



# **NHS Kirklees and NHS Calderdale Clinical Commissioning Groups Commissioning Policy for Individual Funding Requests**

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**Responsible Clinical Commissioning Group (CCG):**

Kirklees CCG, Calderdale CCG

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## **Executive Summary**

This policy applies to all Individual Funding Requests (IFRs) for people registered with General Practitioners in the following Clinical Commissioning Groups (CCGs), where the CCG is the responsible commissioner for the treatment or service

- Kirklees CCG
- NHS Calderdale CCG

This policy does not apply where any one of the above CCGs is not the responsible commissioner.

This policy supersedes all previous policies and must (where appropriate) be read in association with the other relevant CCGs commissioning policies.

All IFR and associated policies will be publically available on the internet for each CCG.

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Executive Summary .....	1
1. Introduction .....	4
2. Scope of the Policy.....	4
2.1 Exclusions to this Policy .....	5
2.2 Dissemination of the Policy .....	5
2.3 Application of the Policy .....	6
3. Aims and Objectives.....	6
4. Equality and Quality Impact Assessments .....	7
5. Procedures and Treatments with Eligibility Criteria .....	7
6. Procedures that require Individual Funding Approval:.....	8
6.1 ABDOMINOPLASTY / APRONECTOMY (“Tummy Tuck”).....	10
6.2 BREAST AUGMENTATION .....	11
6.3 MASTOPEXY (Breast Lift) .....	12
6.4 REVISION OF BREAST AUGMENTATION .....	12
6.5 BREAST ASYMMETRY .....	13
6.6 BREAST REDUCTION FOR GYNAECOMASTIA – MALE .....	15
6.7 NIPPLE INVERSION.....	16
6.8 HAIR REPLACEMENT .....	16
6.9 HAIR REMOVAL .....	17
6.10 ACNE SCARRING .....	18
6.11 BLEPHAROPLASTY (Surgery for drooping or mis-shaped eyelid/s)	18
6.12 BODY CONTOURING PROCEDURES (Skin Excision for Buttocks, Thighs & Arms) .....	18
6.13 FACELIFT / BROWLIFT.....	19
6.14 PINNAPLASTY (Correction of Prominent Ears) .....	20
6.15 LIPOSUCTION.....	20
6.16 LABIAPLASTY .....	21
6.17 REPAIR OF EXTERNAL EAR LOBES (Lobules) .....	21
6.18 RHINOPHYMA.....	21
6.19 SCAR REVISION / KELOIDECTOMY.....	22
6.20 SKIN HYPO-PIGMENTATION & SKIN RESURFACING TECHNIQUES	22
6.21 SEPTO-RHINOPLASTY / RHINOPLASTY .....	22
6.22 CIRCUMCISION (for religious reasons).....	24

6.23 TATTOO REMOVAL .....	24
6.24 IVF – INFERTILITY TREATMENT and SURROGACY .....	24
6.25 REVERSAL OF VASECTOMY AND FEMALE STERILISATION .....	25
6.26 COMPLEMENTARY OR ALTERNATIVE THERAPIES .....	25
6.27 ALLERGY TREATMENTS AT A SPECIALIST ALLERGY CENTRE .....	26
6.28 LYCRA GARMENTS .....	26
6.29 FUNCTIONAL ELECTRICAL STIMULATION (FES) (For Foot Drop of Central Neurological Origin) .....	27
6.30 OPEN / UPRIGHT MRI SCANNING .....	28
6.31 BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS .....	29
6.32 BOTULINUM TOXIN FOR PROPHYLAXIS MIGRAINE .....	29
6.33 SPINAL CORD STIMULATION .....	30
6.34 SACRAL NEUROMODULATION .....	31
6.35 ADVICE & PATHWAY FOR THE SUPPLY OF NHS FUNDED WIGS .....	32
6.36 ADULT SNORING SURGERY (IN THE ABSENCE OF OSA) .....	33
6.37 DILATATION AND CURETTAGE (D&C) FOR HEAVY MENSTRUAL BLEEDING IN WOMEN .....	34
6.38 INJECTIONS FOR NONSPECIFIC LOW BACK PAIN WITHOUT SCIATICA .....	35
6.39 KNEE ARTHROSCOPY FOR PATIENTS WITH OSTEOARTHRITIS .....	36
7. References .....	38
Appendix 1 List of Complementary / Alternative Therapies .....	39
Appendix 2 Equality Impact Assessment Checklist Tool .....	43
Appendix 3 Version Control Sheet .....	48

## **1. Introduction**

The Clinical Commissioning Groups (CCGs), NHS Kirklees CCG and NHS Calderdale CCG were established on 1<sup>st</sup> April 2013 under the Health & Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006.

As part of these duties, there is a need to commission services which are evidenced based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. The Clinical Commissioning Groups are accountable to their constituent populations and Member Practices for funding decisions.

The above Clinical Commissioning Groups throughout this policy will be referred to as the CCGs.

The policy identifies procedures / treatments which the CCGs consider to be primarily cosmetic in nature and which have relatively small health benefits compared to other competing priorities for NHS resources.

The policy will be applied in conjunction with the CCGs operating framework for decision making for Individual Funding Requests (IFRs) which is available on each CCGs website.

## **2. Scope of the Policy**

The majority of service provision is commissioned through established service agreements with providers. However, there are instances when a treatment or procedure does not form part of the core commissioning arrangements.

Due consideration must be given to these procedures / treatments which do not form part of the core commissioning arrangements, or need to be assessed as exceptions to the CCGs commissioning policies.

Where a procedure or treatment is being requested that is not part of the core commissioning arrangements then an IFR must be submitted to the CCG in line with the IFR process detailed within the CCGs operating framework. The IFR process provides a mechanism to allow such requests to be considered for individuals in exceptional circumstances and all requests must strictly fulfil the criteria for exceptionality as defined within the CCGs current operating framework for considering IFRs.

Whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCGs reserve the right not to commission other procedures considered cosmetic and not medically necessary.

## **2.1 Exclusions to this Policy**

The following are classed as exclusions to this policy:

- Specialist services that are commissioned by NHS England or Public Health England.
- Suspected cancer, diagnoses should be dealt with via a two week wait referral and not via an IFR request.
- Emergency or Urgent Care

## **2.2 Dissemination of the Policy**

The policy will be disseminated via all the agreed communications and engagement channels internal and external to the CCGs.

The policy will be available to all stakeholders who are responsible for the broader dissemination of the policy within their individual organisations and services.

All members of staff responsible for commissioning services have a responsibility to familiarise themselves with the content of this policy.

A full copy of the policy will be available to the general public via each CCGs website.

## **2.3 Application of the Policy**

The policy applies to all staff (clinical and non- clinical) who are involved in any way with the commissioning, authorising of treatments or proposed clinical interventions commissioned by the CCGs.

This policy must be followed by all staff who are employed by the CCGs including those on temporary, fixed-term or honorary contracts, secondments, pool staff and students. It must also be followed by any organisation contracted to commission, authorise or administer healthcare on behalf of the CCGs.

Both referrers (including GP practices) and provider organisations are expected to adhere to the principles, criteria and policies set out in this document. Any service requested or provided outside of the funding criteria set out in this policy will be undertaken at the organisations' own risk.

## **3. Aims and Objectives**

The aim of this policy is to detail the eligibility criteria for procedures / treatments that the CCGs do not routinely commission.

The objectives of this policy are to;

- Reduce the variation in access to procedures / treatments that are not routinely commissioned by the CCGs.
- To ensure that the procedures / treatments detailed within the policy are commissioned where there is robust evidence of clinical benefit and cost-effectiveness.
- To have systems in place that enable a consistent approach to decision-making within appropriate timescales.
- To ensure decisions made are based on the best available evidence at the time of consideration.
- To give clarity to our local population on what procedures / treatments are funded by the CCGs and under what circumstances.

- To give clarity to referring clinicians and providers of commissioned services on what procedures / treatments are funded by the CCGs and under what circumstances.

#### **4. Equality and Quality Impact Assessments**

The CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

This policy is not intended to discriminate against any group or individual on the grounds of age, gender, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, the CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. Equality (EIA) and Quality Impact Assessments (QIA) have been carried out for this policy. The EIA is attached as Appendix 2 of this policy and the QIA is available on request.

#### **5. Procedures and Treatments with Eligibility Criteria**

The following section provides further detail on the eligibility criteria that is applicable to the procedures / treatments that are not routinely commissioned.

In this policy aesthetic or cosmetic surgery is defined as surgery undertaken to improve one's appearance or reshape normal body parts to improve appearance. This differs from reconstructive surgery that is undertaken to reshape abnormal structures of the body, from accidents, injuries, infections, cancers or other diseases, as well as congenital deformities.

Revisional procedures will only be considered electively for clinical reasons due to evidenced clinical complications. Any revisional procedures will require prior approval unless they are required on an urgent / emergency basis.

Psychological distress will rarely be considered as a reason for cosmetic surgery. Only in rare clinically exceptional circumstances in which severe and enduring psychological



dysfunction can be demonstrated, and for which all alternative psychotherapeutic interventions have been tried.

**NOTE: Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated)**

Patients who are current smokers should be referred or re-directed to a smoking cessation programme prior to surgical intervention.

In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.

Patients with a BMI >30 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.

**6. Procedures that require Individual Funding Approval:**

All of the following procedures / treatments are criteria led and will require completion of an Individual Funding Request form by an appropriate clinician.

- Abdominoplasty / Apronectomy
- Breast Augmentation (Breast Enlargement)
- Mastopexy (Breast Lift)
- Revision of Breast Augmentation
- Breast Asymmetry
- Breast Reduction for Gynaecomastia (Male)
- Nipple Inversion
- Hair Replacement (Including Hair Transplant and Correction of Male Pattern Baldness)

- Hair Removal
- Acne Scarring
- Blepharoplasty
- Body Contouring Procedures (Buttock, Thigh & Arm Lift)
- Facial Procedures (Face Lift & Brow Lift)
- Pinnaplasty (Correction of Prominent Ears)
- Liposuction
- Labiaplasty
- Repair of External Ear Lobes (Lobules)
- Rhinophyma
- Scar Revision / Keloidectomy
- Skin Hypo-Pigmentation & Skin Resurfacing Techniques
- Rhinoplasty / Septo-rhinoplasty
- Circumcision (for Religious Reasons)
- Tattoo Removal
- Infertility Services & Surrogacy
- Reversal of Sterilisation (Male & Female)
- Complementary & Alternative Therapies
- Allergy Treatments
- Lycra Garments
- Functional Electrical Stimulation (FES) for Foot Drop
- Open / Upright MRI Scanning
- Botulinum Toxin for Axillary Hyperhidrosis
- Botulinum Toxin for Prophylaxis Migraine
- Spinal Cord Stimulation
- Sacral Neuromodulation
- Wig pathway
- Adult Snoring Surgery (in the absence of OSA)
- Dilatation and Curettage (D&C) for heavy menstrual bleeding in women
- Injections for nonspecific low back pain without sciatica
- Knee arthroscopy for patients with osteoarthritis

## 6.1 ABDOMINOPLASTY / APRONECTOMY (“Tummy Tuck”)

Abdominoplasty / Apronectomy will not be routinely commissioned by the CCGs for requests made for:

- Cosmetic / aesthetic reasons, including stretch marks
- Psychological benefit without associated clinical need

Abdominoplasty / Apronectomy may rarely be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m<sup>2</sup> (stable is defined as within the acceptable range detailed above **AND** stable at the same measurement for **at least 2 years**) **AND** be suffering from severe functional problems:

- Those with complex scarring following trauma or previous abdominal surgery
- Those who have undergone treatment for morbid obesity and have excessive skin folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years. (significant is defined as moved down two levels of the BMI SIGN guidance as shown below)
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery

Severe functional problems include:

- Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics
- Experiencing severe difficulties with daily living, i.e. ambulatory or urological restrictions
- Where previous post-trauma or surgical scarring (usually midline vertical or multiple) leads to very poor appearance and carries a risk of infection
- Problems associated with poorly fitting stoma bags

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- Confirmation that the panniculus hangs below the symphysis pubis when the patient is standing normally
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity

Body Mass Index is referred to as per SIGN guidance where:

- Less than 18.5      Underweight
- 18.5 -24.9        Normal BMI
- 25.0 - 29.9        Overweight
- 30.0 - 39.9        Obese
- 40 or above        Extremely Obese

## 6.2 BREAST AUGMENTATION

**Note:** Breast augmentation which is part of reconstructive surgery after trauma or previous mastectomy or other excisional breast surgery does not go through the Individual Funding requests process as it is part of the treatment pathway for those conditions.

Breast augmentation will not be routinely commissioned by the CCGs for:

- Cosmetic reasons, for example for “small” but normal breasts or for breast tissue involution (including post-partum changes).
- Requests made for psychological benefit without associated clinical need.

Breast augmentation may rarely be considered on an exceptional basis, for example where the patient:

- Has congenital amastia (complete absence of bilateral breast tissue) or
- Has suffered trauma to the breast during or after development or
- Has endocrine abnormalities or

- Has developmental asymmetry (at least 3 cup sizes) or
- Has tubular breasts – type iii with severe breast constriction with minimal breast base and hypoplasia of all four quadrants ([see Tuberos Breast: Clinical Evaluation and Surgical Treatment](#) )
- Gender re-assignment – where requests for breast augmentation are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m<sup>2</sup>

### **6.3 MASTOPEXY (Breast Lift)**

Mastopexy will not be routinely commissioned by the CCGs for cosmetic reasons, for example weight loss, post lactation or age related ptosis.

Mastopexy may be included as part of the treatment to correct breast asymmetry and reduction. In this instance, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria.

### **6.4 REVISION OF BREAST AUGMENTATION**

Revision of breast augmentation will not be routinely commissioned by the CCGs.

Removal of implants (including implants inserted within the private sector) will be considered if at least one of the following criteria is met;

- Remnant breast cancer or cancer on the contralateral breast or
- Intra or extra capsular rupture of silicone gel filled implants or
- Implants complicated by recurrent infections or
- Extrusion of implant through the skin or
- Implants with Baker Class IV contracture associated with severe pain (classifications detailed below) or
- Implants with severe contracture that interferes with mammography

Implant replacement will **only** be considered if the NHS commissioned the original procedure and that the patient is still eligible for breast implant/s under the CCGs current commissioning criteria.

Note – Approval will be given for implant replacement/s for any patients whose original procedure was undertaken as part of the NHS commissioned cancer pathway.

Gender re-assignment – where requests for revisional breast surgery are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m<sup>2</sup>
- Ultrasound scan results to evidence implant rupture and / or capsular contracture
- Evidence to support the clinical need for revisional surgery
- Evidence to support that the patient meets the current criteria for augmentation

### **Baker Classification**

Class I - Augmented breast feels soft as a normal breast.

Class II - Augmented breast is less soft and implant can be palpated, but is not visible.

Class III - Augmented breast is firm, palpable and the implant (or distortion) is visible.

Class IV - Augmented breast is hard, painful, cold, tender and distorted

### **National supporting evidence**

[NHS England Interim Commissioning Policy: Breast Implant removal and re-insertion November 2013](#)

### **6.5 BREAST ASYMMETRY**

Surgery to correct breast asymmetry will not routinely be commissioned by the CCGs for cosmetic reasons.

Breast Prosthesis or Implants often have a limited lifespan and are likely to require replacement or revision during the patient's lifetime. Therefore, where possible, breast reduction of the larger breast should be the preferred option for patients seeking to correct breast asymmetry.

Surgery may rarely be considered on an exceptional basis when there is no ability to maintain a normal breast shape using non-surgical methods, for example where the patient:

- Has developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia) OR
- Patients with gross asymmetry (defined as a difference of 3 cup sizes) **AND** BMI in the range 18 – 27 kg/m<sup>2</sup>
- Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting
- Age over 19 years to allow for completion of puberty

In addition to the above, the following will also be required:

- Written confirmation from a professional bra fitter evidencing a difference in breast size of at least 3 cup sizes difference.

Only the following cup sizes are recognised in the UK;

- AA
- A
- B
- C
- D
- DD
- E
- F
- FF
- G
- GG
- H
- HH
- J

- JJ
- K
- L

## National supporting evidence

[NHS England Interim Commissioning Policy: Breast Asymmetry November 2013;](#)

### 6.6 BREAST REDUCTION FOR GYNAECOMASTIA – MALE

Surgery to correct benign gynaecomastia will not routinely be commissioned by the CCGs for cosmetic reasons. The CCG will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids.

Surgery may be considered on an exceptional basis, for example where the patient:

- Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat) **AND**
- Has a BMI of 25 kg/m<sup>2</sup> or less and stable for 12 months (stable is defined as within the acceptable range detailed above and stable at the same measurement for 12 months), unless a specific uncorrectable aetiological factor is identified such as androgen therapy for prostate cancer **AND**
- Has been screened prior to referral to exclude endocrinological and drug related causes or if drugs have been a factor then a period of one year since last use should have elapsed **AND**
- Has completed puberty - surgery is not routinely commissioned below the age of 19 years
- Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger

In addition to the above, the following will also be required:

- BMI to have been measured within 2 months of the request being submitted
- Evidence that screening for endocrine and drug-related causes has taken place and their results
- Documented additional information where circumstances include:
  - Pain
  - Gross Asymmetry
  - The Gynaecomastia is iatrogenic



## National supporting evidence

[NHS England Interim Commissioning Policy: Breast Reduction for Gynaecomastia \(male\) November 2013](#)[https](#)

### 6.7 NIPPLE INVERSION

Surgical correction of benign nipple inversion will not be routinely commissioned by the CCGs for:

- Requests made for cosmetic/aesthetic reasons.
- Requests made for psychological benefit without associated clinical need.

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded <sup>1</sup>

Surgical correction of nipple inversion may only be funded where it has been documented that there was an inability to breastfeed during a previous pregnancy and the patient is considering a subsequent pregnancy. In this instance all of the following criteria must be met in full:

- The nipple(s) must be non-retractable based on clinical examination **AND**
- The patient is post pubertal **AND**
- The inversion has not been corrected by correct use of a non-invasive suction device

## National supporting evidence

[NICE Guidance NG12 Recommendations organised by symptom and findings of primary care investigations lumps or masses](#)

### 6.8 HAIR REPLACEMENT

#### Hair Transplantation

Hair transplantation will not be routinely commissioned by the CCGs for cosmetic reasons, regardless of gender.

Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is required following cancer or trauma.

## **Correction of Male Pattern Baldness**

Treatments to correct male pattern baldness will not be routinely commissioned by the CCGs for cosmetic reasons. This is excluded from treatment by the NHS.

### **6.9 HAIR REMOVAL**

Hair removal will not be routinely commissioned by the CCGs for cosmetic reasons.

Patients concerned with the appearance of their body and facial hair should be advised about managing their condition through conservative methods including shaving, waxing, and depilatory creams although such treatments are also not routinely commissioned or funded by the CCGs.

Hair removal may be considered on an exceptional basis, for example where the patient:

- Has undergone reconstructive surgery resulting in abnormally located hair bearing skin to the face, neck or upper chest (areas not covered by normal clothing)
- Has a proven underlying endocrine disturbance resulting in hirsutism (e.g. Polycystic Ovary Syndrome)
- Are undergoing treatment for pilonidal sinuses to reduce recurrence

In addition to the above, the following will also be required:

- Evidence of the underlying endocrine disturbance eg. blood test results or ultrasound scan report

Where patients meet the above criteria, laser treatment for hair removal requested for hirsutism will only be approved for the removal of facial hair. In this instance three laser treatment sessions will be approved.

### **National supporting evidence**

[NHS England Interim Commissioning Policy: Hair removal \(including Electrolysis and Laser Therapy\) November 2013:](#)

## 6.10 ACNE SCARRING

Procedures to treat facial acne scarring will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.

## 6.11 BLEPHAROPLASTY (Surgery for drooping or mis-shaped eyelid/s)

Blepharoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery on the upper lid/s maybe considered on an exceptional basis, for example:

- Impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow
- Significant ectropion or entropion that requires correction or for the removal of lesions of the eyelid skin or lid margin

In addition to the above, the following will also be required:

- Results from an appropriate visual fields test. Results from tests will be required with the eyelid/s both retracted and un-retracted to rule out any pathological causes.

## 6.12 BODY CONTOURING PROCEDURES (Skin Excision for Buttocks, Thighs & Arms)

Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m<sup>2</sup> (stable is defined as within the acceptable range detailed above AND stable at the same measurement for at least 2 years) **AND** be suffering from severe functional problems:

- has an underlying skin condition, for example cutis laxa (rare inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds)

- has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living (ie. walking, dressing and ambulatory restrictions) which have been formally assessed

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity
- If it is an adjunct to another surgical procedure, then patients would be required to meet the established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

### **6.13 FACELIFT / BROWLIFT**

Facial procedures and Botulinum Toxin will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin, e.g. cuffs axa pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery

In addition to the above, for a Browlift procedure the following will also be required:

- Results from an appropriate visual fields test with eyelid un-retracted

## 6.14 PINNAPLASTY (Correction of Prominent Ears)

Surgical correction of prominent ears will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for example where the patient:

- Must be 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

Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy.

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.

### National supporting evidence

[NHS England Interim Commissioning Policy: Pinnaplasty / Otoplasty November 2013;](#)

## 6.15 LIPOSUCTION

Liposuction will not be routinely commissioned by the CCGs for cosmetic reasons or to correct the distribution of fat.

Cases may be considered on an exceptional basis, for example when;

- It may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies)
- If it is an adjunct to other surgical procedures e.g. surgery for gynaecomastia. In this instance, patients would be required to meet the

established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

## **6.16 LABIAPLASTY**

Labiaplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery may be considered on an exceptional basis, for example where the patient has;

- Congenital conditions **or**
- Recurrent disease or chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment **or**
- Excess androgenic hormones

**Note:** Treatment for female genital mutilation is not considered cosmetic and does not require funding approval.

[NHS England Interim Commissioning Policy: Labiaplasty/Vaginoplasty/Hymenorrhaphy](#)

## **6.17 REPAIR OF EXTERNAL EAR LOBES (Lobules)**

Repair of external ear lobes will not be routinely commissioned by the CCGs for cosmetic reasons.

This procedure is only commissioned by the CCGs for the repair of totally split earlobes as a result of direct trauma.

Repair of external ear lobes as a result of a gauge piercing is excluded from treatment by the CCGs.

## **6.18 RHINOPHYMA**

Surgical / laser treatment of rhinophyma will not be routinely commissioned by the CCGs for cosmetic reasons.

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered on an exceptional basis for surgery or laser treatment.

## **6.19 SCAR REVISION / KELOIDECTOMY**

Revision surgery for scars including keloid scars will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for example where the patient:

- Has significant deformity
- Has severe functional problems, or needs surgery to restore normal function
- Causes significant pain requiring chronic analgesic medication
- Bleeding
- Obstruction of orifice or vision
- Has a scar resulting in significant facial disfigurement

## **6.20 SKIN HYPO-PIGMENTATION & SKIN RESURFACING TECHNIQUES**

### **Skin Hypo-Pigmentation**

The recommended NHS suitable treatment for hypo-pigmentation is cosmetic camouflage. Access to a qualified camouflage beautician must be available on the NHS for this and other skin conditions requiring camouflage.

### **Skin Resurfacing Techniques**

All resurfacing techniques including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

Any requests for skin resurfacing techniques for scarring would be required to meet the established criteria for scar revision as shown above in section 6.19.

## **6.21 SEPTO-RHINOPLASTY / RHINOPLASTY**

Septo-rhinoplasty and Rhinoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Septo-rhinoplasty may be considered on an exceptional basis, for example in the presence of;

- Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty associated with a bony deviation of the nose, where an operation on the nasal septum would not be effective in restoring the nasal airway without a simultaneous operation to straighten the nasal bones.
- Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy); or when done in association with cleft palate repair.

Rhinoplasty may be considered on an exceptional basis, for example;

- When it is being performed to correct a nasal deformity secondary to congenital cleft lip and / or palate
- To correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect when all of the following criteria are met:
  - Nasal airway obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing), **AND**
  - Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids; **AND**
  - Airway obstruction will not respond to septoplasty and turbinectomy alone.

In addition to the above, the following will also be required:

- Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); **AND**
- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; **AND**
- Documentation of results of conservative management of symptoms

**Note:** For requests that meet the above criteria in relation to sporting / activity trauma, the CCGs reserve the right to decline funding where the request is for a repeat surgical procedure in relation to trauma where it is as a direct cause of the same sport / activity.



## **6.22 CIRCUMCISION (for religious reasons)**

Circumcision for social, religious or cultural reasons will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example;

- When an underlying medical condition means that routine surgery in the usual setting may be unsafe

## **6.23 TATTOO REMOVAL**

Tattoo removal will not be routinely commissioned by the CCGs.

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
- Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo")
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial functioning.)

## **National supporting evidence**

[NHS England Interim Commissioning Policy: Tattoo Removal November 2013:](#)

## **6.24 IVF – INFERTILITY TREATMENT and SURROGACY**

Criteria has been agreed across the Yorkshire and Humber. See separate policy on each CCG website.

The CCGs arrangements are in line with the Yorkshire & Humber policy but the CCGs will only fund one full cycle of IVF where the eligibility criteria are met in full.

Surrogacy arrangements will not be funded, but the CCGs will fund treatment (IVF component and storage) in identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the eligibility criteria are met in full.

## **6.25 REVERSAL OF VASECTOMY AND FEMALE STERILISATION**

Surgery for the reversal of a vasectomy or female sterilisation will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example:

- the death of an existing child through accidents or illness
- There is clear evidence (over and above the patient's assertion) that the original operation had been performed under duress. E.g. Cases when the patient was very young when the procedure was carried out and evidence from the referring clinician shows that they did not receive any counselling

Funding is not agreed for these procedures for patients who are in a new relationship or who are not in contact with children from a previous relationship. The CCGs reserve the right to decline funding where either partner has living children (this includes adopted children but not fostered) from that or any previous relationship.

## **6.26 COMPLEMENTARY OR ALTERNATIVE THERAPIES**

Complementary and alternative therapies are not routinely commissioned as stand-alone treatments by the CCGs.

See Appendix 1 for the list of therapies which are not routinely commissioned. The list is not exhaustive and other therapies not listed but that are considered 'alternative' therapies will be considered in the same way.

Those complementary and alternative therapies which are an integral part of an agreed care pathway within existing contracts (supported by a service specification) are excluded from this policy.

## **6.27 ALLERGY TREATMENTS AT A SPECIALIST ALLERGY CENTRE**

The CCGs will support referrals being made to an NHS Specialist Allergy Centre when the condition has been thoroughly assessed and standard treatment given by a GP or Clinician has not improved the condition and that the condition is considered “resistant” to conventional treatment.

The CCGs will not support referrals made to non-NHS providers.

## **6.28 LYCRA GARMENTS**

Lycra garments are not routinely commissioned by the CCGs. Cases may be considered on an exceptional basis for example;

- The patient should have cerebral palsy or similar condition with significantly abnormal postural muscle tone.
- There are no contraindications present (see below).
- Referral should identify the specific significant benefits offered by the therapy for this patient.
- Evidence provided that other therapies have been considered but were deemed to be insufficient.
- Evidence of the patient / carer’s willingness to comply with treatment (e.g. signed agreement or previous successful use).
- If the patient is over 18, successful previous use of Lycra garments and benefits evidenced.
- Requests for replacement garments should include a user or professional evaluation of benefits.

### **Contraindications**

- Lycra garments are contraindicated when adequate monitoring and supervision are not available, there is deemed to be a lack of purposeful intent or, dependent on site of the garment, if severe epilepsy or chronic respiratory problems are present. Lycra splinting is not recommended if there is severe uncontrolled reflux or chronic skin conditions.
- Problems with comfort, reflux sickness and putting on / taking off the suit have been reported. Temperature can also be an issue, particularly in

summer. These factors may all impact on compliance and motivation of the patient.

- A study carried out with the support of Scope and Birmingham Community Health Trust from 1998 – 2000 also found that some people stop wearing the garments altogether because of:
  - The level of support needed to get the garments on and off
  - Toileting issues
  - Garment took too long to dry after washing
  - Unable to maintain the function gains achieved without continued use

Funding requests for replacement garments will be required to evidence on-going clinical benefit. Funding for a replacement garments will not normally be agreed within:-

- 12 months from last approval for children aged up to 18 or
- 18 months to 2 years from last approval for patients aged 18+

### **6.29 FUNCTIONAL ELECTRICAL STIMULATION (FES) (For Foot Drop of Central Neurological Origin)**

The CCGs will routinely commission Functional Electrical Stimulation (FES) for drop foot, with the non-implantable wired device (skin surface FES - OPCS A70.7 application of transcutaneous electrical nerve stimulator), in line with NICE IPG278. Provisions for clinical, governance, consent, audit and research are fully expected to be in place for this service.

- The patient must be over 18 years of age and being treated for foot drop (deficit of dorsiflexion and / or eversion of the ankle) which must be of central neurological origin, due to an upper motor neurone lesion i.e. one that occurs in the brain or spinal cord at or above the level of T12.
- Upper motor neurone lesions resulting in dropped foot occur in conditions such as stroke, brain injury, multiple sclerosis, incomplete spinal cord injury at T12 or above, cerebral palsy, familial /hereditary spastic paraparesis and Parkinson's disease.

### **Exclusions**

The following forms of FES are not commissioned by the CCGs:

- Other forms of electrical stimulation for conditions other than foot drop
- FES for upper limb
- Implanted FES
- Wireless FES

Funding will only be considered for wireless or implantable devices where there are exceptional clinical circumstances.

### **National supporting evidence**

[NICE Guidance IPG 278 - Functional Electrical Stimulation for drop foot of central neurological origin](#)

## **6.30 OPEN / UPRIGHT MRI SCANNING**

### **Open MRI**

Referral to an NHS Open MRI scanner for an Open MRI scan as an alternative to a conventional MRI scan may be commissioned in the following circumstances as an exception where the following criteria are met:

- Patients who suffer from claustrophobia where an oral prescription sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). For the use for Spinal cord compression and neural axis tumours, the use of an Open MRI is recommended rather than the use of a general anaesthetic as there is a lesser risk to the patient.
- Patients who are obese and cannot fit comfortably in a conventional MRI scanner as determined by a Radiology department policy. (The issue re size is how the weight is distributed).

### **Upright MRI**

Upright MRI scanning within the Private sector is not routinely commissioned by the CCGs.

Upright MRI scanning may be considered for cases on an exceptional basis where;

- Evidence supports that due to severe pain (having utilized appropriate pain medication) **AND**
- The patient cannot lie properly for the required scan time in a conventional MRI scanner due to the patient's condition

### **6.31 BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS**

Botulinum Toxin for axillary hyperhidrosis will not be routinely commissioned by the CCGs.

Treatment may be considered on an exceptional basis for intractable, disabling focal primary hyperhidrosis when all of the following criteria are met;

- Topical aluminium chloride or other extra-strength antiperspirants are ineffective or result in a severe rash **AND**
- Iontophoresis has been ineffective **AND**
- Unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics) if sweating is episodic **AND**
- Significant disruption of life has occurred because of excessive sweating

#### **Exclusion**

The CCGs will not commission Botulinum Toxin to treat hyperhidrosis in people with social anxiety disorder. – NICE CG159

**NOTE** - for approved requests the CCGs will fund a maximum of 2 treatments per year per patient, not to be repeated more frequently than every 16 weeks.

#### **National supporting evidence**

[NICE CG159 - Social anxiety disorder: recognition, assessment and treatment;](#)

### **6.32 BOTULINUM TOXIN FOR PROPHYLAXIS MIGRAINE**

Botulinum Toxin for prophylaxis migraine will not be routinely commissioned by the CCGs.

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.

Treatment with Botulinum Toxin Type A that is recommended according to the above 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.

**NOTE** - for approved requests the CCGs will fund a maximum of 4 treatments per year per patient of Botulinum Toxin, not to be repeated more frequently than every 2 treatments without specialist review.

### **National supporting evidence**

[NICE Guidance TA260 - Botulinum toxin type A for the prevention of headaches in adults with chronic migraine](#)

### **6.33 SPINAL CORD STIMULATION**

Spinal Cord Stimulation (SCS) device and leads fall outside PbR tariff. Clinicians are responsible for deciding if the treatment is appropriate for individual patients. NICE Technology Appraisal Guidance 159 recommends SCS for adults with chronic neuropathic pain who:

- Continue to experience chronic pain (measuring at least 50mm on a 0-100mm visual analogue scale) for at least 6 months despite all other reasonable treatment alternatives having been tried with an unsatisfactory outcome **AND**

- Who have had a successful spinal cord stimulation trial (this determines suitability for permanent implantation by assessing tolerability and the degree of pain relief likely to be achieved by full implantation)

SCS is **NOT** commissioned for adults with chronic pain of ischaemic origin, except in the context of research as part of a clinical material (due to lack of evidence of clinical effectiveness).

SCS may only be commissioned after an assessment by a multidisciplinary team (MDT) experienced in chronic pain assessment and management of people with SCS devices, including experience in the provision of ongoing monitoring and support.

If different SCS systems are considered to be equally suitable for a person the least costly should be used. (Assessment of cost should take into account acquisition costs, the anticipated longevity of the system, the stimulation requirements of the person with chronic pain and the support package offered).

### **National supporting evidence**

[NICE Guidance TA159 - Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin](#)

### **6.34 SACRAL NEUROMODULATION**

Sacral Neuromodulation in relation to urinary retention and constipation will be commissioned in line with NICE IPG 536. Individual funding must be sought prior to commencement of treatment.

Sacro Neuromodulation for faecal and urinary incontinence are currently commissioned by NHS England.

### **National supporting evidence**

[NICE IPG 536: Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention \(published 25/11/15\)](#)



## 6.35 ADVICE & PATHWAY FOR THE SUPPLY OF NHS FUNDED WIGS

NHS wigs will be routinely funded outside of cancer pathways for the following indications:

1. Consultant Dermatologist request

**AND**

2. Specialist diagnosis of

- a) Alopecia totalis

**OR**

- b) Scarring alopecia including

- Scleroderma
- Lichen planus
- Discoid lupus
- Folliculitis decalvans
- Frontal fibrosing alopecia

A Consultant Dermatologist will determine the patients' diagnosis and suitability for a wig and issue a prescription where appropriate.

Patients are entitled to either two stock modacrylic fibre wigs per year **or** one stock real hair wig every 2 years.

There are no nationally set limits on the number of wigs a patient can have from the NHS. However, this is a locally agreed own limit.

The patient will be expected to pay the current standard prescription charge for either of the above types of wig. This prescription charge is payable to either the hospital Trust or any NHS wig provider that accepts NHS prescriptions. The balance of the cost of the wig is paid by the NHS.

Some [patients may be exempt from paying this prescription charge.](#)

Many hospital Trusts will carry wigs as part of their appliance offering, however advice can be provided to patients on other NHS wig providers who will accept an NHS prescription.

## **Exclusions**

Bespoke wigs including bespoke human hair wigs are not routinely prescribed. The patient's clinician would need to submit an Individual Funding Request to the Clinical Commissioning Group on behalf of the patient to request funding for a bespoke human hair wig or any other non-standard wig.

The funding request must evidence on what exceptional grounds that the patient should be prescribed a bespoke wig. Evidence of 'allergy' needs to be proven by patch testing prior to the clinician submitting an Individual Funding Request.

Should funding be successfully granted, patients would be expected to pay the current standard prescription charge (see more information on the NHS England link above for charges and exemptions).

The CCG will fund up to a maximum of one bespoke real hair wig every 2 years up to a maximum balance cost of £1,500.

## **Re-issue process in subsequent years**

For bespoke wigs agreed through the Individual Funding Request process, once the initial request has been approved the patient can request subsequent years funding from the Clinical Commissioning Group when the wig is due for replacement.

The patient will be required to write to the IFR team informing them that the wig is due for replacement. The IFR team will process the request and confirm in writing to the patient that a replacement wig has been authorised.

## **6.36 ADULT SNORING SURGERY (IN THE ABSENCE OF OSA)**

This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of

patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment of the OSA.

It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.

### **Alternative Treatments**

There are a number of alternatives to surgery that can improve the symptom of snoring. These include:

- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)

### **6.37 DILATATION AND CURETTAGE (D&C) FOR HEAVY MENSTRUAL BLEEDING IN WOMEN**

NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.

Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), can be used to investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) can treat heavy periods.

D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.

Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods.

Medication and intrauterine systems (IUS) can be used to treat heavy periods.

For further information, please see:

- [NICE Guidance NG88: Heavy menstrual bleeding: assessment and management](#)
- [NHS website for England: Hysteroscopy and alternatives to hysteroscopy](#)

### **6.38 INJECTIONS FOR NONSPECIFIC LOW BACK PAIN WITHOUT SCIATICA**

NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work.

Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.

For people with non-specific low back pain the following injections should not be offered:

- Facet joint injections
- Therapeutic medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.

Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic.

Alternative options are suggested in line with the National Back Pain Pathway.

Further information is provided in [NICE Guidance NG59: Low back pain and sciatica in over 16s: assessment and management](#)

### **6.39 KNEE ARTHROSCOPY FOR PATIENTS WITH OSTEOARTHRITIS**

NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis, unless the knee locks (in which case it may be considered).

More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and pain management.

If symptoms do not resolve, knee replacement or osteotomy are effective procedures that should be considered.

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. [ESCAPE pain](#)), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement or joint preserving surgery such as osteotomy is appropriate.

For further information, please see:

- [NICE guidance IPG230 Interventional procedure overview of arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis](#)

- [NICE Guidance IPG 230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis](#)
- [NICE Do not do recommendation for referral for arthroscopic lavage and debridement as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking](#)

## 7. References

[Department of Health \(2013\). The NHS Constitution the NHS belongs to us all.](#)

[Department of Health \(2012\). The Functions of Clinical Commissioning Groups](#)

[Department of Health \(2010\). Equity and Excellence: Liberating the NHS. Available](#)

[Scottish Intercollegiate Guidelines Network \(2013\). Information about SIGN.](#)

[The NHS Confederation \(2008a\) Priority Setting: Legal Considerations.](#)

[The NHS Confederation \(2008b\) Priority Setting: Managing Individual Funding Requests](#)

[NHS Modernisation Agency. Information for Commissioners of Plastic Surgery Services; Referrals and Guidelines in Plastic Surgery \(2005\)](#)

[NHS England - Evidence-Based Interventions: Response to the public consultation and next steps](#)

## Appendix 1 List of Complementary / Alternative Therapies

Active release technique  
Acupressure  
Acupuncture  
Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries)  
technique Alexander technique  
AMMA therapy  
Antineoplaston Therapy and Sodium Phenylbutyrate  
Apitherapy  
Applied kinesiology  
Aromatherapy  
Art therapy  
Aura healing  
Autogenous lymphocytic factor  
Auto urine therapy  
Bioenergetic therapy  
Biofield Cancell (Entelev) cancer therapy  
Bioidentical hormones  
Brain integration therapy  
Carbon dioxide therapy  
Cellular therapy  
Chakra healing  
Chelation therapy for Atherosclerosis  
Chung Moo Doe therapy  
Coley's toxin  
Colonic irrigation  
Colour therapy  
Conceptual mind-body techniques  
Craniosacral therapy  
Crystal healing  
Cupping  
Dance/Movement therapy  
Digital myography  
Ear Candling



Egoscue method  
Electrodermal stress analysis  
Electrodiagnosis according to Voll (EAV)  
Equestrian therapy - Hippotherapy  
Essential Metabolics Analysis (EMA)  
Essiac  
Feldenkrais method of exercise therapy (also known as awareness through movement)  
Flower essence  
Fresh cell therapy  
Functional intracellular analysis  
Gemstone therapy  
Gerson therapy  
Glyconutrients  
Graston technique  
Greek cancer cure  
Guided imagery  
Hair analysis  
Hako-Med machine (electromedical horizontal therapy)  
Hellerwork  
Hoxsey method  
Human placental tissue  
Hydrolysate injections  
Humor therapy  
Hydrazine sulfate  
Hydrogen peroxide therapy  
Hypnosis  
Hyperoxygen therapy  
Immunoaugmentive therapy  
Infratronic Qi-Gong machine  
Insulin potentiation therapy  
Inversion therapy  
Iridology  
Isador  
Juvent platform for dynamic motion therapy

Kelley/Gonzales therapy  
Laetrile  
Live blood cell analysis  
Macrobiotic diet  
Magnet therapy  
MEDEK therapy  
Meditation/transcendentalmeditation  
Megavitamin therapy (also known as orthomolecular medicine)  
Meridian therapy  
Mesotherapy  
Moxibustion  
MTH-68 vaccine  
Music therapy  
Myotherapy  
Neural therapy  
NUCCA procedure  
Ozone therapy  
Pfrimmer deep muscle therapy  
Polarity therapy  
(Poon's) Chinese blood cleaning  
Primal therapy  
Psychodrama  
Purging  
Qigong longevity exercises  
Ream's testing  
Reflexology (zone therapy)  
Reflex Therapy  
Reiki  
Remedial massage  
Revici's guided chemotherapy  
Rife therapy/Rife machine  
Rolfing (structural integration)  
Rubenfeld synergy method (RSM)  
Sarapin injections  
Shark cartilage products

Telomere testing  
Therapeutic Eurythmy-movement therapy  
Therapeutic touch  
Thought field therapy (TFT) (Callahan Techniques Training)  
Trager approach  
Traumeel preparation  
Vascular endothelial cells (VECs) therapy  
Vibrational essences  
Visceral manipulation therapy  
Whitcomb technique  
Wurn technique/clear passage therapy  
Yoga

## **Appendix 2 Equality Impact Assessment Checklist Tool**

**Title of Policy:** Commissioning Policy for Individual Funding Requests

**Names and roles of people completing the assessment:**

Claire Wood – Assistant Manager Individual Funding Requests

Sarah MacKenzie - Cooper – Equality & Diversity Manager

**Date assessment started:** 01/07/2017

**Date completed:** 29/1/2018

### **1. Outline**

**Give a brief summary of the policy:**

The purpose of the policy is to enable officers of the CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to General Practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs.

**What outcomes do you want to achieve?**

That the CCGs commission services equitably, and only when clinically necessary and in line with current evidence on cost effectiveness.

### **2. Analysis of impact**

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
General			Equality monitoring of IFR request has been introduced and will be continuously reviewed against outcomes. Where any trends are noticed further work will be undertaken to establish any areas for action.
Age	Yes. Some of the IFR criteria have age limitations. This is based on clinical evidence or considered a justifiable proxy for physical maturity. In the case of Pinnaplasty this is only considered for children up to the age of 19 due to the significant psychosocial dysfunction for children and adolescents and impact on education.	This could be negative for those people who fall outside the age related criteria.	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process. The IFR policy is published on the CCGs websites so clinicians and patients can access the criteria and be fully informed of any restrictions.
Carers	Not applicable	N/A	N/A
Disability	Yes. There is recognition that there may be	Potentially negative	This is addressed in the policy (section 5).

Characteristics	<p>Are there any likely impacts?</p> <p>Are any groups going to be affected differently?</p> <p>Please describe.</p>	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
	<p>psychological impacts of some of the conditions which present to IFR however clinical need must be evidenced.</p>		<p>Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.</p>
Sex	<p>Some procedures are likely to be sex related; e.g. Labiaplasty. Where this is the case the clinical thresholds will need to be met.</p> <p>Most procedures are gender neutral.</p>		<p>The IFR committee receives redacted patient information which should mitigate the impact for gender neutral processes. Equality monitoring of requests will be reviewed.</p>
Race	<p>No evidence to date – equality monitoring introduced and will be reviewed.</p>	N/A	N/A
Religion or belief	<p>There may be an expectation that circumcision for religious reasons should be approved however it is only undertaken for clinical reasons.</p>	N/A	<p>Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.</p>

Characteristics	<p>Are there any likely impacts?</p> <p>Are any groups going to be affected differently?</p> <p>Please describe.</p>	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
Sexual orientation	Not applicable	N/A	Not applicable
Gender reassignment	<p>IFRs are considered in the patients affirmed gender and therefore subject to the clinical criteria within the policy.</p> <p>Other treatments may be available through the gender reassignment pathway, if not an IFR could be submitted.</p>	N/A	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Pregnancy and maternity	<p>Some IFRs could be impacted by pregnancy and maternity, e.g. breast procedures. There may be a delay to allow for full recovery after childbirth.</p> <p>Inverted nipple treatment is only available to support breast feeding in specific clinical circumstances.</p>	N/A	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Marriage and civil partnership	Not applicable	N/A	Not applicable

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
Other relevant group	No evidence	N/A	Not applicable

### 3. Monitoring, Review and Publication

#### How will you review/monitor the impact and effectiveness of your actions

We will review the basic equality monitoring data received. The number of IFR equality monitoring forms received is limited so we will report any issues that are noted across the CCGs. Following the introduction of this policy we will report annually to the constituent CCGs.

**Lead officer:** Claire Wood

**Review date:** June 2022

#### 4. Sign off

**Lead Officer:** Vicky Dutchburn

**Title:** Head of Strategic Planning & Transformation

**Date of Approval:** 11/3/2019



### Appendix 3 Version Control Sheet

The table below evidences the history of the steps in development of the document.

Version Control:

Version	Date	Author	Status	Comment
0.1	June 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.1	Initial starting draft
0.2	July 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.2	Updated using Joint Commissioning Policy from North Kirklees & Wakefield CCGs
0.3	August 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.3	Updated using NHS England commissioning policies & NICE Guidance
0.4	October 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.4	Updated after discussions with Dermatology and Plastics Departments at LTHT
0.5	December 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.5	Updated after review of STP & other CCGs IFR policies
0.6	January 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.6	Updated after review of North East London CSU commissioning policy for complementary therapies
0.7	February 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.7	Updated after wig pathway included

Version	Date	Author	Status	Comment
0.8	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.8	Additional wording in relation to revisonal procedures
0.9	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.9	Additional wording in relation to breast re-augmentation
0.10	June 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.10	Change to format of criteria in relation to breast reduction
1.0	June 2018	Claire Wood – Assistant Manager IFR GHCCG	FINAL V1.0	Approved by: Greater Huddersfield CCG - 13/06/2018 North Kirklees CCG - 13/06/2018 Calderdale CCG - 14/06/2018
2.0	March 2019	Claire Wood - Assistant Manager IFR GHCCG	FINAL V2.0	Criteria updated in light of national mandated policies published by NHSE.
3.0	July 2019	Claire Wood - Assistant Manager IFR GHCCG	FINAL V3.0	Criteria removed in line with the National mandated policies published by NHSE.
4.0	April 2021	Claire Wood - Assistant Manager IFR KCCG	FINAL V4.0	Updated to reflect policy being adopted by new organisation, Kirklees CCG