Value-based commissioning: procedures of limited clinical value (2015)

A joint commissioning policy of clinical commissioning groups in Nottinghamshire County (excluding Bassetlaw) and Nottingham City

Final draft

Version control

Version B	July 2010	Hernias: criteria removed MRI criteria – harmonised with criteria for discectomy Apneoa: Embed Epworth Sleepiness Scale IBS: clarify that criteria relates to adults; link to NICE Guidelines for IBS Reference to APC position statement on Homeopathy Formatting changes
Version C	September 2010	Annotated to clarify meaning of "restricted" Added Chinese Medicine to list of alternative therapies Tonsillectomy: added that episodes must be appropriately treated Xray/MRI: prompt to City GPs to Direct Access Guidelines for investigating spinal disc lesions IBS: further highlight that this applies only to adults
Version D	January 2011	Introduction: reword for consistency, and set out what is meant by low value Cataract: amended criteria Inguinal hernia: added criteria Glucosamine: removed; belongs in prescribing policy Shoulder arthroplasty: removed criteria – general restriction regarding IPG applies Ganglion: clarified existing criteria Aim & implications of policy: added text to explain policy to patients and summary list of procedures for GPs/patients
2014	January 2014 June 2014	Former PCT names replaced with CCGs Dental implants removed – commissioned by NHS England Caesarean section removed – to address NICE 2011 Hyperbaric oxygen therapy for wound healing removed – now commissioned by NHS England Labial reduction removed – now covered by East Midlands Cosmetics Policy Gastroplasty removed – commissioned by NHS England Varicose veins surgery removed – covered by East Midlands Cosmetics Policy Carpal tunnel surgery added Surgery for Dupuytrens – updated Primary hip replacement – removed (to be addressed in local pathway developments) Primary knee replacement – removed (to be addressed in local pathway developments) Hip arthroscopy – amended with link to the relevant policy document Spinal cord stimulation – commissioned by NHS England Clause added for NICE do not do's

Patient guide to the policy & why your doctor has to observe it

NHS funds

- NHS Clinical Commissioning Groups in Nottinghamshire County and Nottingham City buy healthcare on behalf of the local population. The money for this comes from a fixed budget. By law, we are required to keep within this budget.
- Demand for healthcare is greater than can be funded from this fixed budget. Unfortunately, this means that some healthcare which patients might wish to receive and which professionals might wish to offer cannot be funded.
- This has always been the situation since the start of the NHS.

Assessing what the overall population most needs

- Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed.
- This assessment of need is made across the whole population and, wherever possible, on the basis of best evidence about what works. We also aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services.
- This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations.
- One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which don't work well enough to justify any use within the local NHS. A similar list has been drawn up for medications, to ensure that the local NHS gets the greatest possible value for the local population. We aim to review these lists to ensure that they reflect the best available evidence and are affordable and fair.

Implications for you

- This may mean that your doctor is not able to offer you a certain treatment because it would not be funded by the local NHS.
- Although most doctors recognise the need for some kind of policy like this, she/he may be uncomfortable because of its implications for you as an individual.
- Even so, your doctor has to observe the policy because it is the policy of the local NHS, and is the best way to ensure that local NHS funds are spent on the things that will bring greatest overall benefit to local people in a way that is affordable and fair.

Please turn page for a brief summary of what is included in this policy and in the related policy covering cosmetic treatments.

Examples of treatments which are not funded by the local NHS

The following list contains examples of some of the treatments that are not funded or are restricted, and are most relevant to patients in a primary care setting

- Surgical or laser treatment for a range of benign skin lesions except in specific circumstances set out in the Cosmetics policy, e.g.
    - **viral warts, seborrhoeic warts, molluscum contagiosum, spider veins, cherry angioma, skin tags, papillomas, naevi, haemangiomas, xanthelasma, epidermoid cysts**
- **Complementary therapies including acupuncture** (except acupuncture for low back pain up to 12 months duration)
- **Grommets, tonsillectomy, adenoidectomy, surgery for sleep apnoea** – strict criteria apply
- **Surgery for snoring**
- **Hysterectomy for heavy menstrual bleeding** – strict criteria apply
- **Cataracts** – criteria apply
- **Circumcision** – except for medical reasons
- **Haemorrhoidectomy** – strict criteria apply
- **Inguinal hernia repair** – strict criteria apply
- Tests for confirming diagnosis of **Irritable Bowel Syndrome** in adults
- **Reversal of sterilisation**
- **Back surgery and injections** – strict criteria apply
- Surgery for **Dupuytrens, Ganglion,** and **Joint injections** – strict criteria apply
- **Cosmetic treatments** except in the very specific circumstances set out in the Cosmetics policy. List of treatments not funded includes (but not limited to):
    - **Excision of excessive skin from thigh/ leg/ hip/ buttock/ arm/ forearm, facelifts, fat grafts, liposuction, phalloplasty, chin implant, cheek implants, collagen implant, cranial banding for positional plageocephaly, earlobe repair, botulinum for wrinkles/ frown lines/ aging neck, resurfacing by laser for skin conditions causing scarring, correction of nipple inversion, breast uplift, hair depilation, electrolysis**

For a full list of all treatments and applicable exclusions and criteria, please refer to Commissioning policy covering access to low priority procedures and other treatments (this document) and the East Midlands Cosmetics Policy. Prescribing of medications is covered by the guidelines produced by the Nottinghamshire Area Prescribing Committee.

1.1 Introduction

The purpose of this policy is to ensure that Clinical Commissioning Groups (the Commissioner) in Nottinghamshire County and Nottingham City (and their successor organisations) fund treatment only for clinically effective interventions delivered to the right patients. It sets out the treatments deemed to be of insufficient priority to justify funding from the available fixed budget.

Approved prescribing of medicines falls outside the scope of this document and is covered in the guidelines and protocols produced by the Nottinghamshire Area Prescribing Committee. Further information can be obtained from the Pharmacy/Medicines Management Department or via www.nottsapc.nhs.uk.

1.2 Definitions

In general, treatments are deemed to be of low value and therefore a low priority for funding where:

1. There is clear evidence that they are ineffective or do more harm than good, or
2. There is no evidence of effectiveness and they are not being delivered in a context that would allow the gathering of an evidence base to judge effectiveness, i.e. through ethically approved research, or
3. There is evidence of effectiveness they but are being offered to patients whose characteristics are different from the characteristics of the patients in the research studies which produced the evidence for effectiveness, or
4. They use resources that would produce more value, namely a better balance of benefit to harm, if invested in some other service for the same group of patients.

1.3 Scope

This policy sets out procedures which are not normally commissioned due to their low value and some others for which strict criteria apply, to ensure that the funded procedures will deliver high value.

1.4 Principles

Commissioning decisions about a procedure are made with reference to the evidence of its clinical effectiveness, cost effectiveness, the affordability of equitable provision, and best value for money.

1.5 Exceptionality

The Clinical Commissioning Groups commission according to the policy criteria. Requests for individual funding will not normally be considered, unless the circumstances fulfil the strict criteria for exceptionality as defined within the current policy for determining Individual Funding Requests, in which case they may be submitted for consideration with the framework and process outlined in the IFR policy.

1.6 Implementation

The policy will be implemented across providers in primary and secondary care. It will be formally incorporated into contracts and will be subject to routine monitoring for compliance.

1.6.1 The schedule of procedures

The schedule is set out below and can be incorporated into contractual and service level agreements. The Commissioners will require all providers in primary and secondary care to embrace and abide by the policy, advising patients accordingly.

This policy should be read in conjunction with other policies published by the Commissioners, e.g. East Midlands Commissioning Policy for Cosmetic Procedures

1.6.2 NICE guidance and recommendations about “do not do”

During the process of guidance development, NICE's independent advisory bodies often identify NHS clinical practices that they recommend should be discontinued completely or should not be used routinely. Such recommendations may be due to evidence that the practice is not on balance beneficial or a lack of evidence to support its continued use. NICE has collated these recommendations into the ‘do not do' recommendations database.

Commissioners do not routinely fund interventions identified in the “do not do” recommendations database.

A copy of the database is maintained here:

http://www.nice.org.uk/usingguidance/donotdorecommendations/index.jsp

2 Schedule

Procedure	Criteria	Basis / Evidence
ENT		
Grommets RESTRICTED	The Commissioner will fund treatment with grommets for children with otitis media with effusion (OME) where: • There has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT; **AND** • The child is placed on a waiting list for the procedure at the end of this period; **AND** • OME persists after three months AND the child (who must be over three years of age) suffers from **at least one** of the following: At least 5 recurrences of acute otitis media in a year. Evidence of delay in speech development. Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss). A significant second disability such as Downs syndrome.	NICE Clinical Guideline on surgical management of otitis media with effusion CG60 SIGN Guideline 66 (2003) *Diagnosis and management of childhood Otitis Media in Primary Care*
Tonsillectomy and/or adenoidectomy RESTRICTED	Unequivocal indications for tonsillectomy: • Suspected malignancy • Peri-tonsillar abscess (Quinsy) • Acute upper airways obstruction • Recurrent sore throat where the following applies: 7 or more episodes in the last year, OR 5 or more episodes in each of the last two years, OR 3 or more episodes in each of the last 3 years; AND There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work; AND/OR Failure to thrive.	Royal College of Paediatrics and Child Health. Guidelines for good practice. Management of acute and recurring sore throat and indications for tonsillectomy. London: RCPCH; 2000 Scottish Intercollegiate Guidance Network. Management of sore throat and indications for tonsillectomy.

	Each of the episodes must be documented in the patient's notes, appropriately treated and characterised by at least one of the following: a. Oral temperature of at least 38.3 C b. Tender anterior cervical lymph nodes c. Tonsillar exudates d. Positive culture of group A beta haemolytic streptococci e. The episodes are disabling and prevent normal functioning (school / work) f. Tonsillar enlargement giving rise to symptoms of obstruction (Recurrent attacks are a succession of definite episodes, as opposed to chronic tonsillitis) The Commissioner will consider funding for tonsillectomy in sleep apnoea syndrome in children when one or more of the following apply: A positive sleep study. A significant impact on quality of life demonstrated. A strong clinical history suggestive of sleep apnoea. **Note:** The case is much more likely to be approved where there is supporting evidence such as sleep studies, growth charts, letters from GPs and letters from employer and school.	Edinburgh: SIGN guidance 34 (1999, reviewed 2005).
Surgery/Treatment for snoring NOT FUNDED	None Other procedures which fall into this policy also include: correction of deviated septums surgical reduction of the tongue removal of tonsils	The Commissioner considers surgical treatment to be a low priority where snoring is the sole problem
Surgical treatment for sleep apnoea RESTRICTED	The Commissioner will fund surgical treatment of sleep apnoea in the following circumstances: Patient has moderate to severe symptoms (measured for example by the Epworth Sleepiness Score: 15-18= moderate, >18 = severe; see bottom of this section for copy of Epworth tool); OR Patient is sleepy in dangerous situations such as driving (regardless of Epworth Sleepiness Score); AND Patient has significant sleep disordered breathing (as measured during a sleep study, usually by the Apnoea/Hypopnoea Index: 15-30/hr = moderate, >30/hr = severe); AND Patient has already tried continuous positive airways pressure (CPAP) unsuccessfully for	

	6 months prior to being considered for surgery OR patient had major side effects to CPAP such as significant nosebleeds; AND A specialist believes the individual patient will benefit (according to available literature the subgroups in which surgical intervention may be effective are not currently known); AND The patient is fully informed as to the limited effectiveness of procedures, the lack of long term outcomes and likely adverse effects including pain following surgery. AND Evidence of compliance to advice about weight loss and alcohol intake This guidance does not make detailed recommendations on the use of individual surgical procedures, although studies have shown varying levels of effectiveness in terms of outcomes and adverse effects between the different surgical procedures. However IFR/prior approval panels should take account of the fact that palatal surgery, such as UPPP and LAUP is not recommended by SIGN (2003) and it may compromise the patient's subsequent ability to use nasal CPAP, although the extent of this risk is not known. Current evidence on soft-palate implants for obstructive sleep apnoea (OSA) raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist. Therefore, soft-palate implants should not be used in the treatment of this condition. Copy of Epworth Sleepiness Tool http://epworthsleepinessscale.com/epworth-sleepiness-scale.pdf	
OBSTETRICS, GYNAECOLOGY & FERTILITY		
D&C for menorrhagia RESTRICTED	The Commissioner will not fund D&C as a diagnostic tool or as a therapeutic treatment for menorrhagia. D&C will be funded in the following circumstances: • as an investigation for structural and histological abnormalities where hysteroscopy and ultrasound has been used as a first line diagnostic tool and where the outcomes	NICE Clinical Guideline on heavy menstrual bleeding CG44

	are inconclusive, • post-dilatation, pre-procedure when undertaking endometrial ablation	
Hysterectomy for menorrhagia RESTRICTED	The Commissioner will only fund hysterectomy for heavy menstrual bleeding when each of the following conditions are satisfied: 1. after an unsuccessful trial with a levonorgestrel intrauterine system (e.g Mirena®) for at least 6 months and it has failed to relieve symptoms (or where it is medically inappropriate or contraindicated AND 2. at least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence (NICE) guidelines: a. Non-steroidal anti-inflammatory agents. b. Tranexamic acid c. Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) AND 3. A surgical treatment such as endometrial ablation, uterine artery embolisation or myomectomy has been offered and has failed to relieve symptoms (or are not appropriate or are contra-indicated). In addition, the Commissioner will fund hysterectomy for heavy menstrual bleeding due to fibroids greater than 3 cm when the following criteria are satisfied: 1. Other symptoms (e.g. pressure symptoms) are present 2. There is evidence of severe impact on quality of life. 3. Other pharmaceutical options have failed. 4. Patient has been offered myomectomy and/or uterine artery embolisation (unless medically contraindicated).	NICE CG44 Heavy menstrual bleeding: investigation and treatment – Jan 2007 Royal College of Obstetricians and Gynaecologists (1999). *Management of Menorrhagia in Secondary Care*
Mirena Coils RESTRICTED	To be fitted by primary care and not secondary care unless specific medical issue which prevents fitting by primary care or fitted as part of contraception provided in conjunction with Termination of Pregnancy.	Except in the circumstances described here, the cost to commissioners is lower in primary care
Reversal of female sterilisation NOT FUNDED	Not funded	

Reversal of male sterilisation NOT FUNDED	Not funded	
OPHTHALMOLOGY		
Cataract Surgery RESTRICTED	The Commissioner will fund Cataract Surgery where there is a visual acuity of 6/12 (corrected) in the worst eye, or for: 1. Patients for whom it is vital to have good visual acuity in the worse eye for the purpose of fulfilling essential occupational responsibilities (e.g. watchmaker). 2. Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions 3. Driving: the legal requirement for driving falls between 6/9 and 6/12 (strictly speaking it is based on the number plate test). It is anticipated that the threshold will not render the majority of people unable to drive as it applies to the worst eye only. Exceptions to this include: * Patients who need to drive who experience significant glare which affects driving; * Patients for whom it is vital to drive at night for the purpose of fulfilling essential domestic, carer or occupational responsibilities, and who experience glare that is related to cataract; * Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field. 4. Patients with glaucoma who require cataract surgery to control intra ocular pressure 5. Patient with diabetes who require clear views of their retina to look for retinopathy Cataract Second Eye 1. Where the cataract procedure on the first eye has achieved a VA of 6/9 or better, and the VA for the second eye is 6/24 or better, then the patient should be discharged, unless receiving treatment for any other eye condition. The patient should be advised to attend an optometrist for a sight test annually or earlier if they notice any deterioration of vision. 2. If the first eye does not achieve a VA of 6/9 or better, then the second eye should be dealt with on clinical merit, taking into account any directly related essential responsibilities (i.e. the requirement for night driving). 3. There are circumstances, where despite good acuities, there may still be a clinical need to operate on the second eye fairly speedily e.g. where there is resultant anisometropia (a large refractive difference between the two eyes) which would result in poor binocular vision or even diplopia. In these circumstances, the notes should clearly	Department of Health. Commissioning Toolkit for Community Based Eyecare Services (DH 2007) NHS Executive. Action on Cataracts: Good practice guidance (Jan 2003)

	record this so that it can be identified during any future clinical audit.	
Laser treatment of myopia NOT FUNDED	Not funded	
Surgery for correction of short sight NOT FUNDED	Not funded	
GENERAL SURGERY		
Anal/rectal skin tags NOT FUNDED	Not funded	
Cholecystectomy for asymptomatic gallstones	Not funded for asymptomatic gallstones. Only funded for patients at risk of developing gallbladder carcinoma or gallstone complications. Where there are no symptoms, cholecystectomy confers no benefit to patients with asymptomatic gallstones, even in patients with one attack of uncomplicated gallstone pain.	WGO Practice Guideline: Asymptomatic Gallstone Disease. Available at: guidelines@worldgastroenterology.org
Circumcision RESTRICTED	Not normally funded in either adults or children unless there are medical indications.	"Statement on Male Circumcision". Statement from the British Association of Paediatric Surgeons, The Royal College of Nursing, The Royal College of Paediatrics and Child Health, The Royal College of Surgeons of England and The Royal College of Anaesthetists. 6 March 2001. "The law and ethics of male circumcision - guidance for doctors"

		BMA, June 2006
Haemorrhoidectomy RESTRICTED	Only funded for recurrent and persistent bleeding that fails to respond to conservative treatment; haemorrhoids that cannot be reduced.	
Inguinal hernia in adults – elective repair RESTRICTED	This procedure is not routinely funded for asymptomatic or minimally symptomatic inguinal hernias in adults. Patients should be referred for surgical assessment if they meet one or more of the following criteria: 1. A history of incarceration of, or real difficulty reducing, the hernia. 2. An inguino-scrotal hernia. 3. Increase in size month to month. 4. Pain or discomfort significantly interfering with activities of daily living. 5. Work related issues e.g. of work/missed work/unable to work/on light duties due to hernia 6. Comorbidity which does not render the patient unfit for elective surgery currently, but which is likely to significantly increase the risks associated with future surgery Patients with femoral hernias should be referred for consultation.	European Hernia Society Guidleines Hernia (2009) 13:343–403 Fitzgibbons RJ Jr, Giobbie-Hurder A, Gibbs JO, et al. Watchful waiting vs repair of inguinal hernia in minimally symptomatic men: a randomized clinical trial. JAMA. 2006;295:285-292.
Irritable Bowel Syndrome (Adults) – tests for confirming diagnosis RESTRICTED	In the absence of red flag symptoms of malignancy, the following tests will not be funded for confirmation of diagnosis in adults who meet the IBS diagnostic criteria: ultrasound rigid/flexible sigmoidoscopy colonoscopy; barium enema thyroid function test faecal ova and parasite test faecal occult blood hydrogen breath test (for lactose intolerance and bacterial overgrowth).	For context, please refer to NICE CG61 Diagnosis and management of IBS in primary care: http://guidance.nice.org.uk/CG61/QuickRefGuide/pdf/English
MSK		
Autologous Chondrocyte	None	NICE TA89

Implantation NOT FUNDED		
Back pain Discectomy for lumbar disc prolapsed RESTRICTED	Absolute Criteria: The patient is 18 years or older; AND The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms; AND The patient has a corresponding neurologic deficit (asymmetrical depressed reflex, decreased sensation in a dermatomal distribution, or weakness in a myotomal distribution, altered bowel or bladder function); OR The patient has radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement; OR There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise–positive between 30° and 70° or positive femoral tension sign); AND Symptoms persist despite some non-operative treatment for at least 6 weeks (e.g. analgesia, physical therapy, bed rest etc).	*Requires review in 2015*
Back pain Spinal fusion RESTRICTED	The Commissioner will fund for unequivocal root compression; spinal stenosis; instability; failure of adequate conservative trial of >6 months duration	*Requires review in 2015*
Back pain Spinal epidural injections RESTRICTED	For low back pain - single injection for patients who have undergone discectomy For sciatica - where patient responded previously. Not funded for patients who have non-specific low back pain up to 12 months duration	NICE Clinical Guidance CG 88 (published May 2009) *Requires review in 2015*
Back pain		

Facet joint injections	Only funded as diagnostic/screening tool prior to radiofrequency denervation or surgery in order to show probability of benefit; as treatment where co-morbidities that preclude other interventions The Commissioner does not fund facet joint injection for patients who have non-specific low back pain	*Requires review in 2015*
Carpal Tunnel	Commissioners fund immediate referral if on presentation symptoms include one or more of: • Thenar wasting, or • Permanaent numbness, or • pain that prevents activities of daily living, e.g. washing or dressing For mild or moderate symptoms such as intermittent paraesthesia or pain, nocturnal waking, clumsiness without thenar muscle wasting/weakness, referral to orthopaedics should only be made: • After symptoms have failed to respond to 12 weeks of conservative management including wrist splinting (any improvement should be apparent within 12 weeks), and one corticosteroid injection in appropriate patients Except in the circumstances specified above, the commissioner will not fund surgery for carpal tunnel syndrome.	NICE Clinical Knowledge Summary on carpal tunnel syndrome http://cks.nice.org.uk/carpal-tunnel-syndrome#azTab Shi and MacDermid Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review Journal of Orthopaedic Surgery and Research 2011, 6:17 The British Society for Surgery of the Hand, Evidence for Surgical Treatment: Carpal Tunnel Syndrome (CTS) http://www.bssh.ac.uk/education/guidelines/carpal_tunnel_syndrome.pdf Royal College of Surgeons 2013 Commissioning guide: Treatment of painful tingling fingers http://www.rcseng.ac.uk/healthcare-bodies/docs/Treatmentofpainfultinglingfingers.pdf
Dupuytrens Contracture RESTRICTED	Symptoms of Dupuytren's contracture are often mild and painless and do not require treatment. Patients may be managed with observation if the contractures themselves are not functionally limiting. Commissioners will fund surgical intervention where one or more of the criteria are met: • Metacarpophalangeal (MCP) joint contracture of 30° (inability to place hand flat on table), or • Any degree of proximal interphalangeal (IP) joint contracture, or • First web contracture, or • Significant functional loss which prevents activities of daily living, e.g. washing, dressing The Commissioner does not fund routinely fund collagenase injections (Xiapex). The Commissioner does not routinely fund radiation therapy for early Dupytren's	NICE Clinical Knowledge Summary British Society for Surgery to the Hand Evidence for Surgical Treatment Guide: Dupytren's Disease

	disease.	
Ganglion Cysts RESTRICTED	Referral to orthopaedics for symptomatic ganglia only: 1. Ganglion on wrist – with evidence of neurovascular compromise or functional disability 2. Seed ganglia at base of digits – with significant pain 3. Mucoid cysts at DIP joint – nail growth disrupted, cysts tend to discharge No referrals for cosmetic surgery for ganglion cysts Excision of ganglion cyst is funded only for patients meeting one or more of these criteria.	Many ganglia resolve spontaneously. Up to 88% recurrence after single aspiration. Surgical treatment for symptomatic ganglia remains controversial. British Society for Surgery of Hand http://www.bssh.ac.uk/education/referralguidelines/ganglion.pdf
Hip Arthroscopy	Covered by a separate policy (see link). In summary, commissioners will fund for the treatment of sepsis, loose bodies and excision of radiological proven labral tears in the absence of osteoarthritis or other pathology for patients meeting the policy criteria. The Commissioner does not routinely fund the use of hip arthroscopy for the management of Hip Impingement Syndrome or other indications.	http://www.mansfieldandashfieldccg.nhs.uk/images/i/ccgcommissioningpolicies/9.%20Policy%20Arthroscopy%20of%20the%20Hip.pdf
Hip and Knee and other joint revisions	The Commissioner will fund revisions using standard prosthesis.	*Requires review in 2015*
Hip resurfacing RESTRICTED	Those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements	*Requires review in 2015*
Joint Injections RESTRICTED	Restricted if patient candidate for joint replacement in 6-12 months. As diagnostic tool prior to joint replacement to confirm joint as source of symptoms or for patients unfit or unsuitable for surgery. (NB there will be a maximum tariff price which reflects carrying out in an aseptic theatre and not a sterile theatre).	*Requires review in 2015*
Knee – diagnostic arthroscopy NOT FUNDED	None	
Knee – washouts & debridement RESTRICTED	Funded only where patient has mechanical features of locking (not gelling, 'giving way' or x-ray evidence of loose bodies).	NICE IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. Aug 2007 NICE CG59 The care and management

		of osteoarthritis in adults. Feb 2008 *Requires review in 2015*
Other joint prosthetics RESTRICTED	Joint replacement for people who: experience joint symptoms (pain, stiffness and reduced function) **AND** have a substantial impact on their quality of life **AND** are refractory to non-surgical treatment. Referral should be made before there is prolonged and established functional limitation and severe pain	*Requires review in 2015*
Therapeutic use of ultrasound in Hip and knee osteoarthritis NOT FUNDED	None	*Requires review in 2015*
Trigger Finger RESTRICTED	Surgical intervention is funded following failure to respond to conservative measures and for fixed deformity / non-correctable.	
MRI of back for low back pain RESTRICTED	MRI of lumbar spine for low back pain in the following circumstances: 1) Red flag symptoms: a) Spinal malignancy b) Infection c) Fracture d) Cauda equina syndrome e) Ankylosing spondylitis or another inflammatory disorder f) Suspected osteoporotic fracture. 2) In the context of a referral for an opinion on spinal fusion 3) In the context of Discectomy for lumbar disc prolapsed (as specified elsewhere in this policy). Nottingham City GPs – please refer to Direct Access Guidelines for investigating spinal disc lesions	NICE – Early management of non-specific low back pain 2010. http://guidance.nice.org.uk/CG88
X-ray (plain) of back	X-ray of lumbar spine for non-specific low back pain – Not funded	NICE – Early management of non-

for low back pain NOT FUNDED	(Funding is only provided for the investigation of specific pathology)	specific low back pain 2010. http://guidance.nice.org.uk/CG88
Osteopathy and chiropractic NOT FUNDED	Not funded unless an agreed care pathway is already in place.	
PAIN MANAGEMENT (OTHER)		
Residential pain management programmes	Not funded	
Acupuncture for non-specific low back pain of up to 1 yr duration RESTRICTED	The Commissioner will fund up to 6 sessions of acupuncture in an 8 week period for recurrent or persistent non-specific low back pain of more than 6 weeks duration, where: 1. the patient is receiving and has positively engaged with a package of care that is consistent with NICE CG88 pathway including information and support to promote self-management, and the offer of appropriate drug treatments to help the patient keep active, AND 2. a baseline assessment of pain and function using the Brief Pain Inventory is documented in the patient notes prior to the first session of acupuncture The Commissioer will fund up to an additional 4 sessions (i.e. up to an absolute maximum of 10 sessions for any given patient), where: 1. an assessment of pain and function using the Brief Pain Inventory made six weeks after the sixth session and prior to the seventh session demonstrates that there has been an improvement of at least 50% since the baseline assessment, AND 2. the patient continues to positively engage with a package of care that includes information and support to promote self-management, and the offer of appropriate drug treatments to help the patient keep active, AND 3. the patient acknowledges that the number of sessions of acupuncture funded for any	NICE – Early management of non-specific low back pain 2010. http://guidance.nice.org.uk/CG88

	given patient is limited to an absolute maximum of 10 For the purposes of this policy, number of sessions includes all sessions of acupuncture received regardless of the provider	
UROLOGY		
Penile Implants RESTRICTED	Not funded except in patients with impotence of organic cause, or for those who have failed to respond to, or are unable to continue with, medical treatment or external devices	*Requires review in 2015*
COMPLEMENTARY THERAPY		
Acupuncture for purposes other than as part of treatment plan for low back pain, Alexander Technique, Applied Kinesiology, Aromatherapy, Autogenic Training, Ayurveda, Chinese Medicine, Chiropractic, Environmental Medicine, Osteopathy, Healing, Herbal Medicine, Hypnosis, Homeopathy*, Massage,	Complementary medicine/alternative therapies are generally not funded on the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be funded either as part of the PBR tariff or explicitly agreed in the SLA. On existing available evidence the Commissioner would not support referral outside the NHS for these services. Prior Approval is required on a case by case basis by the IFR Panel for any requests outside the above criteria. The panel will require proven evidence of effectiveness of the therapy, failure of conventional treatment and assurance concerning the training and qualifications of the proposed provider practitioners. Homeopathy Not funded. *For definitive statement of policy on this please refer to the Nottinghamshire Area Prescribing Committee's position statement Hypnotherapy Not commissioned. Insufficient research evidence to demonstrate effectiveness (e.g. IBS)	Various including Cochrane reviews

Meditation, Naturopathy, Nutritional Therapy, Reflexology Reiki, Shiatsu, Other alternative therapies		
BEHAVIOURAL/ PSYCHOLOGICAL (IF NOT COVERED ELSEWHERE)		
Therapeutic community method for treatment for borderline personality disorder	Not funded	
Out of Area or referrals to the independent sector for Children with suspected Autism	Referrals to the independent sector or out of area will only be considered where the child's care has been assessed by CAMHS or paediatric services and where there is a recommendation by either or both agencies that such a referral is necessary.	
MISCELLANEOUS		
Out of area treatment for chronic Fatigue Syndrome/ME	Not funded. Local pathway in place.	