglia OR 2. They are mucoid cysts arising at the distal inter-phalangeal joint and cause significant skin breakdown, significant nail deformity or repeatedly discharge OR 3. They cause significant functional impairment and/ or pain is unrelieved by aspiration or injection OR 4. There is diagnostic uncertainty.	Patients should be re-assured about the benign nature of other ganglia and be informed that: • 33% of dorsal ganglions and 45% of volar-wrist ganglia would resolve spontaneously in six years • the recurrence rate after excision of wrist ganglia is between 10 – 45%.
Bunion surgery (Hallux Valgus)	Criteria for intervention:	

Treatment	Criteria for funding	Additional information
	1. significant pain on walking not relieved by chronic standard analgesia **OR** 2. deformity such that fitting adequate footwear is difficult **OR** 3. overlapping or underlapping of adjacent toe(s) **OR** 4. hammer toes **OR** 5. recurrent or chronic ulceration **OR** 6. bursitis or tendinitis of the first metatarsal head	
Botulinum toxin	WELC CCGs will not fund the use of Botulinum for cosmetic treatments. Botulinum A toxin is routinely funded only for: 1. Spasticity, hand and wrist disability associated with stroke, blepharospasm, hemofacial spasm, spasmodic torticollis 2. Severe hyperhidrosis, overactive bladder syndrome Botulinum B toxin is routinely funded only for: 1. spasmodic torticollis 2. as alternative to Botulinum toxin A in presence of antibodies to Botulinum A. For palmar or plantar hyperhidrosis, other procedures such as iontophoresis appear to be more effective and have fewer side effects and should be considered as initial treatment. Botox treatment needs to be repeated after 6-9 months. Botulinum A will also be approved for treatment of migraine for patients who meet the criteria described in NICE TA 260:	

Treatment	Criteria for funding	Additional information
	1.1 Botulinum toxin type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies and whose condition is appropriately managed for medication overuse. 1.2 Treatment with botulinum toxin type A that is recommended according to 1.1 should be stopped in people whose condition: is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) or has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months. **NICE Guidance** TA260 Botulinum toxin type A for the prevention of headaches in adults with chronic migraine CG145 Spasticity in children and young people with non-progressive brain disorder	
Continuous glucose monitoring devices for Type 1 diabetes ***(New)***	WELC CCGs will not routinely fund the use of Continuous Glucose Monitoring devices for patients with Type 1 Diabetes. Applications for funding may be made through the Individual Funding Request team and will need to demonstrate the specific clinical circumstances which differentiate the patient.	
Sacral nerve stimulation for urinary incontinence	WELC CCGs will not routinely fund the use of sacral nerve stimulation to treat urinary incontinence.	

Treatment	Criteria for funding	Additional information
(New)		
Double balloon enteroscopy (DBE) ***(New)***	WELC CCGs will not routinely fund double balloon enteroscopy (DBE) for diagnostic purposes. WELC CCGs will not routinely fund DBE for therapeutic interventions, but in some cases where alternative interventions have been exhausted (including wireless capsule endoscopy, radiological imaging, single balloon enteroscopy), the patient is symptomatic, and surgical first line therapy is not suitable, an IFR application may be accepted.	
EXOGEN bone healing ***(New)***	WELC CCGs will fund the use of the EXOGEN ultrasound bone healing system to treat **long bone fractures** with **non-union** (failure to heal after 9 months). **NICE Guidance** MTG12: EXOGEN ultrasound bone healing system for long bone fractures with non-union or delayed healing	
Knee washout for osteoarthritis ***(No change)***	This intervention is not routinely funded. Referral for arthroscopic lavage and debridement should only be considered in the few patients with knee osteoarthritis AND a clear history of mechanical locking i.e. not gelling, 'giving way' or X-ray evidence of loose bodies.	In accordance with NICE guidance (Aug 2007) on arthroscopic knee washout, with or without debridement, for the treatment of OA[6] and the NICE clinical guideline on OA (Feb 2008) on indications for which arthroscopic lavage and debridement is clinically and cost-effective[7].

[6] National Institute for Health and Clinical Excellence - Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis - Guidance issue date: 22 August 2007. http://www.nice.org.uk/IPG230
[7] National Institute for Health & Clinical Excellence (NICE), Clinical guideline CG59 The care and management of patients with Osteoarthritis, February 2008 www.nice.org.uk/cg59.

Treatment	Criteria for funding	Additional information
	NICE Guidance https://www.nice.org.uk/guidance/ipg230/resources/guidance-arthroscopic-knee-washout-with-or-without-debridement-for-the-treatment-of-osteoarthritis-pdf	
White cell apheresis ***(New)***	WELC CCGs will not routinely fund this intervention as the evidence of effectiveness is currently insufficient to justify routine commissioning this treatment for the cohort of patients with refractory, steroid unresponsive or steroid dependent inflammatory bowel disease.	
Autologous chondrocyte (cartilage) implantation ***(New)***	WELC CCGs will not routinely fund this procedure. **NICE Guidance** http://www.nice.org.uk/guidance/ta89/resources/guidance-the-use-of-autologous-chondrocyte-implantation-for-the-treatment-of-cartilage-defects-in-the-knee-joints-pdf	
Homeopathy ***(No change)***	Homeopathy is not routinely funded by WELC CCGs due to the lack of evidence of clinical effectiveness.	
Herbal medicines ***(No change)***	Herbal medicines are not routinely funded by WELC CCGs due to the lack of evidence of clinical effectiveness and the risk of toxicity from non-quality assured therapies.	
Acupuncture and osteopathy ***(No change)***	Acupuncture and osteopathy are not routinely funded by WELC CCGs due to the limited evidence of clinical effectiveness. This includes funding for acupuncture to treat dental pain and nausea and vomiting.	
Ketogenic diet for epilepsy *(No change)*	This intervention is not routinely funded by WELC CCGs due to the lack of evidence of clinical effectiveness.	

Treatment	Criteria for funding	Additional information
Any procedure outside of current NHS service level agreements ***(No change)***	All referrals to voluntary or private sector specialists with whom WELC CCGs do not have a service level agreement and procedures carried out by them require prior funding approval. The application should make clear to the IFR Panel why this referral is being made and address the following: 1. identify the local NHS commissioned service for this condition AND 2. state why this is not appropriate for this particular patient AND 3. What the local NHS commissioned service includes AND 4. For what assessment and/or procedure funding is being sought AND 5. The potential costs and benefits (from the provider) of the proposed assessment and/or procedure	The patient should be informed before any application is made, that WELC CCGs would not normally fund an intervention that is not available to all patients with the same condition.

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