NHS
Nottingham and Nottinghamshire
Integrated Care Board

Value Based Clinical Commissioning Policy

September 2023 – September 2026

Reference Number	Version	Status	Author
COM-010	1.4	Final	Carolyn Fox, Head of Provider Transformation *(Full details of managerial and clinical staff involved in the Commissioning Policy Alignment project can be provided upon request)* **Sponsor** Lucy Dadge, Director of Integration **Team** Integration Directorate

Title	Value Based Commissioning Policy		
Amendments	N/A		
Purpose	The purpose of this policy is to ensure that Nottingham and Nottinghamshire Integrated Care Board (the Commissioners) fund treatment only for clinically effective interventions delivered to the right patients.		
Superseded Documents	Service Restriction Policy; and Service Restriction Policy – Additional Information (Nottingham and Nottinghamshire CCG, 2018) Commissioning for Outcomes Policy (Bassetlaw CCG, 2021)		
Audience	All staff within the Nottingham and Nottinghamshire Integrated Care Board, Provider organisations and GP Practices. Nottingham and Nottinghamshire patients and members of the public.		
Consulted with	N/A		
Equality Impact Assessment	Equality and Quality Impact Assessment (EQIA) undertaken; approved on the 31 August 2023. Outcome: Neutral *(Full details and copy available upon request)*		
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Introduction

Across the country most, if not all, ICBs have a set of policies and procedures for limiting the number of low clinical value interventions. The Audit Commission's report 'Reducing expenditure on low clinical value treatments' analyses variation on approaches to this work. This approach was based on the 'Save to Invest' programme developed by the London Health Observatory incorporating the 'Croydon List' of 34 low priority treatments.

In addition, the national Evidence-Based Interventions (EBI) programme was launched in 2018 in partnership with the Academy of Medical Royal Colleges, NHS Clinical Commissioners, the National Institute for Health & Excellence (NICE), NHS England & Improvement, Royal Colleges, specialist societies, commissioners, providers and the public. The aim of the programme is to improve the quality of care and is designed to reduce the number of medical or surgical interventions as well as some other tests and treatments which the evidence tells us are inappropriate for some patients in some circumstances. It is also recognised that sometimes these interventions can do more harm than good.

As well as improving outcomes, a further aim of the national EBI Programme is to free up valuable resources so they can be put to better use elsewhere in the NHS. The EBI programme develop and publish national policy on a range of procedures / interventions, the first set of proposals being consulted on nationally during 2018 and published as national policy in April 2019. The second wave of procedures was published as national policy in November 2020 and is included within this policy. A third wave of procedures has now also been published in May 2023 but this is not yet mandated within this policy.

How this Policy works

This policy sets out a consistent approach by Nottingham and Nottinghamshire Integrated Care Board (N&N ICB). This approach is applied to any patient registered within the N&N ICB Primary Care Networks. The policy is applicable to providers inside the N&N ICB and those providers in other ICB's.

This policy does not apply to the following pathways:

- Care as part of treatment for cancer
- Gender reassignment procedures as commissioned via NHS England
- Urgent care

Throughout this procedure we use the terms "male" and "female". For the benefit of this procedure "male" and "female" relate to the biological sex of the individual and not their gender.

The ICB recognises that not everyone assigned female at birth with continue to associate with the term "female" or "woman", and vice versa for those assigned "male" at birth. The ICB also recognises that around 1.7% of the world's population is intersex [reference:

https://www.manchester.ac.uk/discover/magazine/features/rights-of-intersex-children/#:~:text=Approximately%201.7%25%20of%20the%20global,common%20as%20being%20a%20twin.). When using the terms “male” and “female” throughout this policy, the ICB is including those born with internal or external genitalia, chromosomes, and or hormones that relate to that sex.

Purpose of this policy

The purpose of this policy is to ensure that Nottingham and Nottinghamshire Integrated Care Board (the Commissioners) 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.

This policy lists a number of procedures and services that the Commissioners restrict funding for. Patients should only be referred for the procedures and services listed if they meet the eligibility criteria set out in the policy. The onus is on the clinician to ensure that appropriate authorisation from the commissioner is achieved, authorisation will be achieved either by prior approval or, where there are significant numbers of procedures, by retrospective audit (as agreed by individual ICBs per provider) to assure compliance with criteria. The clinician must provide sufficient information to evidence how the patient meets the criteria.

If a provider undertakes one of the procedures contained within this policy that requires prior approval and has not gained approval the commissioner will not pay for the procedure. If a provider undertakes one of the procedures contained within this policy that requires retrospective audit and is found not to meet the criteria when the audit is undertaken commissioners will not pay for the procedure.

Roles and Responsibilities

Roles	Responsibilities
Integrated Care Board	The Integrated Care Board is responsible for developing this policy and making it publicly available; reviewing its content periodically or where there is a change in the evidence base relating to a particular intervention; and for ensuring full compliance with the policy.
Provider organisations	Provider organisations are responsible for ensuring that all procedures and services are provided in line with this policy and that appropriate authorisation from the Commissioner is gained either by prior approval or following retrospective audit.
Referring clinicians	At the point of decision to refer, clinicians are responsible for ensuring that all referrals are made in line with this policy and that only those patients meeting the eligibility criteria set out in the policy are referred. The onus is on the clinician to ensure that appropriate authorisation from the Commissioner is gained.

Implementation and Compliance (Communication, Monitoring and Review and Training)

This policy will be reviewed and approved by the ICB's Strategic Planning and Integration Committee every three years and made available to the public via the ICB's website. Our Policies and Procedures - NHS Nottingham and Nottinghamshire ICB

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.

Any individual who has queries regarding the content of this policy or has difficulty understanding how this policy relates to their role, should contact the Acute Contracting, Planned Care or the Individual Funding Request (IFR) Team(s).

Procedures not expressly covered in this policy

If a procedure is not covered in this policy and is documented on the indicative activity plan, with or without an activity value or finance value, this would indicate that both provider and commissioner recognize the activity as commissioned and therefore is chargeable. If a procedure is not shown on the indicative activity plan and is also not covered in this policy this would indicate that both the provider and commissioner acknowledge that the procedure is unlikely to have been actively commissioned and on that basis the provider should seek clarification and appropriate approval before carrying out the procedure otherwise the procedure will not be funded.

Where prior approval is required the following will apply:

- At the point of decision to refer for a specific procedure, which requires prior approval, the referrer will ensure that the clinical criteria are met. The referrer must then apply for prior approval, informing the patient of the prior approval process. Please note prior approval is not required if a patient is being referred to secondary care for consultant management other than a procedure listed in this policy e.g. if referral is for diagnostic tests or investigations or treatment options
- A consultant who wishes to undertake a procedure covered by this policy must seek approval in the same way and using the same criteria as their GP colleague. This process applies regardless of the hospital at which the patient may be treated and only applies to NHS commissioned secondary care, but is applicable in all provider settings where that care is provided. Providers should ensure that the prior approval code is recoded in the free text field in the SUS entry to ensure that the procedure is not queried.

Individual Funding Request (IFR) – The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

Exceptionality is defined as:

'The patient or their circumstances are significantly different from the general population of patients with the condition in question ***and*** *the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'*

Where procedures do not require prior approval to be obtained for NHS funding before the treatment takes place, these are identified as 'Monitored Approval' within the policy document. Further information on this category of policy is included within the FAQ section.

Due to the expansion of this document through the inclusion of national EBI Policies, along with the nature of some of the procedures / interventions identified within the EBI programme being more related to pathways, the number of policies identified in the Monitored Approval category has significantly increased. In response to this, and specific feedback received about improving the usability of the policy, the document has been split into two sections for ease of use by end users:

- Section 1: Prior Approval and Monitored Policies
    - This section includes all policies which require approval to be confirmed prior to the treatment taking place via Blueteq.
    - Procedures where prior approval isn't required but the activity will be monitored through the contract performance route.
- Section 2: Not routinely commissioned and IFR
    - This section includes all policies which require approval to be confirmed prior to the treatment taking place via IFR as they are not routinely commissioned.

Prior approval Process

On receipt of the prior approvals request the ICB, or those conducting triage on their behalf, will ensure that the requests receive appropriate clinical review to confirm compliance with policy and equity with other approval decisions.

The ICB will have a 10 working day turnaround from date of receipt for all Primary Care requests. For the purposes of patient confidentiality we only accept e-mail requests which should be sent to nnicb-nn.ifrteam@nhs.net

Primary Care

Once approval has been issued, a referral can then be sent to secondary care in the normal way. Please attach a copy of the prior approval form with your referral letter and clearly state the prior approval reference number.

If the referral is not complete with the approved application form/approval number, the Secondary Care provider will not be able to carry out the procedure or respond to contractual challenges and can return the referral to the GP.

Procedures undertaken by primary care that are listed in this policy must have prior approval from the ICB.

Secondary Care

The patient can be added to the waiting list for the requested treatment only if prior approval has been received. Patients must not be listed for treatment until prior approval has been sought and approved. Providers should ensure that the prior approval code is recoded in the free text field in the SUS entry to ensure that the procedure is not queried.

Why do we need policies?

NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. This is a key challenge for all NHS organisations, and a prime focus for commissioning among ICBs. These policies help clinicians identify interventions with limited benefit, thereby providing potential for reinvesting elsewhere, where potential benefits are greater.

The alternative to having policies of this kind is to leave each decision to individual GPs, to manage individual dilemmas without guidance and without the context of the health needs of the wider population.

Having one single policy provides equity of access to procedures and services across the ICB's population.

What do these policies cover?

These cover interventions where there is significant risk that patients undergoing them will gain little health benefit.

The procedures have low rather than no clinical value. Some may be effective, but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others.

Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.

Who are they for?

They are to assist clinicians in making referral decisions, where the principal reason for referral is for surgical intervention. They are also to assist providers of treatment and surgical services and are a statement about what the NHS will routinely pay for.

Is securing funding a guarantee of treatment?

Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. The ultimate decision about safety and appropriateness of treatment is a clinical one which must be discussed with the patient.

What about treatments that have already started under private arrangements?

If treatments have already been started under private arrangements, the overarching assumption is that a whole package of care has been purchased and its potential complications taken account of and explained to the patient. Therefore, it would be unreasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency, or some other exceptional circumstance – see specific policies for further details. Running out of funds, whilst unfortunate, is not exceptional.

Notwithstanding this point, it is recognised that an individual who has commenced treatment that would have been routinely commissioned by the NHS on a private basis can, at any stage, request to transfer to complete the treatment within the NHS. However, at the point that the patient seeks to transfer back to NHS care, the patient would be required to be reassessed by an NHS clinician in line with the relevant current policy to ensure compliance with the latest criteria. In addition, where criteria is met, the patient will not be given any preferential treatment by virtue of having accessed part of their care privately, and will be subject to standard NHS waiting times.

Likewise, if a device has been privately purchased and initiated, the NHS will not pick up the costs of consumables or maintenance, unless the patient meets NHS criteria. For example, a patient who has purchased a continuous glucose monitor would be expected to have sufficient funds to purchase consumables for the life of the device unless they meet the NHS criteria for the device.

What about treatments that have been started and completed under private arrangements?

Funding is not provided retrospectively. If treatment has been completed under private arrangements it is assumed that the patient has sufficient funds to cover this treatment.

What about the continuation of experimental treatments/loaned device trials?

The continuation of experimental treatments/loaned device trials will not be routinely

funded. Initiating patients on treatments without clear evidence of safety, efficacy, effectiveness or cost-effectiveness raises patient expectations that the treatment will be continued. Where treatments are initiated by providers on a loan/ experimental basis this is done at the provider's own risk. The provider must be clear with the patient about the end point/ exit strategy for the trial and/ or continuing care.

This excludes formal clinical research trials for which there are separate arrangements between funders and providers.

What if surgeons undertake procedures outside the indications in these policies?

There is no guarantee of payment in accordance with the legally binding contract.

Individual Funding Request (IFR) Frequently Asked Questions

When should we use the IFR Process?

The IFR process is to be used in circumstances when a patient does not meet the clinical criteria for a procedure as set out in this policy document but can demonstrate exceptionality in accordance with the definition.

Exceptionality is defined as:

'The patient or their circumstances are significantly different from the general population of patients with the condition in question ***and*** *the patient is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.'*

Can psychological considerations be taken into account within the definition of exceptionality?

Accounting for psychological factors in arriving at a decision about eligibility for NHS funding is hard to do in a clear and fair way. These considerations have been removed from this policy as psychological distress unfortunately does not constitute clinical exceptional circumstance.

NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Guidance 31).

How can pain and significant functional impairments/ limitations to activities of daily living endured by patients be demonstrated in an IFR case?

Pain has been defined as an "unpleasant sensory and emotional experience arising from actual or potential tissue damage" with clinical pain being "whatever the person says he or

she is experiencing whenever he or she says it occurs" and is therefore subjective.[1] There is insufficient evidence to use questionnaire derived scores to evidence pain in individuals. Therefore, in lieu of a standard assessment tool, alternative clear and objective evidence must be provided when demonstrating patient pain and significant functional impairments/ limitations to activities of daily living.

This evidence should include documented assessments and/ or patient history, including:

- A description of the pain and which daily activities are no longer achievable;
- Prescribing history;
- Recorded sickness/ absence due to pain/ functional impairment;
- Evidence from functional tests/ investigations, such as gait analysis, physiotherapy/ OT assessment;
- History of the pain/ impairment and the response to/ impact/ effect of conventional therapies available.

Significant functional impairment is defined as:

- Symptoms that result in a physical/ functional inability to sustain employment/ education despite reasonable occupational adjustment, or act as a barrier to employment or undertaking educational responsibilities;
- Symptoms preventing the patient carrying out routine domestic or carer activities;
- Symptoms preventing the patient carrying out self-care or maintaining independent living.

[1] Fink, R. (2000) Pain assessment: the cornerstone to optimal pain management, Baylor University Medical Centre Proceedings, 13(3): 236-239

Section 1:

Prior Approval and Monitored Policies

Breast Surgery

Breast Asymmetry correction

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy: National EBI

Background:

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

This policy does not apply to breast or chest surgery for or following gender reassignment surgery.

Policy:

The Commissioner will only fund surgery to correct breast asymmetry when ALL the following criteria are met:

- Sexual maturation has been reached.
- BMI as measured by the NHS is between 18 and 25 and has been within this range for 1 year as measured and recorded by the NHS
- Confirmed non-smoker and/or documented abstinence prior to procedure.
- Asymmetry equal to, or greater, than 30% difference in volume between the breasts as measured by 3D body scan to assess breast volume.

The surgical correction of asymmetry includes reduction and augmentation or a combination of both. Mastopexy is also included in conjunction with either reduction or augmentation surgery.

Mastopexy is not funded as a standalone procedure.

Breast – Augmentation

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

This policy does not apply to breast reconstruction following mastectomy for treating breast cancer.

This policy does not apply to breast or chest alterations following gender reassignment surgery.

Policy:

This commissioner will only routinely fund breast enlargement (augmentation mammoplasty) surgery if one of the following criteria is met:

- Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry e.g. Poland Syndrome / Tuberous Breast Deformity
- To correct breast asymmetry due to trauma or as a result of surgery (mastectomy or lumpectomy) that results in a significant deformity.

Surgery for primarily cosmetic reasons is not eligible for NHS funding (see section 2)

Breast – implant removal
(+/- re-insertion)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:

National EBI

Background:

Breast implants may be inserted during reconstructive surgery for treatment or prevention of breast cancer or for cosmetic purposes. Surgery to remove a breast implant may be used to treat the complications of breast implants inserted for reconstructive or cosmetic purposes.

This policy does not apply to breast reconstruction as part of the treatment for breast cancer.

This policy does not apply to breast or chest surgery for or following gender reassignment surgery.

Policy:

Removal of breast implants is only commissioned for the following indications in patients who have undergone cosmetic augmentation mammoplasty performed either in the NHS or privately:

- breast disease
- implants complicated by recurrent infections
- implants with capsule formation that is associated with severe pain
- implants with capsule formation that interferes with mammography
- intra or extra capsular rupture of silicone gel-filled implants.

Where the implants are removed in strict compliance with the above AND whose original surgery was NHS funded the insertion of replacement implants is also commissioned.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

The insertion of replacement implants where the original surgery was funded privately is not commissioned.

Breast Reduction

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:

National EBI

Background:

This policy does not apply to breast reduction/ mastectomy as part of the treatment for breast cancer.

Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.

This policy does not apply to breast or chest surgery for or following gender reassignment surgery.

Policy:

Surgical treatment is commissioned if ALL criteria are met:

- Sexual maturation has been reached*
- Causing back pain which has not responded to 1 year of documented conservative management such as physiotherapy
- Symptoms not relieved by appropriately measured brassiere fitted by a trained bra fitter
- BMI as measured by the NHS is between 18 and 25 and has been within this range for 1 year as measured and recorded by the NHS
- Confirmed non-smoker and/or documented abstinence prior to procedure
- Mean breast size is equal to or greater than 1000 cc*
- Ratio of combined breast volume to adjusted partial torso volume is equal to or greater than 13% as measured by 3D body scan to assess breast volume
- The patient and surgeon understand that only one cycle of breast reduction will be commissioned

* Young women with juvenile macromastia (juvenile gigantomastia) can be treated prior to reaching sexual maturation

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Cardiology

Diagnostic coronary angiography for low risk, stable chest pain

Category: *(IFR / Prior Approval / Monitored Approval)*

Monitored Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

NICE guidelines recommend that where a diagnosis of chest pain cannot, by clinical assessment alone, exclude stable angina, 64-slice (or above) CT coronary angiography should be offered as first-line. Invasive coronary angiography should only be offered to patients with significant findings on CT coronary angiogram or with inconclusive further imaging.

This guidance applies to adults aged 19 years and over.

Policy:

When results of non-invasive functional imaging are inconclusive and patients are assessed as having low risk, stable cardiac pain, invasive coronary angiography (cardiac catheterisation) should be offered only as third-line investigation.

Patients who have chest pain that is not an Acute Coronary Syndrome (ACS), but there is concern that it is due to an ischemic cause (stable angina) should, in the first instance, be offered a CT Coronary angiography (64 slice or above). This is based on:

- Clinical assessment indicating typical or atypical angina; or
- Clinical assessment indicates non-anginal chest pain but the 12-lead resting ECG shows ST-T changes or Q waves.

Significant coronary artery disease (CAD) found during CT coronary angiography is ≥ 70% diameter stenosis of at least one major epicardial artery segment or ≥ 50% diameter stenosis in the left main coronary artery.

If the CT coronary angiography is inconclusive, non-invasive functional imaging for myocardial ischemia should be considered in the following forms:

- Stress echocardiography; or
- First-pass contrast-enhanced magnetic resonance (MR) stress perfusion; or
- MR imaging for stress-induced wall motion abnormalities; or
- Fractional flow reserve CT (FFR-CT); or
- Myocardial perfusion scintigraphy with single photon emission computed tomography (MPS with SPECT).

Invasive coronary angiography should only be offered as third-line investigation when the results of non-invasive functional imaging are inconclusive.

Exercise ECG for screening of coronary heart disease

Category: *(IFR / Prior Approval / Monitored Approval)*

Monitored Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Exercise electrocardiogram (ECG) is a type of cardiac stress test that should no longer be used to screen for coronary heart disease (CHD).

This guidance applies to adults aged 19 years and over.

Policy:

Exercise ECG has no role in the screening of asymptomatic and low risk patients for coronary heart disease because it has a very low pre-test probability of identifying pathology. Risk calculators, such as Systematic Coronary Risk Evaluation (SCORE), are instead recommended to identify patients who are at greater risk of CHD.

Under the guidance of cardiologists, the test has a limited role for diagnosis in selected patients with symptoms suggestive of CHD, and/or where CHD has been diagnosed to confirm functional capacity or severity.

Pre-operative Chest X-Ray

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Chest radiographs in the pre-operative assessment of adult, elective surgical patients prior to routine surgery is not recommended.

This guidance applies to adults aged 19 years and over.

Policy:

Pre-operative chest radiographs should not be routinely performed in adult elective surgical patients. However, they may be appropriate in specific cohorts of patients, including when the following criteria apply:

- Patients undergoing cardiac or thoracic surgery
- Patients undergoing organ transplantation or live organ donation
- At the request of the anaesthetist in:
    - Those with suspected or established cardio-respiratory disease, who have not had a chest radiograph in the previous 12 months, and who are likely to go to critical care after surgery
    - Those with a recent history of chest trauma
    - Patients with a significant smoking history who have not had a chest radiograph in the previous 12 months, or those with malignancy and possible lung metastases
    - Those undergoing a major abdominal operation, who are at high risk of respiratory complications.

Pre-operative ECG – Heart tracing before an operation

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Performance of a resting electrocardiogram (ECG) in asymptomatic adult patients undergoing low-risk, non-cardiac elective surgery during the preoperative assessment is not necessary.

This guidance applies to adults aged 19 years and over.

Policy:

Pre-operative electrocardiograms should not be routinely performed in low risk, non-cardiac, adult elective surgical patients. However, they may be appropriately performed when the following criteria apply:

- Patients with an American Society of Anaesthesiologists (ASA) physical classification status of 3 or greater and no ECG results available for review in the last 12 months
- Patients with a history of cardiovascular or renal disease, or diabetes
- Patients with any history of potential cardiac symptoms (e.g. cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated
- Patients over the age of 65 attending for major surgery.

Where pre-operative tests are completed outside the centre in which surgery will be completed, avoid unnecessarily repeating these tests on admission and ensure appropriate transfer of images takes place.

Specialist blood test (troponin) for investigations of chest pain

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Troponin blood testing should be used to diagnose acute myocardial infarction. It should only be used in cases where a clinical diagnosis of acute coronary syndrome or myocarditis is suspected or for prognostic purposes when pulmonary embolism is confirmed.

Policy:

In order to rule out suspected acute coronary syndrome (moderate or high risk of myocardial infarction) in people presenting with acute chest pain, NICE recommends early rule out using high-sensitivity troponin tests. High-sensitivity troponin assays were developed to detect troponin in the blood at lower levels than non-high-sensitivity troponin assays. Using the high-sensitivity assays as part of an early rule-out protocol can reduce time to discharge. Guidance on early rule out of NSTEMI using high-sensitivity troponin assays recommends a 2-test strategy, typically on admission and at 3 hours. However, the committee concluded that there was insufficient evidence to recommend a specific test strategy and agreed that early rule-out protocols should be chosen according to local preference.

High-sensitivity troponin measurements should not be considered in isolation but interpreted alongside the clinical presentation, the time from onset of symptoms, the 12-lead resting ECG, pre-test probability of NSTEMI, the possibility of chronically elevated troponin levels in some people and that 99th percentile thresholds for troponin I and T may differ between sexes. If ACS is not suspected, high-sensitivity troponin test should not be used. For people at low risk of myocardial infarction only perform a second high sensitivity troponin test if the first troponin test at presentation is positive.

Diagnosis of myocardial infarction is the detection of a rise and/or fall of cardiac troponin with at least one value above the 99th percentile of the upper reference limit and at least one of the following:

- symptoms suggesting myocardial ischaemia
- new / presumed new significant ST-segment-T wave (ST-T) changes or new left bundle branch block (LBBB)
- development of pathological Q waves on the ECG
- imaging evidence of new loss of viable myocardium or new regional wall motion abnormality
- identification of an intracoronary thrombus by angiography.

The appropriate use of high-sensitivity troponin testing should reduce the need for further investigation, result in shorter stays in hospital and overall result in cost-savings (if used in an early rule out clinical protocol).

According to this recommendation, if acute coronary syndrome is suspected in a primary care setting, a referral should be made for prompt investigation and treatment.

This guidance applies to adults and children.

Dermatology

Congenital pigmented lesions

Category:
(IFR / Prior Approval / Monitored Approval)

Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:
Congenital pigmented naevi initially appear as flat, pigmented lesions of various sizes. They are usually solitary lesions but can be multiple. They may be very large (giant congenital naevi). Less often they may appear after birth in the first two years of life (congenital naevus tardive). As the lesion ages, it tends to become raised and may become hairy. The main clinical concern is the development of malignant melanoma.

Policy:

Treatment commissioned only if ALL of the following criteria are met:

- The patient is aged less than 18 years at the time of referral
- The child (not just the parent/carer) expresses concern
- The lesion is located on the face
- The lesion is at least 1cm in size

Laser treatment - Skin

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Laser skin resurfacing removes skin very precisely, layer-by-layer by vaporizing it. Lasers remove the outer layer of your skin – the epidermis – and heats the underlying layer, called the dermis. The lasers stimulate the growth of new collagen fibers resulting in new skin that is smoother and firmer.

Policy:

Only commissioned if at least one of following:

- Port wine stains - on the face only (not scalp or neck) unless single lesion can be treated in a single session
- Rare genodermatosis e.g. Tuberose Sclerosis causing functional disability
- Translocation of hair bearing skin during surgery but NOT for excessive hair growth (hirsutism)
- Intractable and recurrent pilonidal sinus.
- Tattoo removal if one of the following two criteria are met:
  o Iatrogenic
  o Result of trauma inflicted against the will of the patient where referral for removal has been sought within one year of the tattoo being performed

Lipoma
Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Benign tumours are usually slow-growing and non-invasive (for example lipoma, fibroma, chondroma, neuromas, and vascular tumours)

The most common benign soft tissue tumour in the neck is a lipoma, which usually presents in mid-adulthood onwards as a painless, soft, mobile, discrete subcutaneous mass, which may occur anywhere on the body.

Policy:

Surgical treatment commissioned if ONE of the criteria apply and the patient has had a documented shared decision making episode:

- Lipoma diameter over 5cms
- Causes significant functional disability resulting in severe restriction of Activities of Daily Living (ADL) or is a function critical to sustaining life
- Causes recurrent trauma due to size and/or position. Lipomas that are under 5cms should be observed only, using Soft Tissue Sarcoma Guidelines (SIGN 2003).

Lipomas located on the body that are over 5cms in diameter, or in a sub-facial position, which have also shown rapid growth and/or are painful should be referred to an appropriate Sarcoma clinic).

Removal of Benign skin lesions

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

This policy refers to benign lesions including but not limited to:

- benign moles (excluding large congenital naevi)
- solar comedones
- corn/callous
- dermatofibroma
- milia
- molluscum contagiosum (non-genital)
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- spider naevi (telangiectasia)
- non-genital viral warts in immunocompetent patients
- xanthelasmata
- neurofibromata

Disfiguring scars and keloid or hypertrophic scars (including acne scarring), whether arising from prior injury or surgery, are also included in the scope of this policy.

Policy:

Surgical removal, or cryotherapy of benign skin lesions are ONLY commissioned if there is at least one of:

- Significant functional disability resulting in severe restriction of Activities of Daily Living (ADL) or a risk to a critical life sustaining function.
- Recurrent infection (at least 2 courses of antibiotics)
- Recurrent bleeding/trauma (at least 3 documented episodes)
- There is a risk on future malignancy (especially with respect to lesions in children)

Benign skin lesions are only commissioned for removal in a secondary care setting where the site, nature of the lesion (e.g. suspicion of malignancy) or age of patient (especially children) requires specialist skills Biopsy of benign lesions is commissioned where the nature of the lesion is uncertain (especially in children –in secondary care) In case of diagnostic uncertainty in adults consider tele-dermatology pathway. In case of rapid growth or other features suspicious of dysplasia/ malignancy use 2ww pathway.

All other benign skin lesions meeting the criteria should be removed in primary care.

- Specific criteria apply to lipomas (see above).
- Epidermoid / sebaceous cysts are included in the "benign skin lesions" criteria

Diabetes

Insulin Pumps

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

This policy is supported by the NICE review on insulin infusion for diabetes

Overview | Continuous subcutaneous insulin infusion for the treatment of diabetes mellitus | Guidance | NICE

Policy:

Initiation of continuous subcutaneous insulin infusion or 'insulin pump' therapy as a treatment for adults and children 12 years and over with type 1 diabetes mellitus will be funded if the patient has attended a Diabetes educational course approved by the ICB, such as DAFNE, and ONE of the following criteria are met:

- Attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having 'disabling hypoglycaemia'
- HbA1c levels have remained high (69 mmol/mol or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes.

Insulin pump therapy should only be started by a trained specialist team. This team should include a doctor who specialises in insulin pump therapy, a diabetes nurse and a dietician (someone who can give specialist advice on diet). They should provide a structured education programme and advice on diet, lifestyle and exercise that is suitable for people using insulin pumps.

Insulin pump therapy is not recommended for people with type 2 diabetes mellitus

Ear, Nose and Throat (ENT)

Grommets for Adults

Category:
(IFR / Prior Approval / Monitored Approval)
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Whilst otitis media is more common in childhood it can occur in adults also.

Policy:

Adults should meet at least one of the following criteria.

- Persistent hearing loss for at least 3 months with hearing levels of 25dB or worse on pure tone audiometry or
- Recurrent acute otitis media – 5 or more episodes in the preceding 12 month period or
- Eustachian tube dysfunction causing pain or
- Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk or
- As a conduit for drug delivery direct to the middle ear or
- In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician. Part of a more extensive procedure at Consultant's discretion such as tympanoplasty, acute otitis media with facial palsy.

This policy applies to all tubes inserted into the tympanic membrane to aid ventilation and pressure equalisation of the middle ear.

This includes grommets - myringotomy tubes - and tympanostomy or T tubes.

This policy relates to Adults only, there is a separate policy for children.

Grommets (and other ventilation devices) in Children

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children.

Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing.

Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems.

Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include:

- Recurrent acute otitis media
- Atrophic tympanic membranes
- Access to middle ear for transtympanic instillation of medication Investigation of unilateral glue ear in adults

Policy:

Grommets for patients with otitis media with effusion (OME) may be funded where ALL the criteria apply:

- There has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist, ENT Specialist or GP with special interest in ENT.
- The patient (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 disability such as Downs syndrome.

Microsuction for the removal of ear wax (Adults)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Microsuction is the process of removing wax from your ears by using a small suction tube and probe to gently remove any excess wax in the ear.

Policy:

Removal of earwax by microsuction in primary or secondary care is restricted.

If removal of earwax is required to carry out a procedure or to gain a view of the tympanic membrane this is considered as part of the overall outpatient tariff.

Microsuction to remove earwax may be commissioned in primary/secondary care where a patient has ONE of the following contraindications to ear irrigation:

- The patient has previously experienced complications following this procedure or it has been repeatedly ineffective.
- There is a history of a middle ear infection in the last six weeks.
- The patient has undergone ANY form of ear surgery (apart from grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Department).
- The patient has a perforation or there is a history of a mucous discharge in the last year.
- The patient has a cleft palate (repaired or not).
- In the presence of acute otitis externa with pain and tenderness of the pinna.
- Two attempts at Irrigation of the ear canal in primary care are unsuccessful

Removal of Adenoids for Treatment of Glue Ear

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Adenoids are lymphatic tissue that reside in the post nasal space and arise from the roof of the nasopharynx. Adenoids are only usually present in children and tend to grow from birth, reaching the largest size when a child is between 3 and 5 years of age, before slowly shrinking away by adulthood.

When the adenoids are enlarged or inflamed they may contribute to glue ear (otitis media with effusion), which can affect hearing. They can also cause symptoms of nasal blockage, mouth breathing, obstructive sleep and other upper respiratory tract symptoms (e.g. persistent runny nose)

When children have persistent glue ear that affects hearing, one option for treatment of the hearing loss is with grommet insertions (ventilation tubes) and guidance for this intervention is already set out in the EBI guidance published in November 2018 – 'grommets for glue ear in children'.

In some circumstances, when a child is undergoing surgery to insert grommets, the adenoids may also be partially resected at the same time. This is a short procedure performed via the mouth to remove excessive adenoidal tissue (adenoidectomy) and is most commonly performed either by electrocautery (monopolar suction diathermy), cold steel dissection (curettage), or coblation. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.

This guidance applies to children aged 18 years and under

Policy:

Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion.

Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:

- The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy
- The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion
- The child is undergoing grommet surgery for treatment of recurrent acute otitis media

This guidance only refers to children undergoing adenoidectomy for the

treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be routinely funded.
These include:

- As part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)
- As part of the treatment of chronic rhinosinusitis in children
- For persistent nasal obstruction in children and adults with adenoidal hypertrophy
- In preparation for speech surgery in conjunction with the cleft surgery team

Septo-rhinoplasty

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

A septo-rhinoplasty (or 'nose job') is an operation to improve the appearance of your nose (rhinoplasty) and to improve how you breathe through your nose (septoplasty).

It involves operating on the bones and cartilage that give your nose its shape and structure and making your septum straight. The septum is the cartilage and bone inside your nose that separates your nostrils.

Policy:

May be commissioned when a patient has:

- Obstructive symptoms persisting despite conservative management for three months or longer,
- An external nasal deformity, preoperative photographs showing the standard 4-way view – base of nose, anterior-posterior, and right and left lateral views
- A relevant history of accidental or surgical trauma, congenital defect or disease
- Documentation of duration and degree of symptoms related to nasal obstruction and results of conservative management.

And ONE or more of the following criteria are met:

- Continuous nasal airway obstruction that results in significantly impaired nasal breathing associated with septal or lateral nasal wall deformities or vestibular stenosis.
- Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy)

Surgery for Chronic Sinusitis

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Chronic rhinosinusitis (CRS) is defined as inflammation (swelling) of the nasal sinuses that lasts longer than 12 weeks. The sinuses are mucus secreting, air filled cavities in the face and head that drain into the nose; their normal function may be disrupted by environmental, infectious or inflammatory conditions which damage the epithelial lining and disturb the balance of the natural microbial community. Patients report a number of symptoms including nasal blockage, discharge, alteration to smell, and facial pressure or pain. They often have a relapsing course, with recurrence after treatment commonplace. Absenteeism and presenteeism are widespread.

It is a common chronic condition that affects approximately 11% of adults and has a significant detrimental effect on the quality of life of those affected, thus creating a significant disease burden.

CRS as a term encompasses a wide range of phenotypes but can broadly be divided into two main types. Chronic rhinosinusitis with Nasal Polyposis (CRSwNP) and Chronic Rhinosinusitis without Nasal Polyposis (CRSsNP).

First-line treatment is with appropriate medical therapy, which should include intranasal steroids and nasal saline irrigation. In the case of CRSwNP a trial of a short course of oral steroids should also be considered.

Where first-line medical treatment has failed patients should be referred for diagnostic confirmation and they then may be considered for endoscopic sinus surgery. This involves surgery using a telescope via the nasal cavity to open the sinuses and, if present, remove nasal polyps, both improving the effectiveness of ongoing medical therapy and relieving obstruction. The surgery is usually undertaken under general anaesthetic as a day-case procedure in otherwise healthy individuals.

This guidance applies to Children and Adults.

Policy:
Surgery for sinusitis will only be funded where the following criteria are met:

- A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3- month trial of intranasal steroids and nasal saline irrigation

AND

- In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)

OR

- Patient has nasal symptoms with an unclear diagnosis in primary care

OR

- Any patient with unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait depending on local pathways.

No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan). There is no role for prolonged courses of antibiotics in primary care. Patients can be considered for endoscopic sinus surgery when the following criteria are met:

- A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan

AND

- Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance ‘Recommended secondary care pathway’.

AND

- Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient’s pathway.

AND

- Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention.

OR

- In patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal. Ideally, the diagnosis should be confirmed during an acute attack if possible, by nasal endoscopy and/or a CT sinus scan.

Tonsillectomy for Recurrent Tonsillitis

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

This guidance relates to surgical procedures to remove the tonsils as a treatment for recurrent sore throats in adults and children.

Recurring sore throats are a very common condition that presents a large burden on healthcare; they can also impact on a person's ability to work or attend school. It must be recognised however, that not all sore throats are due to tonsillitis and they can be caused by other infections of the throat. In these cases, removing the tonsils will not improve symptoms.

Policy:

Tonsillectomy will only be funded for adults or children in accordance with the criteria specified below:

A six month period of watchful waiting is recommended prior to referral for tonsillectomy in order to establish a pattern of symptoms.

The ICB will only fund tonsillectomy when one or more of the following criteria have been met:

- Recurrent attacks of tonsillitis as defined by:
    - Sore throats are due to acute tonsillitis which is disabling and prevents normal functioning
    - 7 or more well documented, clinically significant*, adequately treated episodes in the preceding year **OR** 5 or more such episodes in each of the preceding 2 years **OR** 3 or more such episodes in each of the preceding 3 years.
- One or more documented episodes of quinsy (peri-tonsillar abscess)
- A child with failure to thrive due to difficulty swallowing secondary to tonsillar hypertrophy
- Obstructive sleep disorder in children** breathing causing severe daytime and night time symptoms

*A clinically significant episode is characterised by at least three of the following (Centor criteria):

- Tonsillar exudate
- Tender anterior cervical lymphadenopathy or lymphadenitis
- History of fever (over 38'C)
- Absence of a cough

** Obstructive sleep disordered breathing is defined as:

- Grade 3 or 4 tonsils AND
- Symptoms persisting for more than three months AND
- Night time symptoms are consistent snoring AND consistent wakefulness OR secondary enuresis OR witnessed apnoea's OR restlessness/excessive sweating AND
- Daytime symptoms of impaired school performance OR hyperactivity/aggression OR altered mood OR excessive tiredness

Gastroenterology

Appropriate Colonoscopy in the lower intestine

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. An estimated 35% of CRC is due to heritable factors.

While colonoscopy is a safe procedure, there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colonoscopy should therefore be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors.

This guidance applies to adults aged 19 years and over.

Policy:
Family history of CRC
For individuals with moderate familial CRC risk:

- Offer one-off colonoscopy at age 55 years
- Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines.

For individuals with high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation):

- Offer colonoscopy every 5 years from age 40 years to age 75 years.

L**ynch Syndrome (LS) and Lynch-like Syndrome**

For individuals with LS that are MLH1 and MSH2 mutation carriers:

- Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.

For individuals with LS that are MSH6 and PMS2 mutation carriers:

- Offer colonoscopic surveillance every 2 years from age 35 years to age 75 years.

For individuals with Lynch-like Syndrome with deficient MMR tumours without hypermethylation/BRAF pathogenic variant and no pathogenic constitutional pathogenic variant in MMR genes (and their unaffected FDRs), and no evidence of biallelic somatic MMR gene inactivation:

- Offer colonoscopic surveillance every 2 years from age 25 years to age 75 years.

Early Onset CRC (EOCRC)

For individuals diagnosed with CRC under age 50 years, where hereditary CRC symptoms have been excluded:

- Offer standard post-CRC colonoscopy surveillance after 3 years
- Then continue colonoscopic surveillance every 5 years until eligible for national screening.

Serrated Polyposis Syndrome (SPS)

For individuals with SPS:

- Offer colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size
- If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.

For first degree relatives of patients with SPS:

- Offer an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case
- Offer a surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.

Multiple Colorectal Adenoma (MCRA)

For individuals with MCRA (defined as having 10 or more metachronous adenomas):

- Offer annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size
- If no polyps 10mm or greater in size are identified at subsequent surveillance examinations, the interval can be extended to 2 yearly.

Familial Adenomatous Polyposis (FAP)

For individuals confirmed to have FAP on predictive genetic testing:

- Offer colonoscopic surveillance from 12-14 years
- Then offer surveillance colonoscopy every 1-3 years, personalised according to colonic phenotype.

For individuals who have a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a APC mutation has not been identified:

- Offer colorectal surveillance from 12-14 years
- Then offer every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached.

MUTYH-associated Polyposis (MAP)

For individuals with MAP:

- Offer colorectal surveillance from 18-20 years, and if surgery is not undertaken, repeat annually.

For monoallelic MUTYH pathogenic variant carriers:

- The risk of colorectal cancer is not sufficiently different to population risk to meet thresholds for screening and routine colonoscopy is not recommended.

Peutz-Jeghers Syndrome (PJS)

For asymptomatic individuals with PSJ:

- Offer colorectal surveillance from 8 years
- If baseline colonoscopy is normal, deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.

For symptomatic patients, investigate earlier.

Juvenile Polyposis Syndrome (JPS)

For asymptomatic individuals with JPS:

- Offer colorectal surveillance from 15 years
- Then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.

For symptomatic patients, investigate earlier.

For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.

Cholecystectomy (for asymptomatic gallstones)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy.

Policy:

The ICB will only provide funding for cholecystectomy in mild or asymptomatic gallstones if one or more of the following criteria are met:

- High risk of gall bladder cancer, e.g. gall bladder polyps ≥1cm, porcelain gall bladder, strong family history (parent, child or sibling with gallbladder cancer).
- Transplant recipient (pre or post-transplant).
- Diagnosis of chronic haemolytic syndrome by a secondary care specialist.
- Increased risk of complications from gallstones, e.g. presence of stones in the common bile duct stones smaller than 3mm with a patent cystic duct, presence of multiple stones.
- Acalculus cholecystitis diagnosed by a secondary care specialist.

The ICB will continue to fund cholecystectomy for patients with moderate to severely symptomatic gallstones, and for acute cholecystitis or mild gallstone pancreatitis Patient has moderate or severely symptomatic gallstones and agrees to surgery

Repeat/Follow up Colonoscopy of the lower intestine

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. Polyps are extremely common and certain types (colorectal adenomas and serrated lesions) have the potential to progress into CRC.

Colonoscopy can assist in the diagnosis of CRC and several other pathologies, including colonic polyps. Polyp removal (or polypectomy) can be performed endoscopically and is an effective way to treat pre-malignancy polyps (which includes both serrated polyps (excluding diminutive [1-5mm] rectal hyperplastic polyps) and adenomatous polyps. It does not include other polyps such as post inflammatory polyps) before they progress to cancer. Colonoscopy with or without polypectomy is a safe procedure however there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used.

Colorectal carcinoma is often treated by surgical resection, especially for people with potentially curative disease. Individuals who have had treatment for colorectal carcinoma and adenomas are known to be at high-risk of recurrence.

While reducing colorectal mortality is an important aim of colonoscopic surveillance, the main aim is to prevent colorectal cancer by resecting premalignant polyps. Many patients benefit from this alone and do not require subsequent surveillance.

This guidance applies to adults aged 19 years and over.

Policy:

Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection.

Risk Surveillance Criteria for Colonoscopy

Either of the following put individuals at high-risk for future colorectal cancer following polypectomy:

- 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); OR
- 5 or more premalignant polyps.

Surveillance colonoscopy after polypectomy

For individuals at high-risk and under the age of 75 and whose life expectancy is greater than 10 years:

- Offer one-off surveillance colonoscopy at 3 years.

For individuals with no high-risk findings:

No colonoscopic surveillance should be undertaken
Individuals should be strongly encouraged to participate in their national bowel screening programme when invited.

For individuals not at high-risk who are more than 10 years younger than the national bowel screening programme lower age-limit, consider for surveillance colonoscopy after 5 or 10 years, individual to age and other risk factors.

Surveillance colonoscopy after potentially curative CRC resection

Offer a clearance colonoscopy within a year after initial surgical resection
Then offer a surveillance colonoscopy after a further 3 years
Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance after pathologically en bloc R0 EMR or ESD of LNPCPs or early polyp cancers:

- No site-checks are required
- Offer surveillance colonoscopy after 3 years
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance after piecemeal EMR or ESD of LNPCPs (large nonpedunculated colorectal polyps of at least 20mm in size)

- Site-checks at 2-6 months and 18 months from the original resection
- Once no recurrence is confirmed, patients should undergo postpolypectomy surveillance after 3 years

Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria.

Surveillance where histological completeness of excision cannot be determined in patients with: (i) a non-pedunculated polyps of 10-19mm in size, or (ii) an adenoma containing high-grade dysplasia, or (iii) a serrated polyp containing any dysplasia:

- Site-check should be considered within 2-6 months

- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria

Ongoing colonoscopic surveillance:

To be determined by the findings at each surveillance procedure, using the high-risk criteria to stratify risk
Where there are no high-risk findings, colonoscopic surveillance should cease but individuals should be encouraged to participate in the national bowel screening programme when invited.

Test of the gallbladder – ERCP in acute gallstones pancreatitis without cholangitis

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended.

This guidance applies to adults aged 19 years and over.

Policy:

Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended. Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or ongoing obstruction of the biliary tree. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.

General Surgery

Appendectomy without confirmation of appendicitis

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
EBI

Background:

Appendicitis is the most common cause of abdominal pain requiring surgical intervention.

In children appendicitis can often be diagnosed clinically, if there is diagnostic uncertainty, an ultrasound can confirm appendicitis. CT is not recommended in children given the risks of ionising radiation; MRI can be used in centres with appropriate expertise.

In adults negative appendicectomy can occur in up to 30% of cases where appendicitis is suspected on clinical grounds but imaging is not performed. In patients with typical symptoms, diagnosis can generally be made based on history, physical examination and blood analysis. The 'triple-screen' (CRP<10, WCC <10.5 and a neutrophil percentage <75%) has a negative predictive value >99% in excluding appendicitis, and imaging for appendicitis is not recommended in this setting.

Recent studies have shown there is a potential role for non-operative management of acute appendicitis, imaging can help identify which patients could be managed conservatively.

Where patients present with atypical or equivocal symptoms, imaging should be sought to reduce the negative appendicectomy rate. While both ultrasound and computed tomography (CT) are effective, ultrasound is preferred as a first-line investigation. This is particularly important in young patients or in female patients when there is a significant incidence of a gynaecological differential diagnosis (where US is superior to CT). CT may be more appropriate in obese patients where ultrasound is more challenging, or for older patients in whom the differential diagnosis may be broad and where CT is usually of more value.

The diagnostic accuracy of MRI to diagnose appendicitis is similar to CT. Where specialist MRI is available it can be considered if CT is contraindicated, it is particularly useful for pregnant patients.

This guidance applies to adults and children.

Policy:

Consider the imaging of patients with the suspicion of acute appendicitis in a defined clinical pathway.

Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary, but imaging can help identify which patients can be managed conservatively. If there is clinical doubt then imaging can reduce the negative appendicectomy rate. Most patients should have an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT, preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management.

A pathway like this is dependent on the availability of an adequately skilled Radiologist (Consultant or Registrar) or Sonographer to perform the ultrasound assessment in a timely fashion. If this is not possible discretion should be used to proceed directly to limited dose CECT of the abdomen and pelvis.

Biological Mesh

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Biological Mesh. Biological grafts are derived from human, bovine, and porcine tissue that has been decellularized to leave a collagen matrix. This structure acts as a regenerative framework that supports remodeling and new collagen deposition.

Policy:

Use of biological mesh is only commissioned for the following indications:

- Hernia
  - Primary ventral and inguinal hernia repair in non-infected fields
  - Recurrent hernias, reinforced hernia repair
  - Hernia prophylaxis
  - Hernia repair in the contaminated or potentially contaminated fields (most widely used)
  - Complex abdominal wall hernia repair
- Breast reconstruction:
  - Mastectomy
  - Reconstructive surgery
- Pelvic organ prolapse:
  - Pelvic organ prolapse (POP)
  - Laparoscopic ventral mesh rectopexy (rectal prolapse)

Other indications will require Individual Funding Requests (IFR)

This policy does not apply to breast or chest surgery for or following gender reassignment surgery.

Haemorrhoid Surgery

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
EBI

Background:

Often haemorrhoids (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection.

Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically:

- Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or
- Irreducible and large external haemorrhoids.

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Hernia Repair

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

For asymptomatic or minimally symptomatic inguinal hernias, the ICB advocates a watchful waiting approach (informed consent regarding the potential risks of developing hernia complications e.g. incarceration, strangulation, or bowel obstruction). Patients should also be advised regarding weight loss as appropriate.

Policy:

The ICB will only fund inguinal hernia surgery when the following criteria are met:

Inguinal:
Surgical treatment should only be offered when one of the following criteria is met:

- Symptomatic hernias i.e. those which limit work or activities of daily living OR
- Hernias that are difficult or impossible to reduce OR
- Inguino-scrotal hernias OR
- An increase in the size of the hernia month on month (please use your clinical discretion when referring/surgical repair of these patients)

Femoral:
All suspected femoral hernias should be referred to secondary care due to the increased risk of incarceration/strangulation.

Umbilical, para umbilical and midline ventral hernia
Surgical treatment should only be offered when one of the following criteria is met:

- Pain or discomfort interfering with activities of daily living OR
- An increase in the size of the hernia month on month OR
- To avoid strangulation and incarceration of bowel where hernia is > 2cm

Incisional:
The ICB will only fund Incisional hernia surgery when the following criteria are met:

- Pain or discomfort interfering with activities of daily living

Upper GI Endoscopy to investigate gut problems

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Endoscopy is an invasive procedure and is not always well tolerated. It carries significant risks and should not be used as a first-line indication in all patients.

This guidance applies to adults aged 19 years and over.

Policy:
The ICB will only fund upper GI Endoscopy when the following criteria are met*:

For the investigation of symptoms clinicians should consider endoscopy:

- Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
- With suspected GORD who are thinking about surgery
- With H pylori that has not responded to second- line eradication
- Eradication can be confirmed with a urea breath test.

Upper Endoscopy should only be performed if the patient meets one of the following criteria:
Urgent: (Within two weeks) Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score OR

Aged 55 and over with weight loss and any of the following:

- Upper abdominal pain
- Reflux
- Dyspepsia (4 weeks of upper abdominal pain or discomfort
- Heartburn
- Nausea or vomiting

Those aged 55 or over who have one or more of the following:

- Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) OR
- Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain OR
- Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.

For the assessment of Upper GI bleeding:

- For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred
- Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation
- Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.

For the investigation of symptoms:

- Clinicians should consider endoscopy:
- Any age with gastro-oesophageal symptoms that are nonresponsive to treatment or unexplained
- With suspected GORD who are thinking about surgery
- With H pylori that has not responded to second- line eradication • Eradication can be confirmed with a urea breath test.

For the management of specific cases For H pylori and associated peptic ulcer: Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer Yes No

For Barrett's oesophagus:

- The non-endoscopic test called Cytosponge can be used (where available) to identify those who have developed Barrett's oesophagus as a complication of long-term reflux and thus require long term surveillance for cancer risk
- Consider endoscopy to diagnose Barrett's Oesophagus if the person has GORD (endoscopically determined oesphagitis or endoscopy – negative reflux disease)
- Consider endoscopy surveillance if person is diagnosed with Barrett's Oesophagus.

For coeliac disease: Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy.

Surveillance endoscopy:

- Surveillance endoscopy should only be offered in patients fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Many of this patient group are elderly and/or have significant comorbidities. Senior clinician input is required before embarking on long term endoscopic surveillance
- Patients diagnosed with extensive gastric atrophy (GA) or gastric intestinal metaplasia, (GIM) (defined as affecting the antrum and the body) should have endoscopy surveillance every three years
- Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent Hpylori infection, should undergo endoscopy every three years.

Screening endoscopy can be considered in:

- European guidelines (2015) for patients with genetic risk factors / family history of gastric cancer recommend genetics referral first before embarking on long term screening.
- Screening is not appropriate for all patients and should be performed in keeping with European expert guidelines
- Patients where screening is appropriate, for individuals aged 50 and over, with multiple risk factors for gastric cancer (e.g. H. Pylori infection, family history of gastric cancer - particularly in first degree relative -, pernicious anaemia, male, smokers).

Post excision of adenoma: • Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate. Yes No

* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the individual funding requests policy for further information. If patient meets the above criteria then prior approval is not required.

Gynaecology

Dilatation and Curettage (D&C) for treatment of Heavy Menstrual Bleeding

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Dilatation and curettage (D&C) is a procedure performed under general anaesthetic in which the opening of the womb (cervix) is widened (dilation) and the lining of the womb is biopsied or removed by scraping (curettage).

NICE Guidelines (NG88) recommends D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding due to a lack of evidence. Ultrasound scans and camera tests can be used to investigate heavy periods.

Policy:
D&C (including hysteroscopy) is not commissioned as a diagnostic tool or as a therapeutic treatment for menorrhagia. It may be commissioned in the following cases:

- 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 are inconclusive.
- Post-dilatation, pre-procedure when undertaking endometrial ablation.

Hysterectomy for Heavy Menstrual Bleeding

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Hysterectomy should not be used as a first line treatment solely for heavy menstrual bleeding.

Policy:

Dilation and Curettage (D&C) is not routinely commissioned to either diagnose or treat heavy menstrual bleeding in line with Evidence Based Interventions Policy.
Patients WILL NOT receive a D&C:

- As a diagnostic tool ALONE for heavy menstrual bleeding, or
- As a therapeutic treatment for heavy menstrual bleeding.

Patients WILL receive hysterectomy in the investigation and management of heavy menstrual bleeding only when the following criteria are met respectively for each procedure:

Hysterectomy for HMB will only be funded if ALL the following criteria are met:

- A levonorgestrel intrauterine system (e.g. Mirena) has been trialled for at least 6 months (unless declined or contraindicated) and has not successfully relieved symptoms AND
- A trial of at least 3 months each of two other pharmaceutical treatment options has not effectively relieved symptoms (or is contraindicated, or not tolerated). These treatment options include:
    - NSAIDs Tranexamic acid
    - Combined oral contraceptive pill
    - Oral and injected progestogens AND

- Surgical treatments such as endometrial ablation, thermal balloon ablation, microwave endometrial ablation or uterine artery embolisation (UAE) have either been ineffective or are not appropriate, or are contraindicated

If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information

Mirena IUS/IUD insertion in secondary care

Category:
(IFR / Prior Approval / Monitored Approval)
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Mirena fitting can be carried out in primary care and secondary care by trained healthcare professionals.

Policy:
ONE of the following commissioning criteria must be met for IUS / IUD to be commissioned in secondary care.

- Specific medical issue which prevents fitting by primary care
- Fitted as part of contraception provided in conjunction with Termination of Pregnancy.
- In combination with secondary care hysteroscopic investigation/treatment or to manage risk such as hyperplasia

No commissioning criteria exist in primary care

Pelvic Organ prolapse

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Pelvic organ prolapse is when 1 or more of the organs in the pelvis slip down from their normal position and bulge into the vagina.

It can be the womb (uterus), bowel, bladder or top of the vagina.
A prolapse is not life threatening, but it can cause pain and discomfort.
Symptoms can usually be improved with pelvic floor exercises and lifestyle changes, but sometimes medical treatment is needed.

Policy:
Surgical repair of pelvic organ prolapse will only be commissioned when the patient has received a documented shared decision making episode and ONE of following criteria are met:

- The prolapse is below the level of the introitus
- The prolapse is symptomatic, has not responded to three months of specialist physiotherapy and pessary use has been tried or considered

Tubal Occlusion (contraception)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National

Background:

Tubal Occlusion is a permanent contraception for a person with female reproductive organs.

Policy:

The following criteria for commissioning apply to this procedure.

Patients must have a documented shared decision making episode, have been counselled and meet ONE of the following criteria:

- Has explored all suitable long-acting reversible contraception (LARC) available and suitable to the patient and the shared decision making has explained all of the risks and complications associated with the procedure of tubal occlusion (i.e. Not easily reversed, No funding for reversal, risks associated with general anaesthetic, no protection from STI's and failure risks)

- Sterilisation is to take place at the time of another clinically appropriate gynaecological procedure such as caesarean section

- Where there is a clinical contraindication to the use of a Mirena / Nexplanon

- Where there is an absolute clinical contraindication to pregnancy, including but not limited to:
    - young women (under 45 years of age) undergoing endometrial ablation for heavy periods
    - women with severe diabetes
    - women with severe heart disease

Ophthalmology

Blepharoplasty

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Blepharoplasty is an operation, which removes excess skin (dermatochalasis) from the upper eyelids. This operation can be carried out on the NHS if the excess skin is affecting vision or making the eyelids heavy and difficult to open. It cannot be done on the NHS if it is just a cosmetic problem.

Policy:

Surgical treatment commissioned if one or more applies;

- excess tissue or drooping of the upper eyelid causing functional visual impairment
- to repair defects predisposing to corneal or conjunctival irritation
- entropion or ectropion if specific commissioning criteria are met
- periorbital sequelae of thyroid disease or nerve palsy or trauma
- prosthesis problems in an anophthalmia socket
- painful symptoms of blepharospasm resistant to conservative management

Applies to upper eyelids only (not lower eyelids) will be funded.

Cataract Surgery

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Cataracts are when the lens, a small transparent disc inside your eye, develops cloudy patches. Over time these patches usually become bigger causing blurry, misty vision and eventually blindness. When we're young, our lenses are usually like clear glass, allowing us to see through them.

Policy:

Before a referral is made, please confirm the patient wishes to have surgery if offered.

First cataract commissioned where there is a visual acuity of 6/12 (corrected) in the worst eye, or for:

- 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).
- Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions.
- 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 but experience significant difficulty due to the cataract.
- 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.
- Patients with glaucoma who require cataract surgery to control intra ocular pressure.
- Patient with diabetes who require clear views of their retina to look for retinopathy.

Cataract Second Eye:

- 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. It is not acceptable for these patients to be retained until vision in the second

eye deteriorates.

- 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).
- 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 record this so that it can be identified during any future clinical audit.

Chalazia Removal

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Chalazia (meibomian cysts) are benign lesions on the eyelids due to blockage and swelling of an oil gland that normally change size over a few weeks. Many but not all resolve within six months with regular application of warm compresses and massage.

Policy:

Incision and curettage (or triamcinolone injection for suitable candidates) of Chalazia should only be undertaken in accordance with the criteria below:

Has been present for more than 6 months and has been managed conservatively

OR

- Interferes significantly with vision

OR

- Is a source of infection that has required medical treatment with antibiotics on two occasions or more

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic procedures

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Occuloplastic procedures are mostly for cosmetic reasons and are not commissioned. However there are a number of conditions which affect vision and functionality affecting activities of daily living and quality of life which may be considered if criteria met.

The following eyelid surgery procedures will NOT be commissioned unless there is any diagnostic uncertainty:

- Removal of eyelid papilloma‘s or skin tags
- Surgery for pingueculum
- Excision of other lid lumps
- Surgery for cosmetic reasons

Policy:
The following conditions are NOT routinely commissioned unless specific criteria are met:

Ectropion / Entropion
Typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball or inwards toward the eyeball

- Conservative management has been exhausted
- Evidence of significant impairment of the punctum
- There is recurrent infection in surrounding skin.

Epiphora
Overflow of tears onto the face- a clinical sign or condition that constitutes insufficient tear film drainage from the eyes in that tears will drain down the face rather than through the nasolacrimal system)

- Despite undergoing conservative management, the patient is experiencing a daily impact of significant watering of the eyes indoors and outdoors
- Affecting visual function
- Interfering markedly with quality of life.

Blepharitis
Blepharitis is a common condition where the edges of the eyelids (margins) become red and swollen (inflamed). Referral to secondary care for simple blepharitis is NOT commissioned. If lids remain persistently swollen consider alternative diagnosis (e.g. malignancy) and refer under the appropriate pathway.

Orthopaedics

Arthroscopic shoulder decompression for subacromial shoulder pain

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

Policy:

Surgical intervention may be commissioned where the following criteria are met:

- Significant and persistent pain resulting in loss of function
- A 12 week course of physiotherapy has been completed
- A sub acromial steroid injection has been considered
- A shared decision episode has included discussion of the most current and robust evidence available for this procedure

Carpal Tunnel Syndrome Release

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Evidence from observational studies shows that symptoms resolve spontaneously in some people: good prognostic indicators are short duration of symptoms, a young age, and carpal tunnel syndrome due to pregnancy.

There is good evidence that surgical treatment relieves the symptoms of carpal tunnel syndrome (CTS) more effectively than splinting. However splinting is effective in about 50% of people in the short term. Carpal tunnel surgery is a low priority procedure for patients with intermittent or mild to moderate symptoms.
Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

Cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

a. corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness); or
b. night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

Referral guidance: Consider referral for electromyography and nerve conduction studies if the diagnosis is uncertain.

Policy:

Surgery may be commissioned if at least ONE of the following criteria applies:

- The symptoms are interfering with activities of daily living AND the patient has not responded to a minimum of 6 months of conservative management, including:
  - >8 weeks of night-time use of wrist splints
  - Appropriate analgesia
  - Corticosteroid injections (given at least twice prior to referral) in appropriate patients
  - A shared decision making process / tool discussing treatment options is clearly documented
- Objective Neurological deficit consistent with CTS i.e. constant sensory blunting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).
- Rheumatoid disease
- Recent wrist trauma
- Previous wrist surgery

The referral must detail conservative methods tried and the length of time that each of these was carried out.

Nerve conduction studies (EMG) are generally NOT needed to confirm the diagnosis. Patients with wasting of the hand muscles should be urgently referred and are outside the scope of this policy.

Dupuytren's Contracture

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Dupuytren's contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. Several treatments are available: needle fasciotomy, fasciectomy and dermofasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

Policy:

Before referral is made the referrer must confirm
• The patient wishes to have surgery if offered
Surgical intervention only commissioned 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

Collagenase (clostridium histolyticum- CCH) injections as an option for treating Dupuytren's contracture, with a PALPABLE cord, may be commissioned in adults if ALL the following criteria apply:
• There is evidence of moderate disease (defined a-d) in up to 2 affected joints: o Functional problems
  o Metacarpophalangeal joint contracture of 30° to 60°
  o Proximal interphalangeal joint contracture of less than 30°
  o First web contracture
• Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon.
• The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available.
• One injection is given per treatment session by a hand surgeon in an outpatient setting.

The Commissioner does NOT fund radiation therapy for early Dupuytrens, see section 2.

Fusion surgery for mechanical axial low back pain

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Spinal fusion is when two individual spinal vertebrae become joined together by bone formed as a result of surgery. This may involve the use of bone graft and/or surgical implants. The aim of the surgery is to stop motion at that joint in order to stabilise the joint. Spinal fusion is not recommended for patients with non-specific, mechanical back pain.

This guidance applies to adults aged 19 years and over.

Policy:

Spinal fusion is not indicated for the treatment of non-specific, mechanical back pain. The NICE exclusion criteria are:

- Conditions of a non-mechanical nature, including:
    - inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
    - serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
    - scoliosis
    - Pregnancy-related back pain
    - Sacroiliac joint dysfunction
    - Adjacent-segment disease
    - Failed back surgery syndrome
    - Spondylolisthesis.

Instead, spinal fusion is usually reserved for:

- Patients with a symptomatic spinal deformity (e.g. scoliosis)
- Instability (e.g. spondylolisthesis; trauma)
- An adjunct during spinal decompression surgery, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, manual therapy and screening patients who are high risk of developing chronic pain (i.e. STaRT Back). Use combined physical and psychological programme for management of sub-acute and chronic low back pain e.g. Back Skills Training (BeST).

Ganglion Excision

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Ganglia are benign fluid filled, firm and rubbery lumps attached to the adjacent underlying joint capsule, ligament, tendon or tendon sheath. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%). Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates up to 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

Policy:

Before referral is made the referrer must confirm the patient wishes to have surgery if offered.

Referral to orthopaedics for excision of symptomatic ganglia commissioned only if:

- Ganglion on wrist – with evidence of neurovascular compromise or functional disability
- Seed ganglia at base of digits – with significant pain
- Mucoid cysts at DIP joint – nail growth disrupted, cysts tend to discharge
- A shared decision making process / tool discussing treatment options is clearly documented

No referrals are commissioned for cosmetic surgery for ganglion cysts

Hallux Valgus

Category: (IFR / Prior Approval / Monitored Approval)
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:
Bunions (Hallux Valgus) Pressure from the way you walk or your foot shape can cause a bunion, a painful bony lump on the outside of the big toe. Narrow shoes and standing for long periods can make bunion pain worse. If bunion pads, toe spacers and better-fitting shoes don't help, you may need surgery (a bunionectomy)

Policy:
Before referral is made the referrer must confirm the patient wishes to have surgery if offered

Requests for the removal of symptomatic bunions will ONLY be commissioned where:

- Conservative measures have failed (these include trying accommodative footwear, considering orthoses and using appropriate analgesia.)
- The patient suffers from severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment
- Severe deformity (with or without lesser toe deformity) that causes significant functional impairment OR prevents them from finding adequate footwear
- Recurrent or chronic ulceration or infection

The clinician should ensure that the patient fulfils all the criteria before they are referred to secondary care. Before referral patients should be informed that:

- They will be in plaster for 6 weeks and unable to drive and it will take at least a further 2 months to regain full function
- The prognosis for treated and untreated HV is very variable

URGENT referral should be considered where HV may be compromising the foot in association with skin ulceration, diabetes or peripheral limb ischemia (or peripheral vascular disease)**.**

Hip Replacement Surgery

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Hip replacement surgery is usually necessary when the hip joint is worn or damaged so that your mobility is reduced and you are in pain even while resting. The most common reason for hip replacement surgery is osteoarthritis, however, other conditions can cause hip joint damage such as rheumatoid arthritis. A hip replacement is major surgery, so it is usually only recommended in certain circumstances if other treatments, such as physiotherapy or steroid injections, have not helped reduce pain or improve mobility.

Commissioned if ALL criteria apply:

- Radiologically proven osteoarthritis
- Patient co-morbidities optimised for surgery
- Documented evidence of appropriate discussion of benefits and complications by use of a shared decision making tool
- Conservative treatments where appropriate including lifestyle modification, analgesia, exercise, physiotherapy and steroid injections have been tried for at least three months
- Patient has been assessed by the CCG MSK hub for that specific joint

A separate referral is required for each hip

Imaging for shoulder pain

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Scans for shoulder pain
X-rays should be used routinely as the first line of radiological investigation for the diagnosis of most routine shoulder pathology. This practice should be followed in primary, intermediate and secondary care.

The use of Ultrasound, MRI and CT scanning should be restricted to those secondary care services that are responsible for the definitive treatment of such patients. The use of these investigations outside secondary care should only be allowed if referral pathways have been developed with the local secondary care specialist shoulder service.

Primary care patients that are deemed urgent or have red flags should be referred urgently to the appropriate secondary care team.

Image guided injections for shoulder pain

Image guided subacromial injections are not recommended in primary, intermediate or secondary care. Evidence does not support the use of guided subacromial injections over unguided subacromial injections in the treatment of subacromial shoulder pain.

Other image guided shoulder injections should only be offered under the guidance of a secondary care shoulder service.

Policy:
For patients who initially present with shoulder pain in primary or intermediate care, the first line of radiological investigation should be a plain x-ray. X-rays diagnose most routine shoulder problems such as osteoarthritis, calcium deposits, rotator cuff arthropathy, impingement, fractures and primary and secondary tumours.

If following an x-ray and clinical assessment, the diagnosis is still in doubt then a referral to the secondary care shoulder service is indicated where further specialist assessment and appropriate investigations including USS, CT scans and MRI scans can be arranged. The British Elbow and Shoulder Society (BESS) have produced treatment and referral guidelines for routine shoulder conditions.

If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management:

- Any history or suspicion of malignancy
- Any mass or swelling
- Suggestions of infection, e.g. red skin, fever or systemically unwell

- Trauma, pain and weakness
- Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape.

Injections for shoulder pain are often indicated as a first line of treatment. The common areas injected are the subacromial space, the glenohumeral joint and the acromioclavicular joint. The most common injection is a subacromial injection. Guided injections (usually utilising ultrasound) are more expensive than unguided injections.

Evidence now indicates there is no additional benefit from a guided subacromial injection over an unguided landmark injection and so these are no longer recommended in primary, intermediate and Secondary care during routine management of patients with subacromial shoulder pain.

The use of other guided injections for glenohumeral joint and acromioclavicular joint problems should only be offered under the guidance of a secondary care shoulder service responsible for definitive treatment of these patients.

Ingrown toenail in secondary care

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Ingrown toenail treatments can and should be carried out by the appropriately commissioned podiatry services.

Referral to secondary care should only be undertaken when:

- the patient is in clinical need of surgical removal of ingrown toe nail, has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed.
  OR
- People of all ages with infection and/or recurrent inflammation due to ingrown toenail AND who have high medical risk*.

*Medical risk is determined by the referring clinician

Joint injection completed in secondary care

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Joint injections for symptom control should be carried out in primary care or by inter-practice referral wherever possible.

Policy:

Steroid joint injections in secondary care are commissioned where ONE of the following criteria are met:

- Under 18 years old
- As a diagnostic tool prior to joint replacement to confirm the source of symptoms
- As a therapy where patients are unfit / unsuitable for surgery AND cannot be provided in primary care.
- Flare of inflammatory disease in a pre-existing inflammatory arthritis

Joint prosthesis

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

This policy relates to all joint replacement surgery other than Hip and Knee.

Joint replacement commissioned for people who:

- Experience joint symptoms (pain, stiffness and reduced function)
- Are refractory to non-surgical treatment.
- Have a substantial impact on their quality of life

Documented evidence of appropriate discussion of benefits and complications by use of a shared decision making tool if available.

Knee Arthroscopy for Osteoarthritis and meniscal tears

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
Arthroscopic washout of the knee is an operation where an arthroscope (camera) is inserted into the knee along with fluid. Occasionally loose debris drains out with the fluid, or debridement, (surgical removal of damaged cartilage) is performed, but the procedure does not improve symptoms or function of the knee joint.

Knee arthroscopy may be commissioned if all criteria are met:

- Arthroscopy of the knee can be undertaken where a competent clinical examination and MRI scan have demonstrated clear evidence of an internal joint derangement (acute meniscal tear, ligament rupture or loose body)
- Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee Arthroscopy for degenerative meniscal tears is not commissioned

Knee MRI for suspected meniscal tears

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
Patients who have knee pain with persistent mechanical symptoms (locking, catching and intermittent sudden pain on movement) that has not responded to three months of initial non-operative care may have a symptomatic meniscal tear. These patients are referred to intermediate or secondary care and in these circumstances an MRI scan is the best investigation to determine the cause of symptoms.

Patients who have a clear history of a significant acute knee injury and mechanical symptoms or who have a locked knee require referral to intermediate or secondary care and should undergo MRI investigation.

The majority of patients who present to primary care with knee pain do not require initial investigation with an MRI scan once red flag symptoms and signs have been excluded.

This guidance applies to adults aged 19 years and over.

Policy:

Patients with a clear history of a significant acute knee injury and mechanical symptoms or who have a locked knee may have a repairable meniscal tear and should undergo referral to intermediate or secondary care and have MRI investigation.

The majority of patients who initially present in primary care with knee symptoms, no red flags and no history of acute knee injury or a locked knee do not need an MRI investigation and can be treated with non-operative supportive measures. Patients with persistent mechanical knee symptoms should be referred to secondary care and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology.

Knee MRI when symptoms are suggestive of osteoarthritis

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
Osteoarthritis (OA), the most common form of arthritis, is characterised by joint pain accompanied by a varying degree of functional limitation and reduced quality of life. The most commonly affected joints are the knees, hips and small hand joints with a poor link between changes visible on a radiograph and symptoms of osteoarthritis.

An initial diagnosis of OA can be made when clinical assessment is suggestive of this pathology. If imaging is required to confirm the diagnosis, then weight bearing radiographs are the first-line of investigation. Magnetic resonance imaging (MRI) for knees is not usually needed.

This guidance applies to adults aged 19 years and over.

Policy:

In primary care, where clinical assessment is suggestive of knee OA, imaging is not usually necessary. If imaging is required then weight bearing radiographs are the first-line of investigation. Patients with persistent symptoms should, after three to four months, be referred to secondary care and should have imaging of the knee to investigate for OA and/or other pathology.

Where imaging is necessary, in secondary care the first-line investigation of potential knee OA is weight bearing plain radiography. If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required.

However, there are a number of situations where MRI of the osteoarthritic knee can be useful:

- Patients who have severe symptoms but relatively mild OA on standard X-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee
- In working up a patient for possible HTO or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments.

In summary an MRI scan can be a useful investigation in the contemporary surgical management of osteoarthritis, giving critical information on the pattern of disease and state of the soft tissues. However, requesting an MRI scan when it is not indicated potentially prolongs further waiting times for patients, can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for appropriate patients.

Knee Replacement Surgery (Primary)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Knee replacement surgery (arthroplasty) is a common operation that involves replacing a damaged, worn or diseased knee with an artificial joint. The most common reason for knee replacement surgery is osteoarthritis, however, other conditions can cause hip joint damage such as rheumatoid arthritis. A knee replacement is major surgery, so is normally only recommended in certain circumstances if other treatments, such as physiotherapy or steroid injections, have not reduced pain or improved mobility.

Policy:

Knee replacement surgery will only be funded in accordance with the criteria specified below:

- Radiologically proven osteoarthritis
- Patient co-morbidities optimised for surgery
- Documented evidence of appropriate discussion of benefits and complications by use of a shared decision-making tool
- Conservative treatments where appropriate including lifestyle modification, analgesia, exercise, physiotherapy and steroid injections have been tried for at least three months
- Patient has been assessed by the CCG MSK hub for that specific joint
- A separate referral is required for each knee

Low Back Pain - Epidural

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Policy:

Epidural injections are not routinely funded for the treatment of non-specific low back pain. The ICB commissions epidural injections when ONE of the following criteria have been met:

- The patient has undergone discectomy – a single injection will be commissioned.
- Patient has acute (up to 12 weeks duration) and severe sciatica and is being treated as part of an integrated MSK pain management pathway

Not commissioned for patients who have non-specific / axial low back pain.

Not commissioned for patients with failed back pain surgery syndrome

Low Back Pain – Medial Branch Block (MBB)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior

Local or National EBI (Evidence Based Interventions) Policy:
Local

Policy:

May be commissioned as diagnostic tool (maximum of two diagnostic MBB injections) prior to radiofrequency denervation or surgery in order to show probability of benefit.

Therapeutic facet joint injections are not commissioned.

Not commissioned for non-specific lumbar back pain

Lumbar discectomy – spinal surgery for a slipped disc

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
A discectomy is the surgical removal of intervertebral disc material to treat the symptoms resulting from compression of one or more spinal nerve roots. This loose material, which is part of the natural degeneration of the disc with age, is often described as bulging, prolapsed, herniated or slipped, resulting in pressure on usually one, but sometimes more nerve roots. The symptoms it causes are called radiculopathy or sciatica and can include pain, tingling, pins and needles, numbness, weakness, and rarely bowel and bladder problems. As more often than not, the symptoms will settle naturally, nonoperative treatment is the preferred initial option.

Policy:
Patients presenting with radiculopathy who show objective evidence of clinical improvement within six weeks (e.g. VAS pain scores, ODI), are more likely than not to continue improving with non-operative treatment as the natural history of most intervertebral disc herniations is favourable.

Primary care management typically includes reassurance, advice on continuation of activity with modification, weight-loss, analgesia, manual therapy and screening patients who are high risk of developing chronic pain (i.e. STaRT Back).

Persistent symptoms may warrant onward referral to spinal services for consideration of interventional pain management injections (e.g. nerve root blocks / caudal epidural injections) or surgery. In the presence of concordant MRI changes, Discectomy may be offered to patients with compressive nerve root signs and symptoms lasting three months (except in severe cases) despite best efforts with non-operative management.

Please note: This guideline is not intended to cover patients who demonstrate a deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal centre for further evaluation and imaging, as nonoperative treatment may lead to irreversible harm.

This guidance applies to adults aged 19 years and over.

MRI scan for the hip for arthritis

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
When clinical assessment is suggestive of osteoarthritis (OA) and plain radiographs demonstrate typical OA features, the use of MRI for the investigation of hip pain is not usually needed.

This guidance applies to adults aged 19 years and over.

Policy:
Do not request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment.

Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip.

The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who:

Are 45 or over AND
Have activity-related joint pain AND
Have either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes.

It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray.

An MRI or urgent onward referral may be warranted in some circumstances. These include:

Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis
Trauma
History or family history of an inflammatory arthropathy
Mechanical, impingement type symptoms
Prolonged and morning stiffness
History of cancer or corresponding risk factors
Suspected Osteonecrosis / Avascular necrosis of the hip

Suspected transient osteoporosis
Suspected periarticular soft tissue pathology e.g. abductor tendinopathy

Important differential diagnoses include inflammatory arthritis (for example, rheumatoid arthritis), femoro-acetabular impingement, septic arthritis and malignancy (bone pain).

Shoulder Arthroscopy

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Policy:

Shoulder arthroscopy will only be commissioned for patients with adhesive capsulitis ('frozen shoulder') if ONE of the following Criteria has been met;

- Conservative treatments, listed below, have ALL been tried and failed;
  - Activity modification
  - Physiotherapy and exercise programme
  - Oral analgesics including NSAIDs (unless contraindicated)
  - Intra-articular steroid injection Repeated injections are NOT commissioned unless there is documented evidence of clear benefit from previous injections Manipulation under anaesthetic (carefully consider use following a fracture as undertaking manipulation under anaesthetic increases the risk of a re-fracture)
- There are red flag symptoms (see below)

If there is diagnostic uncertainty despite competent examination or if there are "red flag" symptoms/signs/conditions then an MRI scan might be indicated.

Red flag symptoms or signs include; recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity. Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis. The clinician must provide full details to support prior approval.

Spinal fusion / Lumbar decompression

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Policy:

Surgical treatment may be commissioned if one of the following criteria are met and the indication is not found in the Surgery for Sciatica statement:

- Unequivocal root compression
- Spinal stenosis
- Instability
- Spondylolithesis causing severe and persistent pain or neurological deficits and not responding to conservative approaches

Spinal discectomy/Lumbar decompression surgery for sciatica

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Policy:

Non-acute spinal surgery will only be commissioned if the following criteria are met:

- 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;
- Symptoms persist despite non-operative treatment for at least 12 weeks (e.g. analgesia, physical therapy, bed rest etc.).
- The patient meets one of the following criteria:
  - 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)
  - 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

This does not apply to those with red flag symptoms or symptoms suggestive of cauda equina.

Trigger Finger Release in Adults

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to "lock" in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss and unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

Policy:

Surgery for trigger finger will only be funded in accordance with the criteria specified below:

- Failure to respond to up to two steroid injections** (one in the case of patients with diabetes mellitus) or splinting of the finger for 3-12 weeks (does not apply if the patient has had 2 previous trigger digits unsuccessfully treated with nonoperative methods)
  AND
- Loss of complete active flexion

** Where injection of trigger finger is not available in primary care, please refer to MSK for this treatment

This policy applies to adults only.

Vertebral augmentation for painful osteoporotic vertebral fractures

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Osteoporotic bones are of reduced density and are more susceptible to fractures. Vertebral compression fractures are a break in a bone of the spinal column that results in a reduction in height of that bone. Osteoporotic vertebral fractures can cause pain and potentially an associated reduction in mobility. The pain can often improve as healing occurs. Deformity and respiratory or gastrointestinal disturbance as a result of fractures may be permanent.

Vertebral augmentation, including vertebroplasty (VP) and kyphoplasty (KP), refers to spinal procedures which involve the injection of bone cement (typically polymethylmethacrylate (PMMA)) into the fractured vertebral body via a needle inserted through the skin, using image guidance). These procedures aim to increase stability and strengthen the bone with the intention of reducing pain and further collapse. The procedure can be performed under local anaesthetic with sedation, or general anaesthesia interventional radiologist, spinal surgeon or pain specialist. Decisions regarding the need for vertebral augmentation are made by the operator, in conjunction with metabolic and pain specialists, geriatricians and the patient.

Policy:

Vertebroplasty (VP) or kyphoplasty (KP) should be offered as a treatment for painful osteoporotic vertebral fractures on a case-by-case basis. As per advice in the NICE Technology Appraisal Guidance 279 (TAG 279), VP or KP may be considered:

- In cases where patients have ‘severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management’ and in particular hospitalised older people
- Where the acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination
- The decision to treat should be taken after multidisciplinary team discussion
- The procedure should take place at a facility with access to spinal surgery services
- Processes for audit and clinical governance should be in place
- VP/KP must be performed in conjunction with additional measures to improve bone health.

NICE TAG 279 delegates the eligible timeframe for intervention to the clinician. However, evidence from a 2016 randomised controlled trial (RCT) offers evidence that older patients (>60 years old) with fractures at most 6 weeks old and severe pain despite optimal pain management that benefit most from the procedure.

Other

Blood Transfusions

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

A blood transfusion may be indicated if a patient has a shortage of red blood cells (RBC) causing haemodynamic instability or impeding oxygen delivery to tissues and organs. This can be for a variety of reasons including severe bleeding, cancer or a blood disorder. However, blood transfusion carries risks and only the minimum number of units should be transfused to avoid harm.

It is recommended to use restrictive thresholds for transfusion, and to give only a single unit at a time, except where the patient has active bleeding.

This guidance applies to adults (or equivalent based on body weight for children or adults with low body weight) only.

Policy:

This guidance focuses on RBC transfusions for adults (or equivalent based on body weight for children or adults with low body weight) only.

Do not give RBC transfusions to patients with B12, folate or iron deficiency anaemia unless there is haemodynamic instability. If haemodynamic instability is present, treat this with transfusion of appropriate blood components (do not delay emergency transfusions).

Where, however, severe acute anaemia (Hb <70g/litre) exists that is symptomatic and prevents rehabilitation or mobilisation, those patients may benefit from a single unit of blood.

For adult patients (or equivalent based on body weight for children or adults with low body weight) needing RBC transfusion, suggest restrictive thresholds and giving a single unit at a time except in case of exceptions below.

Restrictive RBC transfusion thresholds are for patients who need RBC transfusions and who do not:

Have major haemorrhage or
Have acute coronary syndrome or
Need regular blood transfusions for chronic anaemia.

While transfusions are given to replace deficient red blood cells, they will not correct the underlying cause of the anaemia. RBC transfusions will only provide temporary improvement. It is important to investigate why patients are anaemic and treat the cause as well as the symptoms.

Note: Consider whether a dramatic fall in haemoglobin could be due to a severe haemolytic episode and not associated with any of the 3 exceptions. This would also be a possible indication to transfuse more than one unit at a time.

When using a restrictive RBC transfusion threshold, consider a threshold of 70 g/litre and a haemoglobin concentration target of 70–90 g/litre after transfusion. For patients with acute coronary syndrome, a RBC transfusion threshold of 80 g/litre should be considered and a haemoglobin concentration target of 80–100 g/litre after transfusion. For patients requiring regular transfusion for chronic anaemia, NICE advise defining thresholds and haemoglobin concentration targets for each individual.

Pathology

Lipid lowering therapy – regular blood tests when taking cholesterol lowering tablets

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Lipid modification therapies are a group of medicines which help to lower the level of low-density lipoprotein (LDL) cholesterol in the blood. High levels of LDL cholesterol are linked to the development of cardiovascular disease (CVD) which includes ischaemic heart disease and stroke. There is strong evidence that lipid modification therapy improves the mortality for people at high risk of cardiovascular diseases as well as those with established disease. Clinically significant side effects associated with lipid modification therapy include skeletal, muscle and liver and toxicity.

Skeletal muscle toxicity related to lipid modification treatment may result in myopathy, myositis and rhabdomyolysis. Whilst these conditions are potentially serious, they occur rarely. The likelihood of muscle toxicity increases with higher lipid modification therapy doses and in patients with predisposing co-morbidities. Creatine kinase is a blood marker which becomes elevated in various skeletal muscle pathologies and is used, alongside signs and symptoms, to diagnose muscle toxicity related to lipid lowering treatment.

Adverse effects on the liver related to lipid modification treatment are very rare and include transaminitis (raised transaminase liver enzymes in the blood) as well as jaundice and liver failure. Liver function testing is used alongside signs and symptoms to diagnose liver toxicity.

This guidance applies to adults aged 19 years and over.

Policy:

Creatine Kinase Testing

- Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy
- Creatine kinase measurement is indicated:
    - Prior to lipid modification therapy initiation in patients who have experienced generalised, unexplained muscle pains or weakness (whether or not associated with previous lipid-monitoring therapy)
    - If a patient develops muscle pains or weakness whilst on lipid modification therapy.

Liver Function Testing

- Baseline liver function should be measured before starting lipid modification therapy
- Liver function should be measured within 3 months of starting treatment and at 12 months, but not again unless clinically indicated
- Routine monitoring of liver function tests in asymptomatic people is not indicated after 12 months of initiating lipid lowering therapy
- ALT can be used as a measure of liver function.

Lipid Testing

- Measure full lipid profile by taking at least one lipid sample before starting lipid modification therapy. This should include measurement of total cholesterol, HDL cholesterol, non-HDL cholesterol and triglyceride concentrations. A fasting sample is not needed.
- Total cholesterol, HDL cholesterol and non-HDL cholesterol should be measured in all people who have been started on high-intensity statin treatment (both primary and secondary prevention, including atorvastatin 20 mg for primary prevention) at 3 months of treatment and aim for a greater than 40% reduction in non-HDL cholesterol.
- Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.

Further details on creatine kinase, liver function and lipid testing during lipid lowering treatment are outlined in NICE guidance and ECS guidance for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk.

Urology

Circumcision (of the penis)

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications.

Policy:

Circumcision for both Adults and Children is not funded for social, cultural or religious reasons.

This policy only applies to circumcision of the foreskin of the penis. It does NOT apply to circumcision of any part of the vagina or female reproductive organs.

Circumcision is commissioned ONLY for medical and NOT cosmetic or religious reasons. One of the following commissioning criteria must be met:

- Lichen sclerosus (chronic inflammation leading to a rigid fibrous foreskin) in males aged 9 years and over
- Distal scarring of the preputial orifice (a short course of topical corticosteroids might help with mild scarring)
- Painful erections secondary to a tight foreskin
- Recurrent infection (balanitis / balanoposthitis)
- Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin)
- Traumatic injury e.g. zipper damage.
- Congenital urological abnormalities when skin is required for grafting

Prior approval is required for any child younger than 5 years old being considered for circumcision stating the reason for not delaying surgery until older than 5 years old. (As per GIRFT)

Cystoscopy for men with un-complicated lower urinary tract symptoms

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Cystoscopy is a diagnostic procedure used to examine the lining of the bladder and urethra. Either a rigid or flexible endoscope may be used, under general or local anaesthesia, respectively. Rigid cystoscopy is undertaken when flexible cystoscopy offers insufficiently clear views, or when biopsy is indicated.

Cystoscopy can cause temporary discomfort, occasionally pain and haematuria and is associated with a small risk of infection.

In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).

This guidance applies to male adults aged 19 years and over.

Policy:

Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings.

Specialist assessment should also incorporate a measurement of flow rate and post void residual volume.

Cystoscopy should be offered to men with LUTS only when clinically indicated, for example, in the presence of the following features from their history:

- Recurrent infection
- Sterile pyuria
- Haematuria
- Profound symptoms

Additional contextual information may also inform clinical decision-making around the use of cystoscopy in men with LUTS. Such factors might include, but not be limited to:

- Smoking history
- Travel or occupational history suggesting a high risk of malignancy

- Previous surgery.

Other adjunct investigations may become necessary in specific circumstances and are dealt with in the NICE guideline. It may be reasonable to undertake flexible cystoscopy before doing some urological surgical interventions.

Prostate – specific antigen testing

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Prostate-specific antigen (PSA) is a protein produced by the prostate gland. Blood PSA levels can be elevated in prostate cancer as well as a number of other conditions including benign prostatic hypertrophy, prostatitis and urinary tract infection. The PSA test is the most commonly used test that can lead to the diagnosis of localised prostate cancer for which potentially curative treatment can be offered. Increased PSA levels may be associated with a raised probability of prostate cancer. However, many men have raised PSA levels without having prostate cancer and many men with prostate cancer don't have raised PSA levels.

Typically, those with persistently raised PSA levels are referred on for further evaluation and may be offered histological assessment by trans-rectal or trans-perineal biopsy. Some centres are now using multi-parametric MRI scans to further assess people before taking biopsies. MRI is less likely than biopsy to detect clinically insignificant cancers and therefore reduces over-diagnosis. MRI also enables a more accurate diagnosis of clinically significant cancers because the MRI image can be used to target the biopsy.

Biopsies help to confirm the presence of cancer and allows an assessment of the cancer grade and stage. It is possible that biopsies not guided by MRI imaging can miss smaller areas of cancer or detect indolent disease of unclear clinical significance (which may subsequently require further investigation or treatment). There are a number of potential adverse effects of biopsies including pain, bleeding, urinary retention, infection (which may become serious sepsis) and sexual problems. It is also recognised this process has a significant psychological burden.

This guidance applies to males born with a prostate, adults aged 19 years and over, and trans, nonbinary, and intersex people with a prostate.

Policy:

Where PSA testing is clinically indicated (see below), or requested by the man aged 50 and over, he should have a careful discussion about the potential risks and benefits of PSA testing which allows for shared decision making before a PSA test. Various tools are available to assist with shared decision making (see below).

PSA testing should be considered in asymptomatic men over age 40 who are at higher risk of prostate cancer due if they are Black and/or have a family history of prostate cancer PSA testing should be considered when clinically indicated (ideally after counselling on the

potential risks and benefits of testing) in men when there is clinical suspicion of prostate cancer, which may include the following symptoms:

- Lower urinary tract symptoms (LUTS), such nocturia, urinary frequency, hesitancy, reduced flow, urgency or retention.
- Erectile dysfunction.
- Visible haematuria.
- Unexplained symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss).

PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history) is not recommended. This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend.

Note: PSA testing for prostate cancer should be avoided if the patient has:

- *An active or recent urinary infection (PSA may remain raised for many months).*
- *Had a prostate biopsy in the previous 6 weeks*

both of which are likely to raise PSA and give a false positive result.

Surgical intervention for benign prostatic hyperplasia

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Transurethral resection of prostate (TURP) is a therapeutic procedure involving removal of tissue from the inner aspect of the prostate using diathermy, via an endoscopic approach. It is commonly undertaken for voiding lower urinary tract symptoms (LUTS) presumed secondary to benign prostatic hyperplasia (BPH).

TURP is undertaken on an in-patient basis, with a catheter left in-situ for 24-48 hours post-op for the purpose of irrigation. TURP may be undertaken under either general or spinal anaesthesia.

TURP causes temporary discomfort, occasionally pain, haematuria and is associated with small risks of infection and acute urinary retention after removal of the catheter. There is also a risk of sexual dysfunction following TURP. There are small but significant risks of significant harm, including severe fluid and electrolyte imbalances associated with absorption of large volumes of irrigating fluid (TUR syndrome). TUR syndrome can be avoided by using bipolar diathermy, a variant of the standard technology.

TURP is the longest established of a range of endoscopic surgical procedures for benign enlargement of the prostate, with varying indications and potential complications. These include, among others:

- Transurethral incision of the prostate (TUIP) or Bladder Neck Incision (BNI)
- Holmium LASER enucleation of the prostate
- 532 nm ('Greenlight') laser vaporisation of the prostate
- UroLift
- Transurethral needle ablation of the prostate (TUNA)
- Transurethral vaporisation of the prostate (TUVP)
- Transurethral water vapour therapy (Rezum).

Open simple/benign prostatectomy is uncommonly undertaken in men with very large prostates and problematic symptoms. Newer ablative therapies are currently under evaluation and non-surgical procedures such as prostatic artery embolisation (PAE).

This guidance applies to males born with a prostate, adults aged 19 years and over, and trans, nonbinary, and intersex people with a prostate.

Policy:

Only men with severe voiding symptoms, or in whom conservative management options and drug treatment have been unsuccessful, should be offered surgical intervention. Surgery is indicated (in healthy men) in complicated BPH i.e. chronic retention with renal impairment as evidenced by hydronephrosis and impaired GFR, and in most cases of acute retention secondary to BPH.

As such, a staged approach to managing voiding LUTS is recommended:

- Conservative, or lifestyle interventions should be discussed.
- Drug therapy should then be considered, in the context of more bothersome LUTS, or LUTS not responding to simple lifestyle interventions.
- Where bothersome LUTS persist alongside high, or unchanged International Prostate Symptom Scores, or in the context of urinary tract infections, bladder stones or urinary retention, surgical intervention should be considered using a shared decision-making approach.

Men considering surgical intervention should be counselled thoroughly regarding alternatives to and outcomes from surgery. The quality of this counselling is deemed to be of major importance with respect to men's future experience and outcomes.

Following a discussion about whether to intervene surgically, men should be counselled about their preferred and most suitable surgical modality, incorporating reference to available evidence. Practical concerns, including the distance required to travel to pursue a given modality of surgical treatment are also important. Appropriate support shoulder be provided to make shared decisions pertinent to physical, emotional, psychological and sexual health. If appropriate, carers should be informed and involved. With respect to surgical modality:

- The UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function and should be considered as an alternative to current surgical procedures for use in a day-case setting in men who are aged 50 years and older and who have a prostate of less than 100 ml without an obstructing middle lobe
- TURP, TUVP (including laser prostatic vaporisation) or HoLEP should be offered to men with voiding LUTS presumed secondary to BPH
- HoLEP should be performed within centres specialising in the technique, or where mentorship arrangements are in place
- TUIP should be offered to men with a prostate estimated to be smaller than 30ml
- Open prostatectomy should only be offered as an alternative to endoscopic surgery, to men with prostates estimated to be larger than 80-100ml
- Transurethral needle ablation, transurethral microwave thermotherapy, high-intensity focused ultrasound, transurethral ethanol ablation of the prostate should not be offered as alternative surgical treatments for voiding LUTS presumed secondary to BPH.

Of note, some men with bothersome LUTS will have undergone multichannel cytometry, establishing clear evidence of bladder outlet obstruction. These men are the most likely to benefit from surgery, with guidance on when to undertake such assessment covered elsewhere in NICE and European guidelines.

Surgical removal of kidney stones

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Urinary tract stones are amongst the most common condition dealt with by urologists with an estimated 6,000 patients admitted to hospital per year with the condition. Shockwave lithotripsy (SWL) is a non-surgical technique for treating these stones in the kidney or ureter. The technique uses high energy shockwaves to break the stones into smaller fragments which can then pass spontaneously.

Stones can be observed to see if they pass spontaneously, or treated with shockwave lithotripsy, or surgical techniques such as ureteroscopy (URS) and percutaneous stone surgery (PCNL), both of which may involve placing a stent.

The optimal management depends on the type, size and location of the stone as well as patient factors such as co-morbidity and pregnancy. For appropriate stones SWL is advantageous as it is non-invasive and so has fewer major adverse events than surgery.

This guidance applies to adults aged 19 years and over.

Policy:

Please refer to NICE Guidance [NG118] (recommendation 1.5) Renal and ureteric stones: assessment and management.

Adult renal stones

<5mm: If asymptomatic consider watchful waiting

5-10mm: If not suitable for watchful waiting offer SWL as first-line treatment (unless contra-indicated or not targetable)

10-20mm: Consider SWL as first-line treatment if treatment can be given in a timely fashion. URS can also be considered if SWL is contraindicated or ineffective

Over 20mm (including staghorn): Offer percutaneous nephrolithotomy (PCNL) as first-line treatment

Adult ureteric stones

<5mm: If asymptomatic consider watchful waiting with medical therapy e.g. Alpha blocker for use with distal ureteric stones

5-10mm: Offer SWL as first-line treatment where it can be given in a timely fashion (unless contra-indicated or not targetable)

10-20mm: Offer URS but consider SWL if local facilities allow stone clearance within 4 weeks.

Vasectomy

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

Vasectomy can be carried out under local anaesthetic and carried out in community clinics outside of the hospital setting.

Policy:

The following criteria for commissioning apply to vasectomies performed in primary care:

- The patient has been counselled about the nature of the operation and the limitations of reversibility including funding.

The following criteria for commissioning apply to vasectomies performed in secondary care:

- The patient has been counselled about the nature of the operation and the limitations of reversibility including funding.
- Medical reasons preventing the procedure being performed in a primary/community setting are present.

This guidance applies to males born with testis, adults aged 19 years and over, and trans, nonbinary, and intersex people with testis.

This policy does not apply to gender reassignment surgery.

Vascular

Varicose Veins Interventions

Category: *(IFR / Prior Approval / Monitored Approval)*
Prior Approval

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Varicose veins are dilated, often palpable subcutaneous veins with reversed blood flow. They are most commonly found in the legs. Estimates of the prevalence of varicose veins vary. Visible varicose veins in the lower limbs are estimated to affect at least a third of the population. Risk factors for developing varicose veins are unclear, although prevalence rises with age and they often develop during pregnancy.

In some people varicose veins are asymptomatic or cause only mild symptoms, but in others they cause pain, aching or itching and can have a significant effect on their quality of life. Varicose veins may become more severe over time and can lead to complications such as changes in skin pigmentation, bleeding or venous ulceration. It is not known which people will develop more severe disease but it is estimated that 3–6% of people who have varicose veins in their lifetime will develop venous ulcers.

Policy:

Referral to and management in secondary care (including sclerotherapy) may be commissioned if ONE of the following criteria are met:

- Varicose eczema
- Lipodermatosclerosis or a varicose ulcer
- At least two episodes of documented superficial thrombophlebitis
- A major episode of bleeding from the varicosity

Section 2:

Not routinely commissioned procedures

This section includes all policies which require approval to be confirmed prior to the treatment taking place via IFR as they are not routinely commissioned.

The procedures listed below are not commissioned in any circumstance by the ICB due to their cosmetic/aesthetic nature, or due to lack of evidence of clinical or cost effectiveness. Clinicians are expected to direct patients to access these procedures privately if their shared decision is that there would be benefit to the individual.

In EXCEPTIONAL circumstances funding could be considered by the IFR process, although clinicians and patients are reminded that the threshold for exceptionality is high and approval would not normally be expected.

Breast Surgery

Breast Enlargement **Category:** *(IFR / Prior Approval / Monitored Approval)* **IFR** **Local or National EBI (Evidence Based Interventions) Policy:** **Local**
Background: This policy does not apply to reconstruction post mastectomy. **This policy does not apply to gender reassignment surgery.**
Policy: Breast Augmentation for purely cosmetic purposes is not routinely commissioned.

Breast Reduction - Gynaecomastia

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Gynaecomastia is defined as the benign enlargement of male breast tissue, resulting from a proliferation of the glandular component of the breast. Firm subareolar gland and ductal tissue will be palpable on examination, as opposed to breast enlargement caused by excess adipose tissue, which is referred to as pseudogynaecomastia. Gynaecomastia is common, with an incidence of more than 30%. It can occur at any age and may be physiological or pathological. It results from relative oestrogen excess or relative testosterone deficiency resulting in a high oestrogen-to-testosterone ratio. Physiological gynaecomastia occurs in the newborn period, during puberty, and with ageing and obesity. Gynaecomastia is more common in men aged over 50, owing to the general decline in testosterone levels and a tendency towards weight gain in later life. In overweight men, breast tissue is stimulated by excess oestrogen resulting from the conversion of testosterone to oestradiol by the enzyme aromatase found in adipose tissue.

Policy:

Surgery to remove gynaecomastia is not routinely commissioned.

This policy does not apply to gender reassignment surgery.

Nipple inversion correction

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

An inverted nipple is a condition defined as the nipple, which is retracted inwards, rather than pointing outwards, as is seen in normal anatomy. It can occur in both sexes and can be congenital or acquired.

Policy:

Surgery to correct nipple inversion is not routinely commissioned.

Cardiovascular

Respirate device for hypertension

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

A respirate device can be used to slow down breathing and create a state of meditation and relaxation. This can reduce blood pressure but there is no clinical evidence to support this.

Policy:

Due to lack of clinical evidence this device is not commissioned.

Complementary and Alternative Medicine

Complementary and Alternative Medicines

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Complementary and Alternative Medicines include:

- Alexander technique
- Applied kinesiology
- Aromatherapy
- Autogenic training
- Ayurveda
- Chinese medicine
- Chiropractic therapy
- Complementary healing therapy
- Environmental medicine
- Herbal medicine
- Homeopathy
- Hydrotherapy
- Hypnosis
- Massage
- Meditation
- Naturopathy
- Nutritional therapy
- Osteopathy
- Reflexology
- Reiki
- Shiatsu
- Therapeutic community method for borderline personality
- Any other complimentary and alternative medicine not on the list above.

Policy:
Not routinely commissioned

Dermatology

Benign Skin Lesions

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Removal of benign skin lesions means treating asymptomatic lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a small risk of infection, bleeding or scarring and is not usually offered by the NHS if it is just to improve appearance. In certain cases, treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to pre-malignant lesions and other lesions with potential to cause harm.

Policy:

Not commissioned for purely cosmetic purposed in any setting (primary care, community care and secondary care)

If there are clinical reasons for removal see separate policy for guidance.

ENT

Intervention for snoring (in the absence of Obstructive Sleep Apnoea)

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:

National EBI

Background:

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner.

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.

Policy:

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)

Pinnaplasty

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Pinning back the ears is known as an otoplasty or pinnaplasty. It's usually done on children and young teenagers, although adults can also have it done.

Policy:

This procedure is not routinely commissioned.

Rhinophyma - surgical correction

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Rhinophyma is a swelling of the nose. If the condition progresses, the nose becomes redder, swollen at the end and gains a bumpy surface which changes its shape. This swelling is because there is formation of scar-like tissue and the sebaceous glands (which produce oil on the skin) get bigger.

Policy:

Surgical correction of Rhinophyma is not routinely commissioned.

Rhinoplasty

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Rhinoplasty is the surgical reshaping of the nose.

Policy:

This procedure is not routinely commissioned.

Snoring – surgical treatment including reduction of the tongue

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Midline glossectomy surgery is used to reduce the size of the tongue and increase the size of your airway. One common midline glossectomy procedure involves removing parts of the middle and back of the tongue. Sometimes, a surgeon will also trim the tonsils and partially remove the epiglottis.

Policy:

This surgical correction for snoring is not routinely commissioned.

Tonsillectomy as a treatment for snoring

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

UPPP is a surgical procedure done under local anesthesia that involves removing some the soft tissues in the back and top of the throat. This includes the uvula, which hangs at the throat's opening, as well as some of the throat walls and palate.

This makes breathing easier by keeping the airway more open. While rare, this surgery can cause long-term side effects like problems swallowing, voice changes, or the permanent feeling of something in your throat.

Policy:

This surgical correction for snoring is not routinely commissioned.

Fertility

Reversal of sterilisation **Category:** *(IFR / Prior Approval / Monitored Approval)* **IFR** **Local or National EBI (Evidence Based Interventions) Policy:** **Local**
Background: Both Vasectomy and Tubal Occlusion are available on the NHS as permanent forms of contraception. Whilst the procedures can be reversed this is not available on the NHS.
Policy: Not routinely commissioned.

General Surgery

Diagnostic Investigations for IBS

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

There's no test to definitively diagnose IBS . Your health care provider is likely to start with a complete medical history, physical exam and tests to rule out other conditions, such as celiac disease and inflammatory bowel disease (IBD).

Policy:
Diagnostic investigations to confirm IBS are not commissioned.

Gynaecology

Hymen Reconstruction

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Hymen reconstruction surgery, also known as hymen surgery, hymenoplasty surgery or hymen restoration, is the surgical repair of the hymen. Using a surgical technique, the torn edges of the hymen are put back together. If done correctly, to the visible eye, there is no apparent scarring and the hymen appears intact. After this type of hymen surgery and without complication, subsequent intercourse will typically tear the membrane causing pain and bleeding.

Policy:
This surgery is not routinely commissioned

This guidance applies to females born with an intact hymen, adults aged 19 years and over, and trans, nonbinary, and intersex people born with an intact hymen.

This policy does not apply to gender reassignment surgery.

Neurology

Cranial Banding for positional plagiocephaly

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Non-synostotic/positional plagiocephaly and brachycephaly are distortions of the skull (flattening to the side or the back of the head) that most commonly become apparent in the first few months of life as a result of the amount of time a baby spends lying on their back. Non-synostotic/positional plagiocephaly and brachycephaly are very common, affecting up to 40% of infants (as opposed to synostotic conditions which are rare).

Cranial Moulding Orthosis – or 'helmet therapy' – is an intervention that claims to correct the shape of the head. A specially moulded solid helmet is created (with space to allow the flattened area to re-mould) that must be worn 23 hours a day. This helmet requires repeated adjustments as the baby grows.

Policy:
This treatment is not routinely commissioned

Ophthalmology

Excimer laser for corneal erosions

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

In phototherapeutic keratectomy, PTK, an excimer laser is used to ablate 5 to 10 µm of Bowman's layer after mechanical debridement of the overlying corneal epithelium. Like superficial keratectomy, this allows the cornea to re-epithelialize with stronger adhesion to the basement membrane.

Policy:
This treatment is not routinely commissioned

Myopia surgical and laser treatment

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Near-sightedness, called myopia, is a condition in which you see nearby objects clearly, but distant objects are blurry. When your eyeball is slightly longer than average or when the cornea curves too sharply, light rays focus in front of the retina and blur distant vision. You can see closer objects more clearly, but not those that are far away.

Policy:
Surgical treatment and Laser treatment to correct Myopia is not routinely commissioned

Toric intraocular lens implant for astigmatism

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

A *toric IOL* is a bespoke lens placed inside an eye to correct a patient's astigmatism, at the same time reducing the patient's short- or long-sightedness. After surgery, the chance of needing glasses for distance is greatly reduced, although *without* the simultaneous placement of a *multifocal lens* (*'toric multifocal'*), patients should still expect to need reading glasses.

Policy:

This treatment is not routinely commissioned.

Orthopaedics

Autologous chondrocyte implantation **Category:** *(IFR / Prior Approval / Monitored Approval)* **IFR** **Local or National EBI (Evidence Based Interventions) Policy:** **Local**
Background: Autologous chondrocyte implantation (ACI) is a procedure to treat articular cartilage defects of the knee.
Policy: Not routinely commissioned

Back Pain – Xray for axial low back pain

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Low back pain does not necessarily correlate with imaging findings. Patients with acute or subacute low back and without clinical evidence of specific serious conditions (neurological symptoms, red flags or extravertebral causes) have been shown to have no improvement or difference in outcome after imaging and therefore imaging should be avoided in those patients

Policy:

Not routinely commissioned

Diagnostic Knee Arthroscopy

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Undertaking an arthroscopy of the knee should not be performed for diagnostic purposes only.

Policy:

Not routinely commissioned.

Dupuytren's radiation treatment for early disease

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Low-dose radiotherapy can provide pain relief and prevent the progression of Dupuytren's contracture

Policy:

Not routinely commissioned

Epidural injections non-radicular/axial pain and failed back surgery syndrome

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

The steroid allows the nerve(s) time to heal. Epidural steroid injections most often lead to temporary pain relief, but in some cases, people experience long-term or permanent pain relief.

Policy:

Not routinely commissioned

Exogen bone healing

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

EXOGEN ultrasound bone healing system for long bone fractures within non-union or delayed healing. EXOGEN delivers low-intensity pulsed ultrasound waves with the aim of stimulating bone healing. It is thought that healing is promoted by stimulating the production of growth factors and proteins that increase the removal of old bone, increase the production of new bone and increase the rate at which fibrous matrix at a fracture site is converted to mineralised bone. Long bone fractures are suitable for treatment if the fracture is stable and well-aligned.

Policy:

Not routinely commissioned for elective procedures.

Extracorporeal shockwave therapy for plantar fasciitis

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Plantar fasciitis is a common foot condition caused by inflammation of the plantar fascia. The plantar fascia is a thick fibrous band of tissue connecting the heel to the ball of the foot and plays a vital role in supporting the arch of the foot.

Shockwave therapy is a treatment for recalcitrant Achilles tendinopathy and plantar fasciitis. It is a non-invasive procedure that delivers shockwaves to the symptomatic area of the foot (Achilles tendon or plantar fascia). The shockwaves are low energy audible sound waves (not electric waves), that increase the blood flow to speed up the body's healing process. Extracorporeal means outside of the body and refers to the way the shockwaves are delivered.

Policy:

Not routinely commissioned.

Facet Joint Injections (therapeutic - low back pain)

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

A facet joint injection is an injection of local anaesthetic, with or without steroid, either directly into the joint or into the path of the small nerve which supplies sensation to the joint.

Policy:

Not routinely commissioned due to short term nature of the effect of the treatment.

Hip resurfacing

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

In hip resurfacing, the femoral head is not removed, but is instead trimmed and capped with a smooth metal covering. The damaged bone and cartilage within the socket are removed and replaced with a metal shell, just as in a traditional total hip replacement.

Policy:

Not routinely commissioned.

Ilizarov treatment / Taylor spatial frame

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

An ilizarov frame is an external frame surgeons use to lengthen or reshape bones or to treat complex mal-union or non-union fractures.
Ilizarov frames can also be used when treating infections in bones. The type of frame used depends on what limb is being treated.

When the frame is in place, stainless steel or titanium rings are usually attached to healthy bone at the top and bottom using heavy wire. Tension is applied in the healthy bone, bypassing the area being treated and keeping it immobile and stress free.

Policy:

Not routinely commissioned.

Injections for lower back pain without sciatica

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Spinal injections of local anaesthetic and steroid in people with non-specific low back pain without sciatica.

Policy:
This treatment is not routinely commissioned

Joint revisions (using bespoke prosthesis)

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Joint replacements have a life span and will need revision surgery after time.

This policy related to the procedures where a bespoke prosthesis is used in the revision surgery.

Policy:

Not routinely commissioned.

Lower back pain imaging

Category: *(IFR / Prior Approval / Monitored Approval)*
Monitored

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:
The evaluation of low back pain by a medical provider should include a complete medical history and examination. It should be established if any “red flag” signs or symptoms are present that could indicate serious underlying pathology.

Serious underlying pathology includes but is not limited to:cysto

- Infection
- Suspected cancer
- Spinal injury
- Spinal cord compression
- Inflammatory conditions
- Patients with cancer and symptoms suggestive of spinal metastases
- Spondyloarthritis in over 16s
- Cauda equina syndrome

This guidance applies to adults aged 19 years and over.

Policy:
Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags, or suspected serious underlying pathology following medical history and examination.

Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease.

Patients presenting with low back pain and sciatica should be reviewed in accordance with the low back pain and sciatica guidance [NG59]. Patients presenting with low back pain without sciatica should be reviewed and if none of the above serious underlying pathology are suspected, primary care management typically includes reassurance, advice on continuation of activity with modification, weight loss, analgesia, manual therapy and reviewing patients who are high risk of developing chronic pain (i.e. STaRT Back).

NICE guidelines recommend using a risk assessment and stratification tool, (e.g. STaRT Back), and following a pathway such as the National Back and Radicular Pain Pathway, to inform shared decision making and create a management plan.

Consider a combined physical and psychological programme for management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training

(BeST). Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management.

For further information please see the following NICE guidance:

- NICE. Low back pain and sciatica in over 16s: assessment and management [NG59]
- NICE. Low back pain and sciatica in over 16s [QS155]

Lumbar radiofrequency facet joint denervation

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
National EBI

Background:

Radiofrequency denervation, also known as ‘dorsal rhizotomy’ or ‘radiofrequency ablation,’ is a non-surgical and minimally invasive procedure that uses heat to reduce or stop the transmission of pain signals arising from one or more spinal facet joints. It is only recommended when other alternatives have failed.

This guidance applies to adults aged 19 years and over.

Policy:
This treatment is not routinely commissioned

Patella resurfacing

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Patella resurfacing can be undertaken during knee replacement surgery and is the removal of the under surface of the kneecap and insertion of a plastic surface in its place.

Policy:
This treatment is not routinely commissioned

Spinal Injections for low back pain other than the two restricted procedures

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

All other spinal injections not mentioned elsewhere in the policy.

Policy:
This treatment is not routinely commissioned

Therapeutic use of ultrasound in hip and knee osteoarthritis

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

This is a short term treatment for the pain to the joint from osteoarthritis.

Policy:
This treatment is not routinely commissioned

Other

Divarication of abdominal rectus

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Divarication of the rectus is a condition where the rectus abdominis muscles are no longer located next to each other as they run up and down the abdomen from the breastbone (xyphoid) to the pubic bone (symphysis pubis). The muscles separate from each other and is easiest to see when the patient does sit-ups and notices a linear bulge running up the centre of the abdomen. The most common cause in women is pregnancy. Heavier men can develop this condition in their upper abdomen as well.

The condition itself has no risk, because the inner aspect of the abdominal wall is smooth. This means that bowel cannot find its way into a hernia and potentially strangulate. However, the divarication can be associated with umbilical or epigastric hernias, discomfort of the abdominal wall to touch, poor balance, and a sense of a loss of a functional “core”. This loss of core strength can explain back pain that occurs in some patients with severe rectus divarication.

Pregnancy induced rectus divarication can cause a significant shape change to the abdominal wall, even for very slender patients. Males have their own unique pattern of rectus divarication noticed as a midline bulge located between the xiphoid and the umbilicus. When patients have significant pain or associated hernias, a repair can be performed.

Policy:

Surgery to correct divarication is not routinely commissioned

Electrolysis treatment for any condition

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Electrolysis is a hair removal treatment.

Policy:

This treatment is not routinely commissioned.

Endoscopy thoracic sympathectomy

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Endoscopic thoracic sympathectomy is used mainly as a treatment for excessive sweating (hyperhidrosis) but can also be used to help treat extreme facial flushing.

Policy:

This treatment is not routinely commissioned.

Gender reassignment procedures not part of the original package of care

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

The commissioning of gender reassignment follows national guidance. If any further procedures are required these are considered cosmetic.

Policy:

Any further treatment is not routinely commissioned.

Hyperhidrosis treatments, non-pharmacological

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Hyperhidrosis is excessive sweating. There are several treatments for this condition including prescription, iontophoresis, botox injections and surgery to remove the sweat gland

This policy relates to all treatments that are non-pharmacological.

Policy:

These treatments are not routinely commissioned.

Lymphoedema treatment in private specialist units

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. It can affect any part of the body, but usually develops in the arms or legs.

It develops when the lymphatic system does not work properly. The lymphatic system is a network of channels and glands throughout the body that helps fight infection and remove excess fluid.

Policy:

Treatment of Lymphoedema in any private clinic is not commissioned via the NHS.

Out of Area referrals for chronic fatigue / ME treatment

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

There are commissioned pathways for all patients within N&N for chronic fatigue and ME treatment.

Policy:

Pathways outside of the contracted agreements are not routinely commissioned.

Out of Area referrals to the independent sector for autism

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

There are commissioned pathways for all patients with or with suspected autism.

Policy:

Pathways outside of the contracted agreements are not routinely commissioned.

Pain Management

Acupuncture

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Acupuncture is a treatment derived from ancient Chinese medicine. Fine needles are inserted at certain sites in the body for therapeutic or preventative purposes.

Policy:

Acupuncture for any condition is not routinely commissioned.

Residential Pain Management programmes

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Residential pain management programmes are offered on an inpatient basis.

Policy:

This service is not routinely commissioned.

Plastics

Plastic Surgery treatments

Category: (IFR / Prior Approval / Monitored Approval)
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Plastic surgery procedures including:

- Abdominoplasty
- Aesthetic operations on umbilicus
- Benign anal rectal skin tags
- Body contouring
- Botulinum toxin for wrinkles, frown lines or aging neck
- Brachioplasty – upper arm lift
- Calf implants
- Cheek implants
- Chemical peels
- Chin implant
- Collagen implant
- Cosmetic surgery
- Earlobe repair
- Facelifts
- Fat grafts
- Forearm implants
- Hair depilation for excessive hair growth
- Hair transplantation
- Labiaplasty
- Laser skin conditions causing scarring
- Laser treatment / therapy / tunable dye laser for aesthetic reason
- Laser treatment for cosmetic reasons
- Laser treatment for facial hyperpigmentation
- Liposuction
- Neck lift
- Removal of excess skin following weight loss by whatever means
- Removal of supernumerary nipples
- Repair of chronic clefts due to avulsion of body piercing
- Resurfacing botulinum toxin for the following indications: wrinkles, frown lines and ageing neck
- Suction assisted lipectomy
- Surgical scars
- Vaginoplasty
- Any other purely cosmetic/aesthetic that is not mentioned within the policy

Policy:

Not routinely commissioned

Urology

Circumcision for non-medical reasons **Category:** *(IFR / Prior Approval / Monitored Approval)* **IFR** **Local or National EBI (Evidence Based Interventions) Policy:** **Local**
Background: Medical reasons for circumcision are covered elsewhere within this policy. Circumcision for any other reason is non medical.
Policy: Not routinely commissioned

Phalloplasty

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Phalloplasty is the construction or reconstruction of a penis or the artificial modification of the penis by surgery

Policy:

Not routinely commissioned

Sacral nerve stimulation

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Sacral nerve stimulation involves electrical stimulation of the nerves that control the bladder and rectal muscles.

Policy:

Not routinely commissioned

Vascular Surgery

Thread veins / Telangiectasia

Category: *(IFR / Prior Approval / Monitored Approval)*
IFR

Local or National EBI (Evidence Based Interventions) Policy:
Local

Background:

Telangiectasia varicose veins – also known as thread veins or spider veins, these are small clusters of blue or red veins that sometimes appear on your face or legs; they're harmless and, unlike trunk varicose veins, do not bulge underneath the surface of the skin.

Policy:

Treatment to correct telangiectasia are not routinely commissioned.

Equality and Diversity Statement

NHS Nottingham and Nottinghamshire ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, as a commissioner and provider of services, as well as an employer.

The ICB is committed to ensuring that the way we provide services to the public and the experiences of our staff does not discriminate against any individuals or groups on the basis of their age, disability, gender identity (trans, non-binary) marriage or civil partnership status, pregnancy or maternity, race, religion or belief, gender or sexual orientation.

We are committed to ensuring that our activities also consider the disadvantages that some people in our diverse population experience when accessing health services. Such disadvantaged groups include people experiencing economic and social deprivation, carers, refugees and asylum seekers, people who are homeless, workers in stigmatised occupations, people who are geographically isolated, gypsies, Roma and travellers.

As an employer, we are committed to promoting equality of opportunity in recruitment, training and career progression and to valuing and increasing diversity within our workforce.

To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed and is included within this policy.