Section 1: IFR & Prior Approval Policies

Policies which require approval to be confirmed prior to the treatment taking place

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Breast Surgery

Breast – Asymmetry	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

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

Policy:

Surgical correction of breast asymmetry will not be routinely funded.

Please note: this policy does not apply to breast reconstruction or other surgery to obtain symmetry as part of the treatment for breast cancer.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Augmentation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

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

Policy:

Breast augmentation will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Inverted Nipple Correction	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The term inverted nipple refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological disturbance. Nipple inversion may occur as a result of an underlying breast malignancy, and it is essential that this be excluded.

Policy:

Surgery for the correction of inverted nipple for cosmetic reasons will not be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Mastopexy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breasts begin to sag and droop with age as a natural process. Pregnancy, lactation and substantial weight loss may escalate this process. This is sometimes complicated by the presence of a prosthesis which becomes separated from the main breast tissue leading to "double bubble" appearance.

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

Policy:

Mastopexy will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Prosthesis Replacement	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breast prosthesis may have to be removed after some complications such as leakage of silicone gel or physical intolerance. This policy deals with the potential replacement of a prosthesis.

Policy:

Breast Prosthesis replacement will only be funded under the following circumstances:

- There is grade 4 capsule formation OR radiological evidence of implant failure OR the patient has a Poly Implant Prosthesis (PIP) implant.

AND

- The original procedure was provided by the NHS.

AND

- The original implant insertion was following cancer surgery, trauma, developmental asymmetry, or surgery for the alleviation of symptoms of gender dysphoria.

AND

- The replacement of prosthesis (on a like-for-like basis) has been discussed with the patient and is agreed as the best course of action by the treating clinician.

Please note – PIP Implants: If a patient has had Poly Implant Prostheses (PIP) breast implants originally fitted on the NHS, these may be removed and replaced. If a patient wishes to have replacement prosthesis following the removal of PIP implants, but the criteria above are not applicable, please follow the IFR process for these individual cases.

Please note: Replacement of both implants may occur where all criteria above are met for at least one implant being removed, and where the treating clinician and patient agreed the removal and replacement of both implants is the most appropriate outcome.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Breast – Reduction	Category: *(IFR / Prior Approval / Monitored Approval)*	Prior Approval
	Local or National EBI (Evidence Based Interventions) Policy:	National EBI

Background:

Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape. As excess weight is likely to exacerbate symptoms associated with large breasts, it is assumed that patients going forward for surgery will be near normal weight.

Assessing eligibility for surgery is problematic not least because there are several recognised approaches to measuring bra size http://www.wikihow.com/Measure-Your-Bra-Size, some of which relate to historical manufacturing standards.

The following approach to calculating cup size is recommended for standardisation (extracted from Modern Sizing section of above reference): subtract band size (below the breast) from the bust size (at the widest point). The difference between the two numbers determines cup size:

Less than 1 inch difference = AA
1 inch difference= A
2 inches = B
3 inches = C
4 inches = D
5 inches = DD
6 inches = DDD (E in UK sizing)
7 inches = DDDD/F (F in UK sizing)
8 inches = G/H (FF in UK sizing)
9 inches = I/J (G in UK sizing)
10 inches = J (GG in UK sizing)

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

Policy:

Breast reduction will only be funded in accordance with ALL of the criteria specified below.
For women:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.

AND

- In cases of thoracic / shoulder girdle discomfort, a physiotherapy assessment has been provided.

AND

- Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).

AND

- Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.

AND

- Body mass index (BMI) is <27 and stable for at least twelve months.

AND

- Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery.

AND

- Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.

AND

- Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Repeat surgeries will not be routinely commissioned.

Breast – Revisions of Breast Reconstruction Surgery & Repeated Courses of Nipple Tattooing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Breast reconstruction is surgery to make a new breast after removal of the breast or part of the breast **due to cancer treatment or prevention**. The aim is to make a breast of similar size and shape to the original breast. Breast reconstruction can be done at the same time as the cancer surgery (immediate reconstruction), or after cancer surgery (delayed reconstruction) and may involve the use of implants to achieve the desired effect. Nipple tattooing is also a recognised procedure in relation to breast reconstruction surgery following treatment for breast cancer, in order to improve the appearance of the breast.

Policy:

A full course of treatment will be funded for patients undergoing either immediate or delayed breast reconstruction surgery, to include all aspects of the reconstruction. This includes the provision of implant(s) for the reconstruction, and one course of treatment for Nipple Tattooing.

Revisions of reconstruction surgery for purely cosmetic reasons and further courses of Nipple Tattooing will not be funded.

Please Note: Breast Reconstruction Surgery Post Mastectomy does NOT require Prior Approval

Cardiology

Exercise ECG for Screening for Coronary Heart Disease	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	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).

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.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

ECG for Screening for Coronary Heart Disease will NOT be routinely funded.

Cardiovascular

Respirate Devices for Hypertension	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Respirate is a portable electronic device that promotes slow, deep breathing. Respirate is approved by the Food and Drug administration for reducing stress and lowering blood pressure.

Policy:

Respirate device for hypertension is not routinely commissioned owing to inadequate evidence of long-term benefit over other relaxation techniques.

As such, clinicians should not routinely prescribe or recommend this product to patients either as monotherapy or an adjunct to pharmacological management because there is limited clinical evidence of effectiveness.

Complementary & Alternative Medicines

Complementary & Alternative Medicines	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Complementary and alternative medicines (CAMs) are treatments that fall outside of mainstream healthcare. These medicines and treatments range from acupuncture, massage and homeopathy to aromatherapy, meditation transcutaneous electrical nerve stimulation (TENS) and colonic irrigation.

Policy:

Complementary and alternative therapies, outside of existing ICB'S commissioned services and pathways, will not be routinely funded.

Dermatology

Hyperhidrosis - Referral	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine, or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits, and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.

Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics, wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods, or crowded areas. Underlying anxiety should be treated.

More patient information and support are available from Hyperhidrosis UK. http://hyperhidrosisuk.org/

References: http://cks.nice.org.uk/hyperhidrosis#!scenario
http://www.bad.org.uk/
http://hyperhidrosisuk.org/

Policy:

Referral for Hyperhidrosis will only be funded in accordance with the criteria below:

- The search for an underlying cause has been exhausted.

AND

- Any underlying anxiety has been identified and managed.

AND

- Advice on lifestyle management has been followed for a minimum of 2 months (use an antiperspirant frequently, avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat)

AND

- 20% aluminium chloride hexahydrate has failed or is contraindicated.

AND

- Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4

AND

- The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections).

Note: There must be a minimum of 6 months duration between Botulinum Toxin injections.

Hyperhidrosis - Thoracic Sympathectomy (Endoscopic or Open)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, mostoften an infectious, endocrine, or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.

Policy:

Thoracic Sympathectomy (Endoscopic or Open) for the treatment of hyperhidrosis is not routinely funded.

Hyperhidrosis Treatment with Botulinium Toxin	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hyperhidrosis is a condition characterised by excessive sweating and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, mostoften an infectious, endocrine, or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits, and the face of otherwise healthy people. The principal management strategies for hyperhidrosis are medical https://cks.nice.org.uk/hyperhidrosis

Botulinum Toxin is only licensed for the treatment of severe axillary hyperhidrosis and its cost effectiveness compared to other treatment options is yet to be established.

Policy:

Botulinum Toxin will only be funded in the management of severe *axillary* hyperhidrosis in accordance with the criteria below:

- The search for an underlying cause has been exhausted.

AND

- Any underlying anxiety has been identified and managed.

AND

- Advice on lifestyle management has been followed for a minimum of 2 months (use an antiperspirant frequently, avoid tight clothing and manmade fabrics, wear white or black clothing to minimize the signs of sweating, consider dress shields to absorb excess sweat)

AND

- 20% aluminium chloride hexahydrate has failed or is contraindicated.

AND

- Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4

AND

- The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections).

AND

- In the opinion of an experienced dermatologist, other treatment options have been exhausted (including anticholinergics eg: propantheline)

AND

- The patient is 17 years or older.

Note: There must be a minimum of 6 months duration between Botulin Toxin injections

Removal of Benign Skin Lesions	Category: *(IFR / Prior Approval / Monitored Approval)*	Prior Approval
	Local or National EBI (Evidence Based Interventions) Policy:	National EBI

Background:

The NHS does not remove benign skin lesions for cosmetic reasons.

The NHS will only remove benign skin lesions that are causing significant physical symptoms as listed below in the policy criteria.

Benign skin lesions (across the body including eyelids) include a wide range of skin disorders such as epidermoid and pilar cysts (sometimes referred to as sebaceous cysts) , dermoid cyst, lipoma(ta), skin tags (including anal skin tags), milia, molluscum contagiosum, seborrheic keratoses (basal cell papillomata), spider naevus (telangiectasia), non-genital viral warts in immunocompetent patients, sebaceous cysts, thread veins, xanthelasma, dermatofibromas, benign pigmented moles, neurofibromata, comedones, and corn/callous.

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:

Removal, cryotherapy, or treatment (in secondary care) of benign skin lesions will only be funded in accordance with the criteria specified below:

- There is well documented evidence of significant pain (see FAQs)

OR

- There is documented evidence of significant recurrent bleeding of 3 or more bleeds within a year of sufficient severity to require a dressing for 24 hours.

OR

- There is documented evidence of significant recurrent infection that has required 3 or more courses of oral antibiotics within in a year OR hospital admission has been required and a course of IV antibiotics has been administered.

OR

- There is impairment of visual fields.

Where the lump is rapidly growing, abnormally located and/ or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2-week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Note: If an IFR is obtained for the treatment of a keloid or hypertrophic scar, the number of treatments with intralesional triamcinolone will be limited to 3.

Rhinophyma	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Rhinophyma is the term used to describe the overgrowth and distortion of the soft tissues of the nose. This uncommon condition develops as an end point of chronic inflammatory processes within the rosacea spectrum. While the cosmetic impact is the most obvious consequence and may lead to social isolation and severe emotional distress, patients also commonly develop airflow obstruction, leading in some cases to complete nasal blockage.

The development of rosacea may be prevented or reduced by appropriate treatment of rosacea in the early stages, but once established there is rarely any benefit from medical management. The most effective surgical treatment for severe or symptomatic cases is a single local anaesthetic day case procedure to remove excess tissue and reshape the normal nasal contours using electrosurgery. The treatment site is left to heal naturally, with excellent results and high patient satisfaction in most cases.

Policy:

Surgical treatment for Rhinophyma is only offered as a treatment option for adults where the following criteria are met:

- There is significant phymatous change and where isotretinoin unlikely to be effective.

AND

- There is clear evidence of significant airflow obstruction or blockage.

AND

- Surgical treatment (including laser ablation when appropriate) has been recommended by a Consultant Dermatologist

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Diabetes

i-Port Advance for use in Children and Adults with Type 1 and Type 2 Diabetes	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The i-Port Advance is a device that may offer an alternative option to pump therapy in patients with Type 1 and Type 2 diabetes. Clinical evidence for the use of i-Port Advance device is limited, however, based on problems associated with insulin administration by injection(s), such as pain, anxiety (needle phobia), lipohypertrophy, and risk of infection, there may be some degree of acceptability for the device which may assist in achieving optimal glycaemic control reducing admissions from diabetic ketoacidosis (DKA) and reducing the insulin doses required.

Please note: Continued use of the i-Port Advance device should be reviewed every 3-6 months by an appropriate clinician. Where a patient meets the criteria, it is understood that Prior Approval remains in place for the period the patient requires the use of the device.

Policy:

The use of the i-Port Advance device in children or adults will be offered as a treatment option where the following criteria are met, and The Northern (NHS) Treatment Advisory Group recommends the use of i-Port Advance® for use in children and adults with Type – 1 diabetes as recommended by specialists for patients that fulfil the following criteria:

As an alternative option in the following groups of patients who would otherwise meet the NICE criteria for insulin pump therapy

- Patients in whom multiple daily injections are impractical and inappropriate where use of an injection port may avoid the need to move to insulin pump therapy.

OR

- Patients with significant anxiety and needle phobia who are avoiding or missing injections.

OR

- Patients with a raised HbA1C > 69mmol /l with poor compliance with treatment or who are injecting into lipohypertrophy despite support and advice to avoid these areas.

AND

- Treatment is only started by a secondary care multidisciplinary diabetes team including diabetes doctors, specialist nurses and dieticians.

AND

Continued use of i-Port Advance® device to be reviewed every 3-6 months.

Please note: Continued use of the i-Port Advance device should be reviewed every 3-6 months by an appropriate clinician. Where a patient meets the criteria, it is understood that Prior Approval remains in place for the period the patient requires the use of the device.

The Northern (NHS) Treatment Advisory Group recommends the use of i-Port Advance® for use in children and adults with Type 2 diabetes as recommended by specialists for patients that fulfil the following criteria in patients on more than one injection of insulin a day rather than an MDI/basal bolus regimen:

- Patients in whom multiple daily injections are impractical and inappropriate and where use of an injection port may improve glycaemic control.

OR

- Patients with significant anxiety and needle phobia who are avoiding or missing injections.

OR

- Patients with a raised HbA1C > 69mmol /l with poor compliance with treatment or who are injecting into lipohypertrophy despite support and advice to avoid these areas.

AND

- Continued use of i-Port Advance® device to be reviewed every 3-6 months.

Ear, Nose and Throat (ENT)

Adult Snoring Surgery (in the absence of Obstructive Sleep Apnoea – OSA)	**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 apnea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. Several alternatives to surgery are available and include weight loss, stopping smoking, reducing alcohol intake, medical treatment of nasal congestion and mouth splints.

Policy:

Due to the significant risks that patients could be exposed to and no evidence of longer-term benefits; this procedure is not routinely commissioned in the management of uncomplicated snoring.

This policy relates to adults only.

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:

Otitis media with effusion (OME) has a good prognosis. It is a self-limiting condition and 90% of children will have complete resolution within 1 year. Active observation for at least 3 months (watchful waiting) rarely results in long-term complications. There is no proven benefit from treatment with any medication or complementary or alternative treatments.

Insertion of ventilation tubes, or grommets, is the most common surgical treatment. Evidence suggests that the benefit of grommets on children's hearing gradually decreases in first year of insertion.

The procedure improves hearing in the short term (up to 12 months after surgery) but has not been shown to improve language or speech development. Parents / cares should have the risks and benefits of treatment clearly discussed with them. There should be evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

Policy:

Referral for a Specialist opinion when:

- Persistence of bilateral otitis media with effusion (OME) and hearing loss over 3 months

OR

- If hearing loss of any level is associated with a significant impact on the child's developmental, social, or educational status.

OR

- If hearing loss is severe.

OR

- The hearing loss persists on two documented occasions (usually following repeat testing after 6–12 weeks).

OR

- The tympanic membrane is structurally abnormal (or there are other features suggesting an alternative diagnosis).

OR

- There is a persistent, foul-smelling discharge suggestive of a possible cholesteatoma.

OR

- The child has Down's syndrome or has a cleft palate.

OR

- The child has recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective.

Ventilation tube (grommet) insertion will be funded in accordance with NICE guidance (CG60):

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

AND EITHER

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse, when averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available).

OR

- Exceptionally in children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.

OR

- The ventilation tube is inserted for the diagnosis of underlying sensorineural hearing loss.

OR

- The treatment of recurrent acute otitis media (defined as three or more episodes in 6 months, or four or more episodes in 12 months with at least one episode in the past 6 months) in whom conservative measures have been ineffective.

OR

- The treatment of chronic retraction of the tympanic membrane

OR

- Children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social, or educational status is judged to be significant.

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 postnasal 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

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Adenoidectomy should only be carried out when the following criteria are met:

- The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)

OR

- The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion.

OR

- The child is undergoing grommet surgery for treatment of recurrent acute otitis media.

OR

- Adenoidectomy as part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (e.g. as part of adenotonsillectomy)

OR

- Adenoidectomy as part of the treatment of chronic rhinosinusitis in children

OR

- Adenoidectomy for persistent nasal obstruction in children and adults with adenoidal hypertrophy

OR

- Adenoidectomy in preparation for speech surgery in conjunction with the cleft surgery team

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

Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities are surgical procedures performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image. The policy applies to all three procedures of Septorhinoplasty, Rhinoplasty, and Septoplasty.

Policy:

Rhinoplasty, Septoplasty, or Septorhinoplasty for nasal deformities will only be funded in accordance with the criteria specified below:

- Where conservative treatment has been exhausted.

AND

- Problems caused by obstruction of the nasal airway.

OR

- Objective nasal deformity caused by direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

OR

- Correction of complex congenital conditions to improve function e.g. cleft lip and palate.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Surgery for Sinusitis - Referral for Specialist Secondary Care Assessment	**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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

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 60mg)

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.

Tonsillectomy for Recurrent Tonsillitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Tonsillectomy is one of the most common surgical procedures in the UK. There is good evidence of effectiveness of tonsillectomy in children and recently evidence has emerged to suggest that it may also be clinically effective in adult, see link https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00519-6/fulltext and https://checkplus.nhs.uk/

Policy:

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

- The sore throats are due to acute tonsilitis.

OR

- There is a suspicion of malignancy.

OR

- Recurrent episodes of quinsy

In cases of sore throats due to acute tonsillitis:

- The episodes of sore throat are disabling and prevent normal functioning.

AND EITHER

- Seven or more well documented, clinically significant episodes of sore throat in the previous year.

OR

- Five or more such episodes have occurred in each of the preceding two years**.**

OR

- Three or more such episodes have occurred in each of the preceding three years.

This policy does not apply to Emergency Presentations (e.g. treatment of parapharyngeal abscess), or clinical conditions that could reasonably be expected to result in an emergency presentation (e.g. airway concerns) tonsil bleeding or deep neck infection. It also does not apply to OSAS in children. These diagnoses will be funded.

There is no restriction on funding for tonsillectomy to treat adult obstructive sleep apnea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful).

Tonsillectomy for the treatment of halitosis associated with tonsillitis will not be routinely funded.

Fertility

Assisted Reproduction Treatments	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR & Prior Approval** ***(please see detail of policy)***
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The Clinical Guideline on *fertility assessment and treatment* was published by NICE in February 2013 (NICE CG156, 2013) and covers all clinical procedures/pathways relating to fertility assessment and treatment.

This document provides a single specific commissioning policy for the NHS with the aim to ensure consistency in the application of the guideline across the Northeast & North Cumbria region.

Over 80% of couples in the general population will conceive within 1 year if:

- the woman is aged under 40 years.

AND

- they do not use contraception and have regular sexual intercourse.

Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate over 90%). [NICE 2004, amended 2013].

The estimated prevalence of infertility is one in seven couples in the UK. A typical Integrated Care Board can expect about 230 new consultant referrals (couples) per 250,000 head of population per year (NICE CG11, 2004).

All couples are eligible for consultation and advice from the specialist service

Policy:

Investigations to determine fertility are routinely commissioned on the NHS.

IVF / ICSI carried out as part of pre-implantation genetic testing is commissioned directly by NHS England and is therefore not covered by this policy.

The NHS does not routinely commission the following:

- Any treatment requiring surrogacy (paid or altruistic).
- Intrauterine or other artificial insemination for an otherwise fertile woman.
- Treatment when sub fertility is due to previous sterilisation procedure.
- Treatment when any party to the pregnancy with proposed parental responsibility has living children.
- Treatment when any party to the pregnancy with proposed parental responsibility has not been registered with a ICB'S in the areas covered by the policy for at least 1 year.
- Treatment for patients who are not eligible for NHS treatment in line with the Overseas Visitors Charging Regulations.

- Fertility preservation for patients whose fertility has not been at risk from iatrogenic or other medical conditions.
- Gamete donation (noting that altruistically donated gametes may be used in treatment at the discretion of treatment providers).
- Treatment for women after their 43rd birthday.
- Treatment when the female hoping to become pregnant is a smoker.
- Treatment when the female has a BMI <19 or >30.
- Treatment when the male party to the pregnancy has male factor infertility and is a smoker.

Policy: NHS funded fertility treatment is available to treat established infertility in the following circumstances:

Treatment for male factor infertility

Absolute or relative male factor infertility has been demonstrated on semenalysis.

In relative male factor sub fertility, there has been 2 years of regular vaginal intercourse* following health optimisation (ie BMI <30 and non-smoking for both parties).

*Regular vaginal intercourse is defined as 3 times per week.

Treatment of female factor infertility

Absolute or relative female factor infertility has been demonstrated on appropriate investigations.

In relative female factor sub fertility, if clinically appropriate, there has been either 2 years of regular heterosexual vaginal intercourse following health optimisation (BMI <30 & non-smoking for both parties) or 6 cycles of medically managed artificial insemination (by an HFEA licensed provider) with health optimisation (BMI <30 & non-smoking).

Treatment of unexplained infertility

There has been either 2 years of regular heterosexual vaginal intercourse following health optimisation (BMI <30 & non-smoking for both parties) or 6 cycles of medically managed artificial insemination (by an HFEA licensed provider) with health optimisation (BMI <30 & non-smoking).

Where the criteria for male factor, female factor or unexplained fertility have been met the NHS will fund IUI and/or IVF (incl ICSI) subject to the following criteria being met:

Ref	Policy	Access Criteria	Guidance Notes
1	**Fertility treatment female wishing to become pregnant under 40 years.** 1. 12 cycles of artificial insemination using partner's sperm or 6 cycles of donor sperm (by an HFEA licensed provider). 2. Up to 3* full cycles of IVF, with or without intracytoplasmic sperm injection (ICSI).	Female: BMI greater than 19.0 and lower than or equal to 30.0 and non-smoker at the start of treatment. Male factor infertility: Non-smoker at the start of treatment. If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles. *Refer to Guidance Notes	**3 full cycles of IVF** Inform people that normally a full cycle of IVF treatment, with or without ICSI should comprise 1 episode of ovarian stimulation and the associated episode transfer of the fresh and frozen embryo(s) relating to that cycle. Access to three cycles is not an automatic right – the outcome of any previous cycle will be taken into account. Treatment must be medically indicated at the start of each cycle. As IVF success rates decline significantly after 3 cycles, previous cycles received irrespective as to whether they were funded by the NHS or privately will be taken into account. If patients have funded 3 or more IVF cycles privately, they will not be entitled to any NHS funded cycles. If patients have funded 2 cycles privately, they will be entitled to 1 NHS cycle. If patients have funded 1 cycle privately, they will be entitled to 2 NHS cycles.

Ref	Policy	Access Criteria	Guidance Notes
2	**Fertility treatment female wishing to become pregnant aged 40 to 42 years.** 1. 12 cycles of artificial insemination using partner's sperm or 6 cycles of donor sperm (by an HFEA licensed provider). 2. Up to 1* full cycle of IVF, with or without intracytoplasmic sperm injection (ICSI). Treatment must start before the woman's 43rd birthday	Female: BMI greater than 19.0 and lower than or equal to 30.0 and non-smoker at the start of treatment Male factor infertility: Non-smoker at the start of treatment. Provided all the following 3 criteria are fulfilled: • They have never previously had IVF treatment. **AND** • There is evidence of good ovarian reserve as identified by a specialist clinician. **AND** • There has been a discussion of the additional implications of IVF and pregnancy at this age. *Refer to Guidance Notes	**1 full cycle of IVF** Inform people that normally a full cycle of IVF treatment, with or without ICSI should comprise 1 episode of ovarian stimulation and the associated episode transfer of the fresh and frozen embryo(s) relating to that cycle. **Ovarian reserve testing** The aim is to select those with at least 10% chance of successful treatment. The criteria remain under review. At present use the following criteria to predict the likely ovarian response to gonadotrophin stimulation in women who are eligible for IVF treatment: • Total antral follicle count of more than or equal to 4 **AND** • Anti-Müllerian hormone of more than or equal to 5.4 pmol/l.

Fertility Preservation

Policy: The NHS will fund fertility preservation for anyone who is at high risk of premature infertility from iatrogenic or other medical conditions including women who are at high risk of idiopathic premature ovarian failure (POF).

Note: in the case of idiopathic POF, high risk is defined as having more than one affected direct family member.

Embryo / Gamete Harvesting & Storage

Policy: The NHS will fund embryo / gamete harvesting and storage for those patients who have had their fertility preservation funded by the NHS in accordance with the fertility preservation policy for:

- An initial period of one year (subject to clinical review at the end of the period)
- A further period of up to 10 years (subject to clinical review at the end of the period)
- For females up to a period for which the female remains eligible for NHS fertility treatment. Once the female has reached the maximum age for NHS fertility treatment the patient should have the option to privately fund storage should this be clinically appropriate.
- For males a period up to 55 years in total from fertility preservation.

Gametes stored by the NHS will not be preserved after the patient has deceased.

Patients who have had gamete storage funded by the NHS will be subject to the NHS fertility treatment policy at the time they wish to use the gametes.

Embryo Storage following NHS funded Assisted Reproduction Treatment

The NHS will fund embryo storage for embryos which have been funded by the NHS in line with the Fertility Policy. Embryos will be stored by the NHS up to the time that the female reaches the maximum age for fertility treatment on the NHS. Any embryos stored or created by the NHS will not be preserved after the patient has deceased.

Note: Any embryos stored before the woman's 43rd Birthday may be implanted within 12 months of the date storage commenced*.

* The rationale for this is that the embryo has been created while the female is compliant in line with the policy.

Gastroenterology

Appropriate Colonoscopy in the Management of Hereditary Colorectal Cancer (monoallelic MUTYH)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

NOTE: Colonoscopy in relation to specific conditions / interventions, should only be carried out where the specified criteria are met – see the appropriate policy under the Monitored Approval section.

Policy:

Appropriate colonoscopy in the management of hereditary colorectal cancer for monoallelic MUTYH pathogenic variant carriers

- **Colonoscopy in the management of hereditary colorectal cancer for monoallelic MUTYH pathogenic variant carriers is NOT routinely commissioned**

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:

Cholecystectomy for asymptomatic gall stones will only be funded in exceptional clinical circumstances through an Individual Funding Request. Bile duct clearance and laparoscopic cholecystectomy will be funded for both symptomatic and asymptomatic stones in the common bile duct.

Note: The referrer should include evidence that there is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right Care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

General Surgery

Anal Fissure (Surgery)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

An anal fissure is a tear in the lining of the lower rectum (anal canal) that causes pain during bowel movements.

Policy:

For referral to secondary care the patient should meet at least one of the following criteria:

- Multiple, off the midline, large or irregular (atypical fissures) as these may be the manifestation of underlying disease.

OR

- Children whose anal fissure has not healed after 2 weeks.

OR

- Severe pain refractory to conservative therapy and impacting on patient wellbeing.

OR

- Persisting anal fissure not healed after 8 weeks of conservative management.

OR

- Symptoms suggestive of systemic disease e.g. inflammatory bowel disease.

Consider referring an elderly person earlier to exclude an anal or low rectal malignancy.

A 2 week wait referral should be considered for patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding **and** any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron-deficiency anaemia'.

Referral for Bariatric Surgery	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local and incorporating the National EBI Policy**

Background:

ICBs took over the responsibility of commissioning bariatric surgery for patients (Adults only – those aged 18 years and over) from NHS England from 1st April 2017. As such, ICBs adopted the same criteria as previously undertaken by NHSE Commissioning colleagues and now in keeping with the Academy of Medical Royal Colleges Evidence Based Interventions List 3 Guidance and NICE CG189, updated July 2023.

Policy:

- For individuals with a BMI of 50 or more, surgery should be considered as a first-line treatment intervention.

Surgery will only be considered as a treatment option for other adults with morbid obesity providing all of the following criteria are fulfilled:

- The individual is considered morbidly obese (obesity class 3) – classified as adults with a BMI of 40kg/m2 or more**.**

OR

- The individual is between 35 kg/m2 and 40kg/m2 in the presence of significant obesity-related complications likely to improve with weight loss (for example cardiovascular disease, hypertension, idiopathic intracranial hypertension, non-alcoholic fatty liver disease with or without steatohepatitis, obstructive sleep apnoea, or type 2 diabetes.).

OR

- The individual has a BMI of 30 kg/m2 or more with type 2 diabetes of less than 10 years duration.

(Note: These BMI thresholds should be reduced by 2.5 kg/m2 if the individual is of South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean family origin.)

AND

- Appropriate non-surgical measures have been tried but the individual has not achieved or maintained adequate, clinically beneficial weight loss.

AND

- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity/complexity assessment, risk stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.

AND

- The individual has been receiving or will receive intensive assessment and management in a tier 3 or tier 4 service**.**

AND

- The patient is otherwise fit for anaesthesia and surgery.

AND

- The patient commits to long-term follow-up after surgery (for example, lifelong annual reviews)

AND

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

Weight Loss Programmes (non-surgical Tier 3/4)

- This will have been for a duration of 12-24 months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist, and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure.

- Important features are the multidisciplinary, structured, and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care, the service will select and refer appropriate patients for consideration for bariatric surgery.

Notes:

1. Where Weight Loss Programmes (non-surgical Tier 3/4) are not available locally, the expectation is that patients, who meet the criteria as stated above, will receive a similar specialist weight management approach in a Tier 4 service provider. This is in line with NICE Guidance and to prevent exacerbation of health inequalities.

2. After surgery, the host bariatric surgery unit should follow up with the patient for two years. Thereafter, responsibility for follow up should be handed over to either the local non-surgical Tier 3 service OR the patient's GP as part of a shared care model with primary care, who should conduct yearly appointments. These appointments should include weight measurement and a request for nutritional blood tests.

Bariatric Surgery - Revisional Procedures	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Revisional surgery is an additional attempt to maintain or secure further improvements in weight loss, resolution and improvement of obesity-related co-morbidities and gains in quality of life.

Policy:

Revisional procedures will only be considered electively for clinical reasons due to complications where one of the following criteria has been met:

- Surgical complications including technical problems arising from the original bariatric surgical procedure. These may present as severe gastrointestinal symptoms such as reflux, nausea, vomiting, dysphagia, or inability to tolerate solid foods.

OR

- Medical complications of the primary procedure including profound macro and micronutrient deficiencies; anaemia, malnutrition, and metabolic abnormalities such as disabling intractable hypoglycaemia.

OR

- Failure of the primary operation to provide adequate, stable, and durable weight loss with adequate resolution of weight related comorbidities, or to address significant weight regain, frequently with re- emergence of pre-operative comorbidities

Groin Hernia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

An inguinal hernia **is the most common hernia** (about 70% of all hernias). Femoral hernias account for less than 10% of all groin hernias. However, they frequently become incarcerated or strangulated due to the small size of this space through which they protrude and hence present as emergencies in most cases[4] with 40% presenting as emergencies[5]. The incidence of femoral hernias is higher in women than men. In general, women have an increased risk of emergency procedure from groin hernias compared to men.

Policy:

Referral to secondary care and subsequent surgical treatment will be provided where patients meet one or more of the following criteria (NB: Policy only applies to adults):

- History of incarceration, difficulty in reducing the hernia,

OR

- Increased risk of strangulation (high risk in female patients)

OR

- Inguino-scrotal hernia

OR

- Progressive increase in size of hernia (month-on-month)

OR

- Significant pain or discomfort sufficient to cause significant functional impairment (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

[4] https://www.hernia.org/types/femoral-hernia/

[5] McIntosh A, Hutchinson A, Roberts A and Withers H. Evidence-based management of groin hernia in primary care—a systematic review. Family Practice 2000; 17: 442–447.

Hemorrhoid Surgery	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

From the Banov et al paper 1985, grading of hemorrhoids is as follows:

- Grade I: The hemorrhoids do not prolapse.
- Grade II: The hemorrhoids prolapse upon defecation but spontaneously reduce.
- Grade III: The hemorrhoids prolapse upon defecation and must be manually reduced.
- Grade IV: The hemorrhoids are prolapsed and cannot be manually reduced.

Policy:

Hemorrhoidectomy will be funded in the following circumstances:

- Grade I or II hemorrhoids with severe symptoms which include bleeding, faecal soiling, itching or pain which have failed to respond to conservative management for 3 months, where banding or Hemorrhoidal Arterial Ligation (HAL) is inappropriate.

OR

- Grade III or IV hemorrhoids (i.e. prolapsed) where banding or Hemorrhoidal Arterial Ligation (HAL) is inappropriate and where there is persistent pain or bleeding.

OR

- Irreducible and large external hemorrhoids

OR

- Symptoms suggestive of systemic disease e.g. inflammatory bowel disease

NB: Fast track referral - In patients aged 50 and over with unexplained rectal bleeding' or 'All ages (<50) with rectal bleeding and any of the following unexplained symptoms or findings: abdominal pain/change in bowel habit/weight loss/iron deficiency anemia'.

Please note that perianal hematoma is not classified as hemorrhoidectomy and will require separate management.

All other circumstances require prior approval.

Sacral Nerve Stimulation for Bladder Symptoms	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Sacral nerve stimulation, also termed sacral neuromodulation, is a type of medical electrical stimulation therapy.

It typically involves the implantation of a programmable stimulator subcutaneously, which delivers low amplitude electrical stimulation via a lead to the sacral nerve, usually accessed via the S3 foramen.

In line with NICE recommendations this policy has separate eligibility criteria and care pathways for men and women.

Policy:

Women

SNS for urinary incontinence or urgency-frequency syndrome in women will only be funded in accordance with the criteria below:

- Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if BMI >30)

AND

- Symptoms are refractory to behavioural interventions: a minimum of 6 weeks of bladder retraining OR 3 months of pelvic floor muscle training (in mixed UI only, where there is some stress incontinence as well as OAB)

AND

- Symptoms are refractory to 4 weeks of anticholinergic medication to a maximal tolerated dose (a number of drugs may be tried in accordance with NICE CG171) [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects (NICE TA290)]

AND

- The woman has been referred to secondary care, reviewed by an MDT and a diagnosis of detrusor over activity has been confirmed by urodynamic assessment.

AND

Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Men

SNS for men with overactive bladder (OAB) caused by detrusor over activity will only be funded in accordance with the criteria below:

- Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.)

AND

- Symptoms are refractory to 4-6 weeks of anticholinergic medication [OR Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290)]

AND

- The man has been referred to secondary care for specialist assessment and a diagnosis of detrusor over activity has been confirmed.

AND

- Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall unless the patient is unwilling or unable to perform clean intermittent catheterisation.

Before a permanent SNS device is fitted, ALL prospective patients must have been approved for and have undergone a positive trial period (2-3 weeks) of temporary stimulation resulting in a 50% or greater improvement in voiding function based on the results of a voiding diary.

SNS will not be funded for patients with:

- Stress incontinence, the most common type of urinary dysfunction.
- Urinary retention due to obstruction (e.g. from benign prostatic hypertrophy, cancer, or urethral stricture)
- Urge incontinence due to psychological or neurological conditions, such as diabetes with peripheral nerve involvement, MS, stroke, or spinal cord injury (see NICE CG 148).

Sacral Neuromodulation (SNM) for Faecal Incontinence	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Sacral neuromodulation (SNM) is a surgical treatment option for selected patients with faecal incontinence. NICE published Interventional procedures guidance IPG99 November 2004 regarding usage of SNM. SNM is now considered the first line surgical treatment option for the majority of patients with faecal incontinence once conservative treatment has failed.

In patients with anal sphincter dysfunction or sensory dysfunction it may be possible to significantly improve symptoms and associated quality of life primarily from modulation of afferent nerve activity. It involves low-level electrical stimulation applied via electrodes through the sacral foramina to the sacral nerve supply of the lower bowel and sphincters. The procedure is done in two stages. First a temporary electrode (PNE) is inserted which is connected to an external stimulator. The test period lasts for 2-week period, during which the patient keeps a daily symptom diary. If significant benefit is achieved (>50% improvement from baseline symptoms) then a permanent implantable pulse generator is implanted. This is programmed and stimulation is continuous. It doesn't need to be switched off for defaecation.

Policy:

Sacral Neuromodulation (SNM) is only offered as a treatment option for adults where the following criteria are met:

- The patient has severe faecal incontinence, significantly affecting quality of life, not responding to standard conservative treatment and all first line treatments have been tried.

AND

- Investigations have demonstrated and confirmed a deficient anal sphincter or sensory dysfunction.

AND

- The patient's distress is such that otherwise surgical intervention or colostomy would be required.

AND

- There has been a two-week trial and a good response to sacral neuromodulation (> 50% reductionin episodes of FI)

Surgery for Divarication of Recti	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Divarication or diastasis of the rectus abdominus muscles (DRAM or DRA) is a condition where the abdominal muscles become separated in the midline of the abdomen (linea alba). This can cause the midline to "bulge" when intra-abdominal pressure is increased.

The condition is relatively common and asymptomatic, although patients may be unhappy.
with the appearance of their abdomen. Evidence suggests that divarication does not carry the same risks as that of actual herniation and therefore it does not normally lead to any complications that.
require intervention.

Policy:

Surgery for Divarication of Recti will NOT be routinely funded

Vasectomy under General Anesthetic	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Vasectomy is a surgical procedure for male sterilization or permanent contraception. During the procedure, the male vas deferens are severed and then tied or sealed in a manner to prevent sperm from entering into the seminal stream (ejaculate) and thereby prevent fertilization.

Policy:

Vasectomies under General Anesthetic (GA) in secondary care will only be funded in the following circumstances:

- There is previous documented allergy or absolute medical contra-indication to Local Anesthetic

OR

- The patient has anatomic abnormalities, i.e. there is an inability to palpate and mobilize both vas deferens or large hydroceles or varicoceles.

OR

- There is past trauma or surgery which has resulted in scarring of the scrotum which would require surgery in an in-patient setting.

OR

- The patient is taking anticoagulants or antiplatelet medications, and risk of hemorrhage (bleeding) is high.

Fear of the procedure, or patient choice are not adequate reasons for requesting vasectomy under GA.

Gynaecology

Dilatation and Curettage (D&C) for treatment of Heavy Menstrual Bleeding	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Dilatation and curettage (D&C) is a procedure performed under general anesthetic 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:

Dilatation and curettage (D&C) are NOT routinely commissioned as a therapeutic or diagnostic intervention for heavy menstrual bleeding or any other uterine bleeding disorder.

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:

For women diagnosed with heavy menstrual bleeding (menorrhagia), with or without fibroids, hysterectomy will not be commissioned unless ALL the following criteria are met:

- Recommendations for the medical treatment of heavy menstrual bleeding (and/or symptomatic large or multiple fibroids) set out in NICE Clinical Guideline NG88 for Heavy Menstrual Bleeding (https://www.nice.org.uk/guidance/ng88) have failed, or are contraindicated, or has been declined by the woman. This includes the use of a progestogen-releasing intrauterine device (levonorgestrel releasing systems - LNG-IUS).

AND

- Uterine endometrial ablation methods have failed or are not clinically appropriate or has been declined by the woman.

AND

- The woman has been fully informed of the implications of surgery and does not wish to retain her uterus and fertility.

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Rightcare Shared Decision-Making tool

Reversal of Female Sterilisation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Policy:

Reversal of sterilisation will NOT be routinely funded.

Neurology

Vagal Nerve Stimulation (Non-Invasive) for Cluster Headache	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Non-invasive transcutaneous stimulation of the vagus nerve (nVNS) is a new treatment modality which aims to treat headache disorders while avoiding the need for an implanted device. The mechanism by which nVNS treats headache is poorly understood but may be due at least in part to inhibition of pain signalling by the neurotransmitter gamma amino butyric acid (GABA).

Cluster headache is a primary headache disorder characterised by recurrent attacks of unilateral pain, often in or around the eye or temple. Attacks usually last between 15 minutes and 3 hours and may be described by patients as the worst pain they have ever experienced. Attacks may be episodic (occur in clusters lasting weeks or months, separated by remission usually lasting months or years) or chronic (attacks occur for a year or more without remission, or remission is absent or lasts less than 1 month). The one-year prevalence of cluster headache is around 0.05%, while the lifetime prevalence is around 0.12%. Episodic cluster headache is the more common form, accounting for 80-90% of cases. The condition is at least 3 times more common in men than in women, for reasons which are not known.

Policy:

Non-invasive transcutaneous vagus nerve stimulation (eg gammaCore) for the treatment of cluster headache will only be funded if the following criteria are met:

- Patient suffers severe cluster headache interfering with lifestyle.

AND

- Treatment recommended by specialist

Ophthalmology

Autologous Serum Eye Drops	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Autologous serum eye drops treat severe keratoconjunctivitis sicca (dry eye). Dry eyes can be helped with intensive treatment with artificial teardrops; however, for some patients the symptoms are not completely relieved. The National Blood Service has developed an alternative to these artificial drops. Autologous serum eye drops are a last resort measure where all other conservative interventions have failed.

Policy:

Autologous serum eye drops will only be funded on a 5-month initial trial basis in accordance with the criteria specified below:

- Patients have been treated unsuccessfully with maximal tolerated conventional and NICE approved therapies (for example, Ciclosporin).

Note: Further funding will be subject to the submission of a progress report following a 5-month trial, outlining the improvements in objective measures.

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 with warm compresses, lid cleaning and massage for 4 weeks.

OR

- Interferes significantly with vision.

OR

- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy.

OR

- Is a source of infection that has required medical attention twice or more within a six-month time frame.

OR

- Is a source of infection causing an abscess which requires drainage.

Where the lump is rapidly growing, abnormally located and / or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2-week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems – Ectropion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Ectropion is a condition, typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball.

Policy:

Surgery for Ectropion will only be funded in accordance with the criteria below:

- Conservative management has been exhausted and there is evidence of significant impairment of the punctum.

AND

- There is recurrent infection in surrounding skin.

OR

- There is significant impact on vision affecting functionality.

OR

- To have safer intraocular procedures / so the patient can undergo another intraocular procedure.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Oculoplastic Eye Problems – Surgery for Minor Eyelid Lesions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Minor eyelid lesions include eyelid papilloma or skin tags, cysts of moll, cysts of zeis, Meibomium cysts.

Policy:

Surgery or treatment for minor eyelid lesions will only be funded in accordance with criteria below:

- There is well documented evidence of significant pain (see FAQs)

OR

- Recurrent infection

OR

- Recurrent bleeding

OR

- Is subject to unavoidable recurrent trauma leading to bleeding.

OR

- There is significant impact on vision affecting functionality.

Where the lump is rapidly growing, abnormally located and / or is displaying features suspicious of malignancy, specialist assessment should be sought using the 2-week wait pathway.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Orthopedics

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 sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Policy:

Arthroscopic shoulder decompression for pure subacromial shoulder pain will be funded in the following circumstances:

- Pure subacromial impingement is not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy.

AND

- Physiotherapy and exercise programmes have been actively undertaken and found to be ineffective in resolving the shoulder pain.

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right Care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

It should be noted that when shoulder decompression is carried out as part of a wider set of procedures, then prior approval will not be required.

Bunions / Minor Foot Problems	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Degeneration of the small joints of the toes and feet is a common problem. It is often caused by inappropriate footwear. It can usually be managed conservatively by changing footwear. Surgery is sometimes sought to avoid the need to change footwear or for cosmetic purposes.

Policy:

Referral for surgery for minor foot problems will only be considered when the following criteria are met:

- The patient has been referred to a podiatrist and conservative management has failed (Including avoiding high heels, exercises, applying ice, non-surgical treatment)

AND

- The patient suffers from severe deformity that causes significant functional impairment (including inability to fit adequate footwear)

OR

- The patient suffers from severe pain that causes significant functional impairment.

OR

- There is recurrent or chronic ulceration due to the deformity.

OR

- There is recurrent or chronic bursitis or tendinitis at the first metatarsal head due to the deformity.

Exclusions: If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not apply to surgery to correct deformity due to acute trauma.

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:

Carpal tunnel surgery will be funded if the following criteria are met:

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right-care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/

AND EITHER

- Severe symptoms that significantly interfere with daily activities (see FAQ) persist or recur after at least 3 months of conservative therapy, including 8 weeks of nocturnal splinting and / or one local corticosteroid injections if clinically appropriate.

OR

- There is neurological deficit, for example sensory blunting, thenar muscle wasting ormotor weakness (moving the thumb away from the hand).

Dupuytren's Contracture – Collagenase Clostridium Histolyticum (CCH) Injections	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	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 dermo fasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

In conjunction with NICE guidelines (TA459), Collagenase Clostridium Histolyticum (CCH) Injections is no longer recommended as an option for treating Dupuytren's contracture as the drug is no longer licensed.

Policy:

Collagenase Clostridium Histolyticum (CCH) Injections for Dupuytren's contracture is NOT routinely funded

Dupuytren's Contracture - Radiotherapy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	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 dermo fasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

Policy:

Radiotherapy for Dupuytren's contracture is NOT routinely funded.

Dupuytren's Contracture - Referral for Secondary Care Opinion	**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 dermo fasciectomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others.

Policy:

Referral for Secondary Care Opinion of Dupuytren's contracture will only be funded in accordance with the criteria specified below:

- Flexion deformity >30° at the MCP Joint or 20° at the PIP Joint

OR

- severe thumb contractures which interfere with function

OR

- Rapidly progressive disease

AND

- Contracture interferes with lifestyle and/or occupation.

NB: If the above criteria are fulfilled and a PAT obtained in primary care, then the specialist will not need to obtain a further PAT for surgery. However, for clarity, the same criteria above apply if there is a decision to proceed to surgery and a PAT must be obtained.

Extracorporeal Shockwave for MSK conditions	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Extracorporeal Shockwave Therapy or ESWT is a treatment that can be used in physical therapy, orthopedics, urology, and cardiology. The shockwaves are abrupt, high amplitude pulses of mechanical energy, similar to soundwaves, generated by an electromagnetic coil or a spark in water. Similar technology using focused higher energies is used to break up kidney and gallstones and is termed lithotripsy. "Extracorporeal" means that the shockwaves are generated externally to the body and transmitted from a pad through the skin.

Policy:

Extracorporeal Shockwave Therapy is NOT routinely funded for musculoskeletal conditions.

Extracorporeal Shock Wave Therapy for Plantar Fasciitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Extracorporeal Shockwave Therapy or ESWT is a treatment that can be used in physical therapy, orthopedics, urology, and cardiology. The shockwaves are abrupt, high amplitude pulses of mechanical energy similar to soundwaves, generated by an electromagnetic coil or a spark in water. Similar technology using focused higher energies is used to break up kidney and gallstones and is termed lithotripsy. "Extracorporeal" means that the shockwaves are generated externally to the body and transmitted from a pad through the skin.

Policy:

Extracorporeal shock-wave therapy for plantar fasciitis is NOT routinely funded

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.

Referral guidance: Include reference to the degree of pain and restriction of normal activities caused by the ganglion.

Policy:

Surgical treatment for ganglia will only be funded in accordance with the criteria specified below:

- There is significant pain and / or a significant functional impairment affecting activities of daily living (see FAQs)

AND

- If aspiration fails to resolve the pain or tingling / numbness

OR

- Where there is recurrent spontaneous discharge of fluid or significant nail deformity (in relation to Myxoid / Mucous Cysts)

Hip Arthroscopy	Category: *(IFR / Prior Approval / Monitored Approval)*	Prior Approval
	Local or National EBI (Evidence Based Interventions) Policy:	Local

Background:

Hip arthroscopy refers to the viewing of the interior of the acetabulofemoral (hip) joint through an arthroscope and the treatment of hip pathology through a minimally invasive approach.

Policy:

Hip Arthroscopy will only be commissioned (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408 **and only for patients who fulfil ALL of the following criteria:**

- A definite diagnosis of hip impingement syndrome / femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI, and CT scans.

AND

- An orthopedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist.

AND

- The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly. compromised functioning for at least 6 months.

AND

- The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.

If the patient does not meet all the criteria described above but the Specialist still recommends this treatment, an Individual Funding Request should be submitted for consideration.

Hip Arthroscopy is **NOT** routinely funded for patients where any of the following apply:

- Advanced osteoarthritis or severe cartilage injury
- A hip joint space on plain radiograph that is less than 2mm wide anywhere.
- Candidates for total hip replacement
- Hip dysplasia.
- Generalised joint laxity especially in diseases connected with hypermobility of the joints.
- Osteogenesis imperfecta (brittle bone disease)

Hip Prostheses and Resurfacing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

ODEP, the Orthopedic Data Evaluation Panel was set up in 2002 to implement NICE guidance on primary hip implants. Hip resurfacing followed in 2004. Since 2002 manufacturers use ODEP to benchmark their Hip, Knee and now Shoulder prostheses, against agreed standards and at regular time points.

Policy:

Prostheses for total hip replacement and resurfacing arthroplasty will only be funded where the prosthesis to be used has a rate (or projected rate) of revision of 5% or less at 10 years (ODEP 10A* rating, or A* rating at less than 10 years).

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.

Policy:

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

- The patient has accessed core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability.
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right Care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Revision Surgery for Hip replacements is not currently included within the scope of this policy.

Knee Arthroscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Knee arthroscopy is a surgical technique that can diagnose and treat problems in the knee joint. 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.

Policy:

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

- Clinical examination (or MRI scan) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body)

AND

- Conservative treatment has failed or where it is clear that conservative treatment will not be effective.

OR

- In exceptional cases, intractable knee pain considered likely to benefit from arthroscopic treatment according to assessment by a Consultant Knee Surgeon.

OR

- There is continuing diagnostic uncertainty following MRI, such that a Consultant Knee Surgeon recommends diagnostic arthroscopy.

Arthroscopy is not commissioned:

- For diagnostic purposes only (noting the exception above).

- To provide arthroscopic washout alone as a treatment for chronic knee pain due to osteoarthritis. This procedure may be appropriate in conditions such as septic arthritis.

This policy restriction does not apply where there is an urgent need for investigation/treatment.

Knee Replacement Surgery (Total)	**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:

- The person has been offered the core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability.
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right Care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Revision Surgery for Knee replacements is not currently included within the scope of this policy.

Low (Lumbar) Back Pain and Sciatica (radicular pain)

This policy has been revised in the light of NICE guideline NG59 and the National Back Pain and Radicular Pain Pathway (NBPRPP). The policy applies to all patients who experience either new episodes or chronic persistent and unremitting symptoms of low back pain and sciatica.

The policy covers treatment procedures for the lumbar spine. It does not cover:

- non-lumbar regions of the spine, and
- serious spinal pathology and the potentially serious neurological sequelae of sciatica (progressive neurological deficit and Cauda Equina Syndrome)

The precise form and content of comprehensive non-surgical treatments including Combined Physical and Psychological Programmes (CPPP) may vary according to Integrated Care Board (ICBs), the extent to which the NBPRPP has been implemented, and the individual needs of the patient.

Low Back Pain – Epidural and nerve root injections for Acute Radicular Leg Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Epidural and nerve root injections are not routinely funded for the treatment of non-specific low back pain.

Injections for acute radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below:

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement.

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- The pain is not responding to analgesia.

AND

- The patient is unable to tolerate rehabilitation and exercises.

AND

- In the opinion of the clinician a nerve root injection is required in order for the patient to mobilise, exercise and engage with rehabilitation.

AND

- The pain has been present for less than 8 weeks.

Note: Nerve root injections should only be performed under imaging. Under these circumstances, a total of up to two injections will be funded per episode.

Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Nerve root injections for diagnostic purposes will be funded where Prior Approval is in place.

Low Back Pain – Epidural and nerve root injections for Chronic Radicular Leg Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Epidural and nerve root injections are not routinely funded for the treatment of non-specific low back pain.

Injections for chronic radicular leg pain (caudal epidural, lumbar epidural, transforaminal epidural or nerve root injections) will only be funded in accordance with the criteria specified below:

- The patient has radicular leg pain (below the knee for lower lumbar herniation, into the anterior thigh for upper lumbar herniation) consistent with the level of spinal involvement.

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Comprehensive non-surgical treatment, including CPPP where available, or where not available, analgesia, psychologically informed rehabilitation and modified value-based activity has not been successful.

Note: Nerve root injections should only be performed under imaging. Under these circumstances, a total of up to two injections will be funded per episode. The interval between two injections must be at least 6 months.

Epidural injections are not recommended or funded for neurogenic claudication caused by central spinal canal stenosis.

Nerve root injections for diagnostic purposes will be funded where Prior Approval is in place.

Low Back Pain – Lumbar Disc replacement	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Lumbar disc replacement will not routinely be funded for patients with low back pain.

Low Back Pain – Medial Branch Block (MBB)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Policy:

Prior to Radiofrequency denervation (Rhizolysis), medial branch block should first take place for diagnostic purposes only.

Medial Branch Block for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful.

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve.

AND

- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

AND

- If a patient has had a previous successful Radiofrequency Denervation (Rhizolysis) that has provided greater than 16 months of pain relief and benefit, then there is no requirement to repeat medial branch blocks prior to performing a repeat Radiofrequency Denervation (Rhizolysis) if this is at the same levels.

Low Back Pain - Radiofrequency denervation (Rhizolysis)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below:

- Comprehensive non-surgical treatment including CPPP where available, or where not available, analgesia, physiotherapy, and modified activity has not been successful.

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve.

AND

- Moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

AND

- Patients can only undergo a repeat rhizolysis if their prior rhizolysis has provided them with an effective duration of pain relief and benefit that is greater than or equal to a period of 16 months.

AND

- Positive response to a diagnostic medial branch block (which also requires PAT funding)

Low Back Pain – Spinal decompression and discectomy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Spinal decompression (laminectomy) and discectomy will only be funded for patients with sciatica (radicular pain) in accordance with the following criteria:

- Magnetic resonance imaging shows compression of the neural elements consistent with the clinical symptoms

AND

- Radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) and neurological deficit consistent with the level of spinal involvement

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

- Symptoms persist despite non-operative treatment for at least 6 weeks (e.g. analgesia, physiotherapy, modified activity, etc.) provided analgesia is adequate and there is no significant neurological deficit.

Low Back Pain – Spinal Fusion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Spinal Fusions will only be funded for patients in accordance with the following criteria:

- Failed Conservative Treatment for at least 3 months (including targeted physiotherapy and appropriate analgesia)

AND

- Discussion and Agreement at Regional Spinal MDT

AND

- Symptomatic Instability (spondylolisthesis)

OR

- Destabilising Decompression

OR

- Revision of Non-Union (previous attempted fusion)

OR

- Revision discectomy

This policy excludes patients where there is evidence of Trauma, Tumour, Infection, Degenerative Scoliosis, or Progressive neurological deficit - including cord or cauda equine compression.

Low Back Pain - Spinal injections (Therapeutic)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Policy:

Therapeutic spinal injections of local anesthetic and steroid are not routinely funded for the treatment of non-specific low back pain.
Spinal injections include:

- Facet joint injections.
- Therapeutic Medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger Point Injections

Paediatric Foot Problems	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Whilst minor foot or gait problems are relatively common presentations in children, referral directly for surgery is rarely needed. Referral for prophylactic or cosmetic reasons for minor foot problems should not be considered in children.

Policy:

Referral of children to orthopedic surgery for minor foot problems should only be considered in the following circumstances:

- Metatarsus varus (also known as metatarsus adductus or "in-toeing") has been diagnosed clinically.

AND

- associated developmental dysplasia of the hips is suspected.

OR

- Child is ≥ 5 years of age and in-toeing is still evident despite community podiatry review.

OR

- Curly toes have been diagnosed clinically.

AND

- Severe deformity is present (as is shown by either deformity of the growing nail of the toe or pressure on the adjacent toe or corn formation on the dorsum of the toe.)

OR

- There is significant pain unmanageable by community podiatry services.

Exclusions: The treatment of children with acute foot trauma or with neurodevelopmental problems or other complex conditions affecting the feet is not covered by this policy. This policy also does not apply when a foot or gait problem is considered to need further investigation by a paediatrician to determine its cause.

Surgery to treat Periprosthetic Infection	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Periprosthetic joint infection (PJI) is a serious complication after arthroplasty, which is associated with pain and functional incapacitation.

Policy:

Surgical treatment for periprosthetic joint infection will only be funded in accordance with the following criteria:

- This patient has been discussed and documented (or if urgent, will be within 10 days of surgery) in a Multidisciplinary Team (MDT) meeting, consisting of; at least 2 surgeons, and at least 1 microbiologist or infectious disease consultant.

AND

- The case and subsequent related procedures will be recorded on the national Bone and Joint Infection Registry

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:

- The patient has co-morbidities associated with an increased risk of trigger finger (e.g. rheumatoid arthritis or diabetes mellitus) and the patient's symptoms have not improved with at least 4 months of conservative treatment (e.g. NSAIDs, splintage, physiotherapy of the affected finger).

OR

- The patient's symptoms have not resolved despite at least one steroid injection in the last 4 months.

OR

- The specialist opinion is that surgery is needed promptly to prevent the development of flexion contractures.

OR

- The finger is permanently locked in the palm.

OR

- The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods.

This policy applies to adults only.

Unicompartmental Knee Replacement (medial, lateral and patello femoral)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Unicompartmental knee replacement (arthroplasty) is a surgical procedure in which only the damaged parts of the knee are replaced.

Policy:

Unicompartmental Knee replacement surgery (medial & lateral and patella femoral) will only be funded in accordance with the criteria specified below:

- The person has been offered the core (non-surgical) treatment options for at least 3 months as part of their management plan:
  - Access to appropriate information as an ongoing, integral part of the management plan rather than a single event at time of presentation
  - Access to activity and exercise including aerobic fitness and local muscle strengthening appropriate to age, co-morbidity, pain severity or disability.
  - Access to facilitated interventions to achieve weight loss if the patient is overweight or obese.

AND

- The patient has moderate to severe persistent joint pain that is refractory to non-surgical treatment and may include joint injections and recommended use of non-steroidal anti-inflammatories and other analgesics and has a substantial impact on their quality of life.

AND

- There is clinically significant moderate to severe functional limitation which is refractory to use of walking aids and other forms of physical therapies and results in diminished quality of life (see FAQs)

AND

- There is evidence that the risks and benefits of treatment options have been clearly discussed with the patient / carer and are documented in the patient notes. This may include the NHS Right Care Shared Decision-Making tool. Patient decision making aids are available to search through the following link: https://library.nhs.uk/knowledgehub/.

AND

- The treating surgeon has performed / supervised >10 medial or lateral unicompartmental knee replacements in the last 12 months and discussed their revision rate during appraisal.

Note: referral for joint surgery should be considered before there is prolonged and established functional limitation and significant pain.

Other

Bobath Therapy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Bobath therapy is an approach in neurological rehabilitation that is applied in patient assessment and treatment (such as with adults after stroke or children with cerebral palsy). The goal of applying the Bobath concept is to focus on handling skills to improve muscle tone, posture, movement skills and function. It aims to assess the patient's needs and adapt to individual requirements. The evidence base for the effectiveness of Bobath therapy in children and adults is poor and there are more effective treatments available.

Policy:

Bobath Therapy will NOT be routinely funded.

Continuous Positive Airway Pressure (CPAP) Device for patients with obstructive sleep apnoea	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

CPAP is recommended as a treatment option for adults with symptomatic obstructive sleep apnoea/hypopnoea syndrome (OSHAS) regardless of severity under certain circumstances.

Policy:

Continuous Positive Airway Pressure (CPAP) is only offered as a treatment option for adults with OSAHS, where the following criteria are met:

- The patient has symptoms that affect their quality of life and ability to go about their daily activities.

AND

- Lifestyle advice and any other relevant treatment options have been unsuccessful or are considered inappropriate.

AND

- Diagnosis and treatment of OSAHS, and the monitoring of the response, has been carried out by a specialist service with appropriately trained medical and support staff.

Helmet Therapy for Treatment of Positional Plagiocephaly / Brachycephaly in Children	**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 becomes 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.

This guidance applies to children aged 2 years and under.

Further information on the National EBI Policies can be found at **www.aomrc.org.uk/ebi**

Policy:

Helmet therapy for treatment of positional plagiocephaly / brachycephaly in children is NOT routinely commissioned

Lycra Garments (for Children)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The limited data which is inconclusive suggests that wearing Lycra garments may improve stability, movement, and function in some children with cerebral palsy in the short term but are not conclusive. The limitations of the evidence make it difficult to characterise whether there are patient groups that may benefit more than others and which if any benefits are sustained in the long term.
Adverse effects reported in studies with various types of Lycra garments (full body suits, vests, shorts) include vomiting, cyanosis, hyperthermia, muscle weakness, inhibition of voluntary movement, respiratory compromise, constipation, friction sores and erythema. Long term safety is not known.

Policy:

Lycra Garments are only offered as a treatment option where the following criteria are met:

- Patient is <18 years old.

AND

- The request is for a new patient, or where the request is for a replacement, there is sufficient evidence that the child has outgrown their previous garment, or there has been 12 months between requests.

AND

- A Lycra garment is recommended by an appropriate paediatric health professional involved in the child's care

AND

- The family of the patient are aware that the funding is only available until age 18

Tirzepatide for overweight and obesity	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**NICE Guidelines**

Background:

NICE guidance has indicated tirzepatide may be used for this indication according to strict criteria set out in the NHSe funding variation. This is to phase in access according to clinical need.

To be prescribed in commissioned services in primary care.

Policy:

Patients will be eligible for tirzepatide as an adjunct to a reduced-calorie diet and increased physical activity in adults for overweight and obesity under the following circumstances:

- Be actively participating in, or willing to actively participate in, wrap around weight loss services

AND

- Body Mass Index (BMI) of 40 or over

OR

- Body Mass Index (BMI) of 37.5 or over for people from:
  - South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds

AND

- Have **AT LEAST FOUR** of the following:
  - Hypertension
  - Dyslipidaemia
  - Obstructive sleep apnoea
  - Atherosclerotic cardiovascular disease
  - Type 2 diabetes mellitus

Definitions:

Hypertension	Established diagnosis of hypertension and requiring blood pressure lowering therapy
Dyslipidaemia	Treated with lipid-lowering therapy, or with low-density lipoprotein (LDL) ≥ 4.1 mmol/L, or high-density lipoprotein (HDL) <1.0 mmol/L for men or HDL<1.3 mmol/L for women, or fasting (where possible) triglycerides ≥1.7 mmol/L

Obstructive Sleep Apnoea (OSA)	Established diagnosis of OSA (sleep clinic confirmation via sleep study) and treatment indicated i.e. meets criteria for continuous positive airway pressure (CPAP) or equivalent
Atherosclerotic cardiovascular disease (ASCVD)	Established atherosclerotic CVD (ischaemic heart disease, cerebrovascular disease, peripheral vascular disease, heart failure)
Type 2 diabetes mellitus	Established type 2 diabetes mellitus

Wigs & Hair Pieces	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hair loss and hypotrichosis for men and women have many causes including androgenetic alopecia, fungal infection, trauma (e.g. due to (trichotillomania), radiotherapy, chemotherapy, nutritional deficiencies (e.g., iron deficiency), and autoimmune diseases (e.g., alopecia areata). Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Treatment of hair loss can include hair transplantation or hair grafting, the 'Interlace' hair system, or Dermatography (tattooing).

Policy:

Requests for wigs to correct male pattern baldness or androgenic hair loss in women (at any age) or for any other reasons that are considered cosmetic are not routinely commissioned. Wigs & Hair Pieces will only be commissioned in the following circumstances:

- The patient has experienced total or severe hair loss resulting from one of the following severe alopecia areata, alopecia totalis, scarring alopecia (including scleroderma, lichen planus, discoid lupus, folliculitis decalvans, frontal fibrosing alopecia); cancer treatment; severe trauma (including burns)

AND

- The patient is aware that they will be entitled to a maximum of 2 acrylic wigs per year.

AND

- The patient is aware that human hair wigs are **not** prescribed on the NHS unless the patient is allergic to acrylic wigs or has a skin condition that will be made worse by an acrylic wig.

AND

- The patient is aware that the approval of a wig is not open ended, and they will need to return to their GP after 3 years for re-assessment in line with the relevant commissioned policy at that time.

NOTE: Patients who satisfy the criteria of this policy will be eligible for a maximum of 2 acrylic wigs per year (from the point of approval) **up to a maximum value** of £465.

Where prior approval is obtained, funding requests will be eligible for a 3-year period without needing to be re-referred. After this point, patients should return to their GP to be re-assessed and where appropriate (ie: they continue to meet the current policy in place at that time), generate a new Prior Approval / IFR.

Patients who do not meet policy criteria are not eligible for funding of wigs.

Plastics

Abdominoplasty or Apronectomy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Abdominoplasty (also known as tummy tuck) is a surgical procedure performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss. However, surgery is not part of the usual response to these normal, physiological processes.

Policy:

Abdominoplasty or Apronectomy will not be routinely funded

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Blepharoplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. It is usually done for cosmetic reasons. Consideration should be given to whether blepharoplasty or brow lift is the more appropriate procedure, particularly in the case of obscured visual fields.

Policy:

Blepharoplasty will only be funded in accordance with the criteria specified below:

- Impairment of visual fields in the relaxed, non-compensated state

OR

- Clinical observation of poor eyelid function leading to discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Face Lift or Brow Lift	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

These surgical procedures are performed to lift the loose skin of the face and forehead to get a firm and smoother appearance of the face. These procedures will not be funded to treat the natural processes of ageing or to achieve a cosmetic outcome.

Policy:

Face lift or brow lift will only be funded in accordance with the criteria specified below.

These procedures will **only** be considered for treatment of the functional impairments arising from:

- Congenital facial abnormalities

OR

- Facial palsy (congenital or acquired paralysis)

OR

- As part of the treatment of specific conditions affecting the facial skin eg. Cutis laxa, pseudoxanthoma elasticum, neurofibromatosis

OR

- To correct the functional consequences of trauma

OR

- To correct functional consequences of deformity following surgery

OR

- In some cases of impaired visual fields, where it may be a more appropriate primary procedure than blepharoplasty.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Gynaecomastia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Gynaecomastia is benign enlargement of the male breast. Most cases are idiopathic. For others endocrinological disorders and certain drugs such as oestrogens, gonadotrophins, digoxin, spironolactone, cimetidine, and proton pump inhibitors could be the primary cause. Obesity can also give the appearance of breast development as part of the wide distribution of excess adipose tissue. Early onset gynaecomastia is often tender, but this usually resolves in 3 to 4 months.

Full assessment of men with gynaecomastia should be undertaken, including screening for endocrinological and drug related causes and necessary treatment is given prior to request for NHS funding. It is important to exclude inappropriate use of anabolic steroids or cannabis.

Policy:

Surgery to correct gynaecomastia will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Liposuction	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures.

Policy:

Liposuction simply to correct the distribution of fat will not be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Pinnaplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Pinnaplasty is performed for the correction of prominent ears or bat ears. Prominent ears are a condition where one's ears stick out more than normal.

Correction is considered to be primarily a cosmetic procedure. Surgery for primarily cosmetic reasons is not eligible for NHS funding.

The exception to this policy is procedures (***remodelling of external ear lobe***) in children with congenital abnormalities of the ear to improve hearing as this is covered by Specialised commissioning and should be managed through the specialised commissioning route.

Policy:

Pinnaplasty will NOT routinely be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Removal of Tattoos	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

A tattoo is defined as a form of body modification, made by inserting indelible ink into the dermis layer of the skin to change the pigment.

Policy:

Tattoo removal will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Resurfacing Procedures: Dermabrasion, chemical peels, and laser treatment	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Dermabrasion involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications. This policy includes all laser skin treatments, for example for Rhinophyma or Rosacea.

Policy:

Resurfacing procedures will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Surgical Fillers (for Treatment of wrinkles and skin ageing)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Surgical Fillers are widely used in cosmetic surgery, for the treatment of wrinkles and skin aging, to improve the appearance of scars and for augmenting the volume of soft tissue such as in the lips.

Policy:

Surgical fillers for the treatment of wrinkles and skin ageing will not be routinely funded.

This commissioning position applies to the use of both natural (e.g. fat, dermis) and synthetic fillers (temporary or permanent) including hyaluronic acid fillers and collagen. Please note, the treatment of complications arising from the cosmetic use of surgical fillers in private practice is not routinely funded.

Surgical Treatment for Hair Loss	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Hair loss and hypotrichosis for men and women have many causes including androgenetic alopecia, fungal infection, trauma (e.g., due to (trichotillomania), radiotherapy, chemotherapy, nutritional deficiencies (e.g., iron deficiency), and autoimmune diseases (e.g., alopecia areata). Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Treatment of hair loss can include hair transplantation or hair grafting, the 'Interlace' hair system, or Dermatography (tattooing).

Policy:

Surgical Treatment for hair loss will not be routinely funded.

Thigh Lift, Buttock Lift and Arm Lift, Excision of Redundant Skin or Fat	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

These surgical procedures are performed to remove loose skin or excess fat to reshape body contours. As the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance, in which case it should not be available on the NHS.

Policy:

These procedures will not be routinely funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Vaginoplasty, Labial Vulvoplasty and Vulvar Lipoplasty	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Surgery for Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty are all cosmetic procedures. This policy does not cover vaginal repair following delivery and is part of obstetric or gynaecological treatment. Clinicians should refer to the following guidance from the Royal College of Obstetricians and Gyaencologists : https://www.rcog.org.uk/en/news/joint-rcogbritspag-release-issues-surrounding-women-and-girls-undergoing-female-genital-cosmetic-surgery-explored/

Policy:

Vaginoplasty will not routinely be funded.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Radiology

Shoulder Radiology: Guided Injections	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

W1 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.

W2 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.

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.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: 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. Scans for Shoulder pain should only be carried out where the specified criteria are met – see the associated policy under the Monitored Approval section.

Guided Injections for Shoulder Pain

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.

Image guided subacromial injections are NOT routinely commissioned.

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

Urology

Surgical Intervention for Benign Prostatic Hyperplasia	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	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 male adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

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. The following criteria need to be met:

- The person is healthy and has complicated benign prostatic hyperplasia (i.e. chronic retention with renal impairment) as evidenced by hydronephrosis and impaired GFR.

OR

- Other evidence of complicated BPH (e.g. urinary tract infections, bladder stones or acute urinary retention)

OR

- Bothersome LUTS persist alongside high, or unchanged International Prostate Symptom Scores despite optimal conservative and drug treatment.

AND

- Shared Decision-Making process has been carried out and the person has been counselled thoroughly regarding alternatives.

Reversal of Male Sterilisation	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens.

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.

Policy:

Reversal of sterilisation will NOT be routinely funded.

Vascular

Liposuction for Chronic Lymphoedema	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Prior Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Lymphoedema is the abnormal accumulation of subcutaneous fat and fluid in body tissue. It leads to chronic swelling that can cause disability, pain, and cosmetic issues. Any part of the body can be affected, but the condition is most common in the arms and legs. Lymphoedema can be complicated by recurrent infection (cellulitis), which further damages the lymphatic vessels and aggravates the condition. Liposuction for chronic lymphoedema is usually done under general anaesthesia, but regional nerve blockade is also possible. Current evidence on the safety and efficacy of liposuction for chronic lymphoedema is adequate to support the use of this procedure.

Policy:

Liposuction for Chronic Lymphoedema will only be funded where the following criteria are met:

- The procedure is non-cosmetic.

AND

- The patient has failed conservative management in line with the current patient pathway for the treatment of lymphoedema.

AND

- Treatment is recommended by, and only started by, a specialist lymphoedema multidisciplinary team as part of a lymphoedema service pathway.

AND

- The patient is willing and able to adhere to lifelong self-management, including compression hosiery, skin care, healthy diet, and exercise.

AND

- Has no remaining movable oedema (ie: treatable with conservative management)

AND

- Has no active cancer, wounds, or active infection

AND

- Has an oedema impacting on function / ability to carry out work or self-care as assessed using the validated LYMQOL tools, OR where their oedema has been replaced by large amounts of adipose tissue.

AND

- A History of recurrent cellulitis

NOTE: Conservative treatments for lymphoedema include manual lymph drainage (MLD), and decongestive lymphatic therapy (DLT).

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Liposuction for the Management of Lipoedema	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**IFR**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Lipoedema is frequently confused with lymphoedema but is a separate condition with similar presentation. It is a disorder of fat distribution, which causes symmetrical and excessive deposition of adipose tissue in the limbs. Any part of the body can be affected, but the condition is most common in the arms and legs leading to chronic swelling that can cause disability, pain, and cosmetic issues.

Policy:

Liposuction for the Management of Lipoedema will NOT be routinely funded

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 a vascular service Guidance: Refer people with bleeding varicose veins to a vascular service[6] immediately.

Policy for Referral:

Refer people to a vascular service if they have any of the following:

- History of bleeding from a varicosity which are at risk of bleeding again.

OR

- Ulceration which is progressive and/or causing significant pain despite treatment

OR

- Active or healed ulceration and/or progressive skin changes that may benefit from surgery.

OR

- Recurrent superficial thrombophlebitis

OR

- Significant pain attributable to varicose veins having a severe impact on quality of life and interfering with actives of daily living (see FAQ).

[6]*A team of healthcare professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of treatment.*

Assessment and treatment in a vascular service

Assessment: Use duplex ultrasound to confirm the diagnosis of varicose veins and the extent of truncal reflux, and to plan treatment for people with suspected primary or recurrent varicose veins.

Interventional treatment: For people with confirmed varicose veins and truncal reflux:

1. Offer endothermal ablation and Endovenous laser treatment of the long saphenous vein.

2. If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy.

3. If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.

If incompetent varicose tributaries are to be treated, consider treating them at the same time.

Non-interventional treatment: Compression hosiery to treat varicose veins is not recommended unless interventional treatment is unsuitable for clinical reasons or patient choice.

Policy for Interventions:

Interventional treatments for varicose veins outlined above will only be funded in accordance with the criteria specified below.

- Persistent ulceration that is progressive or causing significant pain (see FAQs)

OR

- Recurrent superficial thrombophlebitis where there is significant pain and disability.

OR

- Progressive skin changes that suggest potential ulceration due to venous insufficiency.

OR

- Significant haemorrhage from a ruptured superficial varicosity.

OR

- Patients with significant pain attributable to chronic venous insufficiency which is having a significant impact on quality of life and interfering with activities of daily living (see FAQs)

Patients whose primary concern is cosmetic will not be funded for surgical treatment.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Section 2: Monitored Approval Policies

Policies that do not need approval to be confirmed prior to the treatment taking place.

Breast Surgery

Breast – Prosthesis Removal	Category: *(IFR / Prior Approval / Monitored Approval)*	Monitored 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.
The proposal does not cover Gender reassignment surgery and implants inserted following surgery for breast cancer or breast cancer prevention performed under the NHS. In these cases, please refer to the Association of Breast Surgery (ABS) Guidance for Commissioning of Oncoplastic Breast Surgery.

Policy:

Surgery to remove breast implants should be considered for the following clinical indications:

- After implant leakage or rupture

OR

- There is a severe capsular contracture (grade III/IV on the Baker classification). This will need to be confirmed by a specialist opinion.

OR

- Implants are complicated by recurrent implant infection or seroma.

OR

- The patient develops Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL).

AND

- This patient is 18 years or over.

Pre and postoperative photographs MUST be recorded for audit purposes. All eligible patients MUST be entered into the Breast and Cosmetic Implant Registry (BCIR) for audit purposes.

Breast prosthesis removal and replacement will not be commissioned in the following:
Patients who initial procedure was privately funded should seek assurance from their private provider in the first instance. If, however, the patient meets one of the above clinical indications, and the private provider is unable to offer the patient surgery, the patient can be offered an NHS referral for breast implant removal but not for replacement.

Only implant removal should be performed, and no other subsequent cosmetic procedure, e.g., mastopexy.

Surgery for primarily cosmetic reasons is not eligible for NHS funding.

Cardiology

Angioplasty for PCI (in-stable angina)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Stable angina is typically chest discomfort which comes on with exertion and is relieved by rest. NICE guidance (CG126) indicates that medical management should be optimised in such patients. This includes lifestyle intervention, medications to reduce risk and appropriate medications to improve angina.

The current primary aim of PCI in-stable angina is to improve angina symptoms.

Ideally medical therapy, which should include therapies for the reduction of cardiovascular risk as well as anti-anginal therapies, should be optimised prior to PCI being considered.

This guidance does not apply to:

- Patients presenting with ST-elevation myocardial infarction, non-ST-elevation myocardial infarction or staged procedures after acute coronary syndrome.
- Patients presenting with unstable angina defined as myocardial ischaemia at rest or on minimal exertion in the absence of acute cardiomyocyte injury/necrosis.
- Patients presenting with crescendo (rapidly worsening) stable angina.
- Patients who may be best treated with coronary artery bypass graft surgery.

All patients being considered for elective revascularisation should have documented evidence that a formal shared decision-making process has taken place with informed patient choice.

***Optimal medical management should be offered and include:**

Lifestyle interventions –

- Weight Management
- Smoking cessation
- Adherence to a cardioprotective diet
- Regular physical exercise

Risk reduction management –

- Antiplatelet therapy or anticoagulant in line with current guidelines
- Adequate lipid lowering therapy.
- ACE Inhibitor or alternative to optimal dose
- Anti-hypertensive therapy to guideline-directed targets

Appropriate glycemic control in patients with diabetes

Anti-anginal medication in line with current guidelines –

- Preferably two anti-anginal agents at recommended daily dose.
- Symptoms should ideally be reassessed after an appropriate period of optimal anti-anginal medication up- titration and assessment of side effects.

****Patient without ongoing angina should be discussed at an appropriate MDM before being offered PCI. This could include patients that are not within these criteria, for example, patients undergoing transcutaneous**

aortic valve implantation, asymptomatic patients with evidence of significant ischaemia, occupational indications, or patient preference.
Policy: **This guidance applies to those 18 years and over.** **PCI should only be performed in patients with stable angina if patients:** • Have ongoing anginal symptoms despite optimal anti-anginal medication* **OR** • Have ongoing angina symptoms with intolerance of anti-anginal medications* **OR** • Are participating in clinical research in stable coronary artery disease. **In addition, if agreed at an appropriately constituted myocardial revascularisation cardio multidisciplinary meeting (MDM)**, PCI may also be performed in patients with stable angina in the following cases:** • In patients with impaired left ventricular systolic function. **OR** • In patients with left main stem disease. **OR** • In patients with significant ischemic burden **OR** • Where PCI is otherwise appropriate by the MDM**

Asymptomatic Carotid Artery Stenosis Screening	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Based on evidence, the EBI programme proposes that patients without relevant cardiovascular symptoms should not be referred for imaging. If a patient is found to have narrowed arteries, they do not require follow up if they continue to have no symptoms.

Policy:

- Patient is 18 years and over.

AND

- Patient can be referred when demonstrating relevant cardio symptoms, (input required from cardiovascular team)

OR

- Patient has evidence of an ischaemic event in the brain.

Asymptomatic carotid artery stenosis screening WILL NOT be offered to the following:

- Asymptomatic individuals should **NOT** be screened for carotid artery stenosis.

OR

- Patients with known peripheral vascular disease should not be asymptomatic screened.

OR

- Patients undergoing other forms of cardiac surgery do not qualify for asymptomatic screening.

OR

- Asymptomatic patients with carotid artery stenosis do not qualify for routine follow ups.

OR

- Peripheral vascular disease patients do not qualify for carotid artery stenosis screening.

Diagnostic Coronary Angiography for low risk, stable chest pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Invasive coronary angiography should only be offered for low risk, stable chest pain as third-line investigation when the results of non-invasive functional imaging are inconclusive:

- Patient has significant findings on CT coronary angiogram (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)

OR

- CT coronary angiography is inconclusive and further non-invasive functional imaging (either 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) is inconclusive

Troponin Test	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

This guidance applies to Adults and Children

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- A clinical diagnosis of acute coronary syndrome is suspected.

OR

- A clinical diagnosis of myocarditis is suspected or myocardial damage following chemotherapy.

OR

- Test is for prognostic purposes when pulmonary embolism is confirmed

Gastroenterology

Appropriate Colonoscopy in the Management of Hereditary Colorectal Cancer	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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 hemorrhage 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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Colonoscopy in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

Appropriate colonoscopy in the management of hereditary colorectal cancer - family history

- For individuals with moderate familial CRC risk a one-off colonoscopy at age 55 years

OR

- Subsequent colonoscopic surveillance should be performed as determined by post-polypectomy surveillance guidelines.

OR

- One colonoscopy every 5 years from age 40 years to age 75 years for individuals that have high familial CRC risk (a cluster of 3x FDRs with CRC across >1 generation)

Appropriate colonoscopy in the management of hereditary colorectal cancer - for Lynch Syndrome (LS) and Lynch-like Syndrome

- The patient has Lynch Syndrome and is a MLH1 and MSH2 mutation carrier and therefore colonoscopic surveillance is in line with every 2 years from age 25 years to age 75 years.

OR

- Patient has Lynch Syndrome and is a MSH6 and PMS2 mutation carrier and therefore colonoscopic surveillance is in line with every two years from age 35 years to age 75 years.

OR

- Patient has 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, and therefore has colonoscopic surveillance every 2 years from age 25 years to age 75 years

Appropriate colonoscopy in the management of hereditary colorectal cancer for Early Onset CRC (EOCRC)

- Patient is diagnosed with CRC, under the age of 50 years and hereditary CRC symptoms have been excluded, colonoscopy surveillance to be carried out as standard post-CRC after 3 years.

OR

- Patient is diagnosed with CRC, under the age of 50 years and hereditary CRC symptoms have been excluded and they have had their previous 3-year interval colonoscopy and is now having colonoscopic surveillance every 5 years until eligible for national screening.

Appropriate colonoscopy in the management of hereditary colorectal cancer for Serrated Polyposis Syndrome (SPS)

- Patient has Serrated Polyposis Syndrome (SPS) and colonoscopic surveillance is every year from diagnosis once the colon has been cleared of all lesions >5mm in size.

OR

- Patient has Serrated Polyposis Syndrome (SPS) and no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, so colonoscopic surveillance interval is every 2 years.

OR

- First degree relatives of patients with SPS undergoing an index colonoscopic screening examination at age 40 or ten years prior to the diagnosis of the index case will be carried out.

OR

- Patient is a first degree relative of a patient with SPS who is undergoing surveillance colonoscopy every 5 years until age 75 years, unless polyp burden indicates an examination is required earlier according to post-polypectomy surveillance guidelines.

Appropriate colonoscopy in the management of hereditary colorectal cancer for Multiple Colorectal Adenoma (MCRA)

- Patient has MCRA (defined as having 10 or more metachronous adenomas) and so is having annual colonoscopic surveillance from diagnosis to age 75 years after the colon has been cleared of all lesions >5mm in size.

OR

- Patient has MCRA (defined as having 10 or more metachronous adenomas) and no polyps 10mm or greater in size are identified at subsequent surveillance examinations, colonoscopic surveillance will be carried out every two years.

Appropriate colonoscopy in the management of hereditary colorectal cancer for Familial Adenomatous Polyposis (FAP)

- Patients are confirmed to have FAP on predictive genetic testing and so colonoscopic surveillance is to be carried out from 12-14 years (or every 1-3 years, personalised according to colonic phenotype)

OR

- Patient has a first degree relative with a clinical diagnosis of FAP (i.e. “at risk”) and in whom a APC mutation has not been identified (so colorectal surveillance is to be carried out from 12-14 years or every 5 years until either a clinical diagnosis is made and they are managed as FAP or the national screening age is reached)

Appropriate colonoscopy in the management of hereditary colorectal cancer for MUTYH-associated Polyposis (MAP)

- Patient has MUTYH-associated Polyposis (MAP) and so colorectal surveillance to be carried out from 18-20 years, and, if surgery has not been undertaken, is to be repeated annually.

Appropriate colonoscopy in the management of hereditary colorectal cancer for Peutz-Jeghers Syndrome (PJS)

For symptomatic patients, investigate earlier.

- Patient is asymptomatic with PSJ then colorectal surveillance is to be carried out from 8 years.

OR

- Patient is asymptomatic with PSJ if baseline colonoscopy is normal, repeat colonoscopy deferred until 18 years, however if polyps are found at baseline examination, repeat every 3 years.

Colonoscopy in the management of hereditary colorectal cancer for Juvenile Polyposis Syndrome (JPS)

- Patient is asymptomatic with JPS offer colorectal surveillance from 15 years.

OR

- Patient is asymptomatic with JPS then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype.

ERCP in Acute Gallstone Pancreatitis without Cholangitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours.

Not included in EBIcheck+ due to this intervention most often taking place as part of an Inpatient admission

Repeat Colonoscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

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.

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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Surveillance Colonoscopy in relation to the conditions / interventions listed should only be carried out where the specified criteria are met.

High Risk Classification:

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

NOTE: 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

Surveillance colonoscopy after polypectomy

- The patient is considered high risk, in line with the specified criteria.

AND

- The patient is under the age of 75with a life-expectancy greater than 10 years.

AND

- Has not had surveillance within the past 3 years.

Surveillance colonoscopy after potentially curative CRC resection

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has not had a clearance colonoscopy within a year since initial resection or surveillance. within 3 years of clearance colonoscopy

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

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has not had a surveillance colonoscopy within the last 3 years

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

- The patient is considered high risk, in line with the specified criteria

AND

- There has been confirmation of no reoccurrence following the original resection

AND

- The patient is undergoing a site check at either 2-6 months, or 18 months on from original resection, OR a surveillance colonoscopy at 3 years.

Surveillance where histological completeness of excision cannot be determined in patients

- The patient is considered high risk, in line with the specified criteria

AND

- The patient has non-pedunculated polyps of 10-19mm in size, OR an adenoma containing high-grade dysplasia, OR a serrated polyp containing any dysplasia

AND

- Site checks are being carried out between 2-6 months of surgery

Upper GI Endoscopy	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Upper GI Endoscopy in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

NOTE: There should be separate consideration for those with symptoms that qualify for a 2WW, for which EBIcheck+ is not relevant and 2WW pathways should be followed.

Upper GI Endoscopy (for the investigations of symptoms)

- Gastro-oesophageal symptoms are non- responsive to treatment or unexplained.

OR

- Suspected GORD who are thinking about surgery

OR

- H pylori that have not responded to second- line eradication (which can be confirmed with a urea breath test)

Upper GI endoscopy (H pylori and associated peptic ulcer)

- If there is a coexisting peptic ulcer, then repeat endoscopy should be considered 6-8 weeks after beginning treatment for H pylori and the associated peptic ulcer.

Upper GI endoscopy (Barrett's oesophagus)

- The patient has GORD (endoscopically determined oesophagitis or endoscopy - negative reflux disease) so endoscopy is to be carried out to diagnose Barrett's oesophagus.

OR

- Endoscopy surveillance for patient's diagnosed with Barrett's Oesophagus

Upper GI endoscopy (Coeliac Disease)

- Patient is 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

Upper GI endoscopy (Surveillance Endoscopy)

- Patient is fit enough for subsequent endoscopic or surgical intervention, should neoplasia be found. Senior clinician input has been provided before embarking on long term endoscopic surveillance.

OR

- 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 threeyears

OR

- Patients diagnosed with GA or GIM just in the antrum with additional risk factors- such as strong family history of gastric cancer of persistent H pylori infection, should undergo endoscopy every three years.

Upper GI endoscopy (Screening Endoscopy)

- Screening is to be performed in keeping with European expert guidelines (2015)

AND

- Individual is 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)

Upper GI endoscopy (Post excision of adenoma)

- Following complete endoscopic excision of adenomas, gastroscopy is to be performed at 12 months or annually thereafter (when appropriate)

General Surgery

Appendicectomy without confirmation of Appendicitis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National 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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Imaging of patients should only take place where there is 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.

Not included in the EBIcheck+ as the intervention is part of a clinically defined pathway

Neurology

Functional Electrical Stimulation for Drop Foot	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve mobility. It is particularly used as a treatment for drop foot. Drop foot is caused by disruption in the nerve pathway to and from the brain, rather than in nerves within the leg muscles.

Policy:

Non-Implantable Devices:

Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG278, providing normal arrangements are in place for clinical governance, consent and audit, and provided ALL the following criteria are met:

- Drop foot is impeding gait and in whom the use of all orthotics (AFO) has proven to be unsuccessful following specialist assessment.

AND

- The patient has demonstrable functional improvement from an individual trial of FES.

AND

- The intervention is recommended by a multidisciplinary team specialised in rehabilitation.

Implantable Devices:

The wireless or implantable device is NOT routinely commissioned. Funding will only be considered where there are exceptional clinical circumstances. The clinician needs to submit an application to the Individual Funding Request Panel.

Functional Electrical Stimulation for issues other than Drop Foot	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve motor function in weak or flaccid muscles. It can be used in rehabilitation of the upper limb as part of a motor training programme.

Policy:

Functional Electrical Stimulation may be offered for issues other than drop foot to patients only where the following criteria are met:

- The request is being made for a patient following an upper limb, upper motor neurone impairment.

AND

- The patient has demonstrable functional improvement from a trial of FES (within a 4-week period)

AND

- Where the recommendation for FES is made by a specialist rehabilitation team for the upper limb as part of a motor training programme

Spinal Cord Stimulation (Adults only)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Spinal cord stimulation (or neuromodulation) involves implanting electrodes next to the spinal cord and modifies the perception of neuropathic pain by stimulating the dorsal column of the spinal cord. These treatments are well established for certain types of severe chronic neuropathic pain, with approval as outlined in the NICE guidelines (TA159) with a role in failed back surgery syndrome (FBSS) and chronic regional pain syndrome (CRPS) as an alternative to further surgery or increasing dose of opioids in FBSS or as an approach in CRPS after pharmacotherapy and nerve blocks have not provided adequate pain relief, in line with the British Pain Society (BPS). Spinal cord stimulation is not suitable for everyone with chronic pain, and that it should be used only as part of a multidisciplinary team approach alongside other therapies and a strategy for rehabilitation and only after a successful trial with a temporary external device.

Policy:

Spinal Cord Stimulation is only offered as a treatment option for adults where the following criteria are met:

- The patient continues to experience chronic pain of neuoropathic origin, (measuring at least 50 mm on a 0–100 mm visual analogue scale or alternative as appropriate) for at least 6 months despite appropriate conventional medical management.

AND

- The patient has had a successful trial of spinal cord stimulation.

AND

- Assessment has been made by a multidisciplinary team experienced in chronic pain and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed.

Oculoplastics

Referral for Dry Eye Syndrome	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Dry eye syndrome, or dry eye disease, is a common condition that occurs when the eyes don't make enough tears, or the tears evaporate too quickly. The tear film covers the cornea and exposed conjunctiva. It contributes to the health of the cornea and conjunctiva by supplying nutrients, flushing away waste products and acting as a protective barrier.

Most cases of sore tired eyes resolve themselves. Mild to moderate cases of dry eye syndrome or sore tired eyes can usually be treated using lubricant eye treatments that consist of a range of drops, gels and ointments that can easily be purchased over the counter.

Patients should be encouraged to manage both dry eyes and sore eyes by implementing some self-care measures and avoidance of environmental factors alongside treatment.

Policy:

Referral for specialist assessment is only recommended in the following circumstances:

- An underlying systemic condition such as Sjogren's syndrome is suspected.

OR

- Symptoms cannot be adequately controlled in primary care after 12 weeks of regular (at least 4 times daily) application of ocular lubricant.

OR

- The person has abnormal lid anatomy or function.

OR

- There is diagnostic uncertainty.

Please note: A prescription for treatment of dry or sore eyes should not routinely be offered in primary care as the condition is appropriate for self-care.

Where a serious eye condition such as acute glaucoma, keratitis, iritis, or cornel ulcer is suspected, referral to a specialist should be made without delay.

Ophthalmology

Glaucoma Referral Criteria	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Routine optometric sight tests have accuracy limitations for detecting or ruling out glaucoma and glaucoma-related conditions, resulting in a high percentage of false positive referrals to secondary care, resulting in unnecessary anxiety for patients who do not need a referral and potential delays for those who do, risking avoidable blindness.

Evidence shows that additional clinical assessment by optometrists will improve the accuracy of referrals.

The EBI programme proposes that the pathway for the referral of glaucoma and related conditions (such as ocular hypertension [OHT] which is raised eye pressure without optic nerve damage) to a hospital eye service is consistent across England to include additional clinical assessments and repeat measurements performed by optometrists, as recommended by NICE NG81. These services are outside of the sight test and need to be locally commissioned.

Note - The policy should only be followed where the required service provision, equipment and commissioned pathways are in place.

Policy:

This guidance applies to those 18 years and over.

Before referral for further investigation and diagnosis of glaucoma and related conditions, offer all of the following tests, which are separate from a sight test:

- Central visual field assessment using standard automated perimetry (full threshold or supra-threshold)

AND

- Optic nerve assessment and fundus examination using stereoscopic slit lamp bio microscopy (with pupil dilatation if necessary) and optical coherence tomography (OCT) or optic nerve head image if available.

AND

- Intraocular pressure (IOP) measurement using Goldmann-type applanation tonometry.

AND

- Peripheral anterior chamber configuration and depth assessments or, if not available, or the person prefers, the van Herick test or Optical Coherence Tomography (OCT).

Before deciding to refer, consider repeating visual field assessment and IOP measurement on another occasion (repeat measures) to confirm a visual field defect or IOP of 24mmHg or more, unless clinical circumstances indicate urgent, or emergency referral is needed.

Refer for further secondary care investigation and diagnosis of glaucoma and related conditions, after considering repeat measures, if:

- There is optic nerve head damage on stereoscopic slit lamp bio microscopy.

OR

- There is a visual field defect consistent with glaucoma.

OR

- IOP is 24 mmHg or more using Goldmann-type applanation tonometry.

This guidance is intended as a standard threshold for access. However, if the patient falls outside of these criteria, there is the option to apply for an Individual Funding Request (IFR).

Optical Coherence Tomography (OCT) use in Diabetic Retinopathy Referral	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Diabetes can affect the eyes and can cause blindness. People with diabetes have their eyes checked each year through a nationally funded screening programme separate from the optometrist sight test service. 2D digital pictures of the retina at the back of the eye are used to check for any retina problems, however these are not accurate in showing the amount of treatable change (fluid build-up known as oedema) present in the central part of the retina, called the macula. Approximately 50% of patients referred for macular problems on the basis of the 2D pictures do not need hospital treatment.

There is an additional tool called Optical Coherence Tomography (OCT) which uses light waves to take 3D pictures. The detailed images from OCT are much more sensitive and accurate at detecting treatable oedema and so the use of OCT 3D pictures, before attendance at a hospital clinic for macular treatment, can reduce unnecessary referrals.

Currently, diabetic eye screening contracts in England do not include the use of OCT.
The EBI programme recommends that the referral pathway for diabetic patients to be seen by hospital eye services is updated across England to include locally commissioned OCT assessments to supplement the NHS England-commissioned diabetic eye screening services.

Where possible, OCT should be made available within the same appointment as the diabetic screening assessment for efficiency, patient convenience and to reduce patient anxiety.
Patients with low-risk maculopathy below treatment levels should be monitored in OCT-supported assessments outside of routine medically led secondary care clinics.

Note - The policy should only be followed where the required service provision, equipment and commissioned pathways are in place.

Policy:

This guidance applies to those 18 years and over.

The proposed guidance uses best available evidence to propose patients with DES diabetic retinopathy grading M1 or above should have integration of OCT within the DES pathways or as part of a referral refinement protocol prior to assessment in secondary care treatment clinics, in addition to the current fundus photography. Where possible, OCT should be made available within the same appointment as the diabetic screening assessment for efficiency, patient convenience and to reduce patient anxiety.

Referral to / assessment in secondary care face to face treatment clinics should NOT be accepted for any patient with diabetic maculopathy grading of M1 or above without an OCT scan and assessment of images to filter referrals. The OCT scan can be performed at either:

— Diabetic eye screening (DES)
OR
— Local referral refinement.

In addition, patients with low-risk maculopathy below treatment levels should be monitored in OCT-supported assessments outside of routine medically led secondary care clinics.

Integration of OCT imaging into patient pathways can be directly made into the screening programme itself, ideally within the same appointment as the screening assessment, which is the most patient-centred pathway. Alternatively, it can take the form of an asynchronous virtual clinic after undertaking a non-medical (usually technician-led) OCT diagnostic assessment. If not available within the DES setting, the right 'place' for OCT capture will depend on local arrangements and availability of resources, such as the imaging equipment, connectivity, and commissioning arrangements. It could be conducted at a diagnostic clinic in the hospital eye service, at a diagnostic hub or mobile unit in the community or in primary care optometry enhanced services. If undertaken outside the DES, appropriate failsafe and recall arrangements need to be incorporated. There will need to be local agreements, based on available multidisciplinary clinical decision-making expertise and experience, as to where decisions are taken on OCT images and how non-consultant decision makers can access virtual decision support from consultant-led hospital teams. It offers an obvious opportunity to reduce the workload and delays in access to the core hospital eye service and avoid unnecessary referrals of patients with diabetic maculopathy to face to face treatment clinics who do not require treatment.

This guidance is intended as a standard threshold for access. However, if the patient falls outside of these criteria, there is the option to apply for an Individual Funding Request (IFR).

Shared Decision Making for Cataract Surgery	Category: *(IFR / Prior Approval / Monitored Approval)*	Monitored Approval
	Local or National EBI (Evidence Based Interventions) Policy:	National EBI

Background:

The EBI programme proposes that the pathway for patients with cataracts to be referred for surgery is updated across England to include shared decision making and not restrict access based on visual acuity.

Shared decision-making tools have been proven to improve conversion rates and lead to better patient experiences and clinical outcomes. Therefore, all referral pathways for cataract surgery should include shared decision-making tools.

Note - The policy should only be followed where the required service provision and commissioned pathways are in place.

Policy:

Cataract referrals should only be accepted where:

- The patient is 18 years or over.

AND

- A formally documented shared decision-making process has been performed by the referring primary care optometrist with the patient (and their family member or carers, as appropriate) as part of a referral. This includes, but is not limited to:
    1. How the cataract affects the person's vision and quality of life
    2. Whether one or both eyes are affected
    3. What cataract surgery involves, including possible risks and benefits.
    4. How the person's quality of life may be affected if they choose not to have cataract surgery
    5. Whether the person wants to have cataract surgery

Note:

In line with NICE guidance, do not restrict access to cataract surgery on the basis of visual acuity.

This guidance is intended as a standard threshold for access. However, if the patient falls outside of these criteria, there is the option to apply for an Individual Funding Request (IFR).

Surgery for Refractive Error (including Excimer Laser following corneal transplant or cataract surgery)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Refractive eye surgery is any eye surgery used to improve the refractive state of the eye and decrease or eliminate dependency on glasses or contact lenses. This can include various methods of surgical remodelling of the cornea or cataract surgery. The most common methods today use excimer lasers to reshape the curvature of the cornea. Successful refractive eye surgery can reduce or cure common vision disorders such as myopia, hyperopia, and astigmatism, as well as degenerative disorders like keratoconus.

Excimer Laser for poor refraction after corneal transplant or cataract surgery is a last resort measure where all other conservative and surgical interventions have failed.

Policy:

Surgery for refractive error is only commissioned in the following circumstances:

- Where poor refraction after corneal transplant or cataract surgery is demonstrated.

AND

- Where all other conservative and surgical interventions have failed.

Orthopaedics

Arthroscopic Surgery for Meniscal Tears	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Arthroscopy of the knee is a surgical technique where a camera and instruments are inserted into the knee through small incisions, usually under general anaesthesia. Following a detailed systematic assessment of the important structures within the knee joint a surgical procedure is performed which can involve repair or resection of meniscal tissue, with or without other associated procedures such as ligament reconstruction or repair of articular cartilage lesions. The British Association for surgery of the Knee (BASK) recently published guidelines for the use of arthroscopic surgery to treat degenerate meniscal tears.

This guidance applies to Adults and Children

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Meniscal tears in the knee are a common finding and in many cases are not related to any significant symptoms, therefore arthroscopic surgery for meniscal tears should only take place when the following criteria are met:

- Non-operative treatments (including paracetamol and topical NSAIDS) have not settled symptoms after 3 months/persistent symptoms ongoing and an MRI has revealed an unstable meniscal tear.

OR

- The patient has had an acute injury, and an MRI scan reveals a potentially reparable meniscus tear.

OR

- Patient has a locked knee and requires an urgent assessment, which showed a bucket handle tear of the meniscus to be present.

AND

- The patient has gone through a shared decision-making process and understands the risks of surgery.

Exogen Ultrasound Bone Healing	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Exogen Ultrasound Bone Healing delivers low-intensity pulsed ultrasound waves for healing non-union fractures and accelerating the healing of fresh fractures.

Policy:

Exogen ultrasound for bone healing only be funded in accordance with the criteria specified below:

- Where there is a long bone fracture with non-union (failure to heal after 9 months)

Ilizarov Technique	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The Ilizarov apparatus is a type of external fixation used in orthopaedic surgery to lengthen or reshape limb bones; to treat complex and/or open bone fracture; and in cases of infected non-union of bones that are not amenable with other techniques.

Policy:

Ilizarov technique is commissioned for routine elective use in orthopaedics in individual carefully selected cases, where there is agreement by a local orthopaedic MDT that of all available treatments, Ilizarov/TSF is the best clinical option for the patient in terms of a favourable functional limb outcome (bone and functional outcomes are not always the same). Ideally, the MDT should comprise at least two consultant Orthopaedic surgeons, with input from specialist nursing, physiotherapy, and musculoskeletal radiology.

Please note: this does not apply to emergency care.

Ring External Fixator / Hexapod External Fixator	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

External fixators used in orthopaedic surgery, such as a Taylor Spatial Frame (TSF), Ilizarov frames or Truelok frames (Orthofix), aid the healing process of complex fractures and bone deformities. These frames can be used in acute trauma settings but also in more "elective" / planned limb reconstruction cases. Both angular and translational deformities can be corrected with an external fixator. The correction of the bone deformity typically takes 3-4 weeks, but the frame will have to remain on the limb until bony union is achieved which can take months / years depending on the clinical situation.

Policy:

An external fixator (Ring or Hexapod) may be offered to patients only where the following criteria are met:

- Appropriate treatment options, including sequelae of non-operative management have been discussed with the patient / carer and documented in notes.

AND

- It is considered to be the most clinically appropriate option as determined by a consultant orthopaedic surgeon with rationale for frame use documented and having undergone local MDT / discussion.

AND

- The patient and or their carer must have the ability to carry out the daily adjustments to aid the healing process of complex fractures and / or angular and / or translational bonedeformities.

OR

- If patient or carer are unable to perform corrections, then the hospital service should be able to facilitate the process

Vertebral Augmentation (vertebroplasty or kyphoplasty) for Painful Osteoporotic Vertebral Fractures	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored 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.

The alternative to vertebral augmentation is conservative management. This consists of pain relief, bracing, and manual therapy. Bone healing can take place over 2-12 weeks. Hospitalisation, immobility, and opioid pain medication often have significant side effects, particularly in older patients.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- Patient has severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management.

AND

- The acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination.

AND

- Multidisciplinary team discussions have taken place.

AND

- The procedure will take place at a facility with access to spinal surgery services.

AND

- Processes for audit and clinical governance are in place.

AND

- Vertebroplasty must be performed in conjunction with additional measures to improve bone health.

NOTE: Older patients (>60 years old) with fractures at most 6 weeks old and with severe pain despite optimal pain management benefit most from the procedure.

Other

Blood Transfusion	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Red Blood Cell transfusions for adults (or equivalent based on body weight for children or adults with low body weight) should only be administered where the following criteria is met:

- A single unit of blood is given to a patient with severe acute anemia (Hb <70g/litre) that is symptomatic and prevents rehabilitation or mobilization.

NOTE: Blood transfusions should not be given to patients due to B12, folate or iron deficiency anaemia alone. Restrictive red blood cell transfusion should not be used for patients with major haemorrhage, acute active bleeding, acute coronary syndrome or who need regular transfusions for chronic anaemia.

Open / Wide-Bore / Upright Magnetic Resonance Imaging (MRI) Scanning	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

As the demand for MRI imaging increases so does the demand for different types of scanners. The main reasons for alternative scanners being requested are claustrophobia and obesity, with a few being requested for clinical reasons (usually upright scans) however, there is a need to manage access to alternative scanners in an equitable way based on need whilst managing a scarce resource. The majority of patients should be referred for a standard MRI scan in the normal way however, if they are unable to undergo scanning in this way due to claustrophobia or obesity, then they should be managed in line with this policy.

Policy:

Upright MRI Scanning (standing, weight-bearing or positional MRI) are NOT routinely commissioned.

Referral for open or wide-bore MRI scanning as an alternative to conventional MRI in secondary care is commissioned only for the specific anatomy requested where:

- The patient has an underlying condition that prevents them from properly lying in a conventional MRI scanner because of severe pain despite analgesia provision.

OR

- The patient is unable to tolerate conventional MRI due to claustrophobia or cannot fit intoa standard scanner due to obesity.

AND

- It is considered essential for the clinical management of the patient and no alternative is available.

AND

- All other options to attain a scan have been tried and failed (including standard scanning under oral sedation in the first instance, unless this is clinically contraindicated)

AND

- The patient is made aware of the limitations (eg: resolution of the resulting image impacting on the quality of the scan result) for the relevant type of scanner before being referred.

Note: Any conditions not described in the policy where the referrer believes there is a requirement for an open or wide-bore MRI scan to be undertaken should be submitted as an Individual Funding Request. Scans undertaken as part of an externally funded trial are excluded from this policy.

Pathology

Liver Function, Creatinine Kinase and Lipid Level Tests – (Lipid lowering therapy)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Liver Function Testing in relation to the conditions / interventions listed, should only be carried out where the specified criteria are met.

Liver Functioning Test

- Baseline liver function to be carried out before starting lipid modification therapy.

OR

- Liver function is being measured (once) within 3 months of starting treatment.

OR

- Liver function is being measured (once) at 12 months following treatment.

Creatine Kinase Testing for Lipid Lowering Therapy

- Prior to lipid modification therapy initiation in patients who have experienced generalized, unexplained muscle pains or weakness (whether associated with previous lipid-monitoring therapy)

OR

- If a patient develops muscle pains or weakness whilst on lipid modification therapy.

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.

OR

- 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.

OR

- Consider an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.

NOTE: Further details are outlined in NICE guidance (CG181) and ESC guidance for the management of dyslipidaemias: lipid modification to reduce cardiovascular risk. Creatine kinase should not be routinely monitored in asymptomatic people who are taking lipid modification therapy.

Prostate-Specific Antigen (PSA) Test	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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, men with persistently raised PSA levels are referred on for further evaluation and may be offered histological assessment by trans-rectal or trans-perineal biopsy. 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 male adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Prostate-Specific Antigen (PSA) Test should only be performed where the following criteria are met:

- The man is asymptomatic and over age 40 and at higher risk of prostate cancer (e.g. they are Black and/or have a family history of prostate cancer)

OR

- Symptomatic men with lower urinary tract symptoms (LUTS), such as nocturia, urinary frequency, hesitancy, urgency or retention, visible haematuria.

OR

- erectile dysfunction

OR

- Symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss).

AND

- A careful discussion about the potential risks and benefits of PSA testing has been held, allowing for shared decision.

NOTE: PSA testing for prostate cancer should be avoided if the man 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 the above are likely to raise PSA and give a false positive result.

Plastics

Hirsutism	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

Laser treatment is increasingly being used as a cosmetic intervention to remove body hair. Patients with excessive body hair are described as having hirsutism. Hair depilation (for the management of hypertrichosis) involves permanent removal/reduction of hair from face, neck, legs, armpits, and other areas of body usually for cosmetic reasons. Hair depilation is most effectively achieved by laser treatment.

Policy:

Hair depilation will only be funded in accordance with the criteria specified below.

One course of treatment will be funded for those patients:

- Who are undergoing treatment for pilonidal sinuses to reduce the recurrence.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Repair of Lobe of External Ear	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**Local**

Background:

The external ear lobe can split partially or completely as result of trauma or wearing earrings. Correction of split earlobes is not always successful, and the earlobe is a site where poor scar formation is a recognised risk.

Policy:

Repair of lobe of external ear will only be funded in accordance with the criteria specified below.

- If the totally split ear lobe is a result of direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred.

Surgery for primarily cosmetic reasons is not eligible for NHS funding

Radiology

Knee MRI for suspected Meniscal Tears	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Degenerate meniscal tears and OA are extremely common in the general population. MRI is not usually recommended for a suspected degenerative meniscal tear.

- Clear history of a significant acute knee injury

AND

- Mechanical symptoms

OR

- Have a locked knee

Knee MRI when symptoms are suggestive of Osteoarthritis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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 affected joints are the knees, hips and small hand joints with a poor link between changes visible on a radiograph and symptoms ofosteoarthritis.

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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: An MRI of the knee is not usually needed for the diagnosis of Osteoarthritis. An MRI should only be offered where the following criteria are met:

- Patient has severe symptoms but relatively mild osteoarthritis on standard X-rays.

OR

- Patient is working up for possible HTO (High Tibial Osteotomy) or partial knee replacement (to focus on the state of the anterior cruciate ligament and retained compartments)

Low Back Pain Imaging	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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:

- 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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Imaging for Low Back Pain should only be offered if serious underlying pathology is suspected.

- Serious underlying pathology is suspected - this may include, 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. Please see the relevant NICE guideline for further information around these conditions.

AND

- A full history and medical examination of the patient has been carried out.

NOTE: 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.

MRI scan of the hip for arthritis	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

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.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Do not request a hip MRI when the clinical presentation (history and examination)and X-rays demonstrate typical features of OA. MRI of the hip for arthritis should only be requested where the following criteria are met:

- The patient is under 45.
  AND
- The patient does not have activity-related joint pain.
  AND
- The patient has morning stiffness lasting more than 30 minutes.

OR

- Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis

OR

- Patient has suffered trauma.

OR

- Patient has history or family history of an inflammatory arthropathy.

OR

- Mechanical, impingement type symptoms

OR

- Prolonged and morning stiffness

OR

- History of cancer or corresponding risk factors

OR

- Suspected Osteonecrosis / Avascular necrosis of the hip

OR

- Suspected transient osteoporosis.

OR

- Suspected periarticular soft tissue pathology e.g. abductor tendinopathy"

NOTE: 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.

Pre-operative chest x-ray	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Pre-operative chest x-ray should only take place where the following criteria have been met:

- Patients undergoing cardiac or thoracic surgery.

OR

- Patients undergoing organ transplantation or live organ donation.

OR

- 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.

OR

- At the request of the anaesthetist in those with a recent history of chest trauma

OR

- At the request of the anaesthetist in patients with a significant smoking history who have not had a chest radiograph in the previous 12 months, or those with malignancy and possible lungmetastases.

OR

- At the request of the anaesthetist in those undergoing a major abdominal operation, who are at high risk of respiratory complications.

NOTE: NICE recommend that chest radiographs should not be routinely offered before elective surgery.

Pre-operative ECG	Category: *(IFR / Prior Approval / Monitored Approval)*	Monitored Approval
	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 pre-operative assessment is not necessary.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: Pre-operative ECG should only take place where the following criteria have been met:

- Patients with an American Society of Anesthesiologists (ASA) physical classification status of 3 or greater and no ECG results available for review in the last 12 months.

OR

- Patients with a history of cardiovascular or renal disease, or diabetes

OR

- 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.

OR

- Patients are over the age of 65 and attending for major surgery.

NOTE: Pre-operative electrocardiograms should not be routinely performed in low risk, non-cardiac, adult elective surgical patients

Shoulder Radiology: Scans for Shoulder Pain	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

W1 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.

W2 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.

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.

This guidance applies to adults aged 19 years and over.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy: 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. Scans for Shoulder pain should only be carried out where the specified criteria are met.

Scans

- Ultrasound, MRI or CT scan has been requested by secondary care services that are responsible for the definitive treatment of the patient.

OR

- Investigations are outside secondary care, and a referral pathway has been developed with the local secondary care specialist shoulder service.

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

Urology

Cystoscopy for Men with uncomplicated Lower Urinary Tract Symptoms	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

Cystoscopy should only be offered when clinically indicated and the patient has LUTS symptoms,

- The patient has lower urinary tract symptoms (LUTS) and suffers recurrent urinarytract infections.

OR

- The patient has lower urinary tract symptoms (LUTS) and has sterile pyuria (urine dip positive for leukocytes without bacterial growth)

OR

- The patient has lower urinary tract symptoms (LUTS) and haematuria.

OR

- The patient has very significant/profound lower urinary tract symptoms (LUTS)

OR

- The patient has lower urinary tract symptoms (LUTS) with pain around urinary tract.

OR

- The patient has lower urinary tract symptoms (LUTS) and risk factors such as long smoking history, travel or occupational history suggesting a high risk of malignancy, or previous. urogenital surgery

Needle Biopsy of Prostate	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Prostate cancer is the second most common cause of cancer death in people assigned male at birth. It is important that cancer pathways give equal access to care across England. Traditionally needle biopsies would have been taken for diagnosis of prostate cancer. However, studies now show that multiparametric magnetic resonance imaging (mpMRI) scans, which produce a detailed picture of the prostate gland, can more accurately detect clinically significant prostate cancer compared to biopsy alone.

All centres involved in the diagnosis and management of prostate cancer should also aim to offer LATP (transperineal biopsy under local anaesthetic) as an option.

Current clinical consensus supports the use of LATP over transrectal biopsy and therefore this should be considered as the first line investigation, where feasible.

Note - The policy should only be followed where the required service provision, equipment and commissioned pathways are in place.

Policy:
This guidance applies to those 18 years and over.

Triage or one-stop clinic.

— All patients with suspected prostate cancer, based on clinical examination and/or Prostate Specific Antigen (PSA) level, should be offered urgent clinical triage by a suitable member of the clinical team (within two weeks), preferably via remote triage consultation (either video or telephone). Offer face-to-face consultations where remote consultations are not considered appropriate.

— Following initial triage, mpMRI should be considered to enable a fully informed discussion regarding the role of prostate biopsy based on clinical examination, mpMRI findings and other risk factors. One-stop clinics could be considered, where feasible

— In addition to PSA, digital rectal examination and mpMRI findings, other risk factors such as PSA density, should be considered for clinically suspected cases of prostate cancer.

Pre-biopsy mpMRI

— Offer mpMRI as the first line investigation for people with suspected non-metastatic prostate cancer. mpMRI should not routinely be offered to people with prostate cancer who are not suitable for radical treatment.

— Consider omitting a prostate biopsy for people whose mpMRI Likert or Prostate Imaging and Data System (PI-RADS) v2.1 interpretation score is 1 or 2, and the PSA density is less than 0.15, but only after discussing the risks

and benefits with the person and reaching a shared decision. If a person opts to have a biopsy, offer a systematic prostate biopsy.

— Prostate biopsy should be offered for patients with PSA density >0.15 on mpMRI specified volume assessment, a strong family history of prostate cancer (e.g., multiple relatives at a young age) or an abnormal prostate on examination, even if Likert or PI-RADS v2.1 score is 1 or 2

— Patients with a Likert or PI-RADS v2.1 score of 3 should be considered for prostate biopsy. This should be following consideration of clinical assessment, PSA density and prostate cancer risk factors, and after discussing the risks and benefits with the patient and reaching a shared decision.

— Offer prostate biopsy to all patients with a Likert or PI-RADS v2.1 score of 4 or 5, unless otherwise clinically contraindicated.

Biopsy route and setting

— Biopsies may be performed by transperineal (TP) or transrectal (TR) routes.

— Preferably offer transperineal biopsy under local anaesthetic (LATP) as a first line investigation.

All centres involved in the diagnosis and management of prostate cancer should aim to offer LATP as an option.

If LATP is not appropriate, then offer alternative options such as general anaesthetic trans-perineal biopsy or local anaesthetic transrectal ultrasound scan (TRUS) biopsy, based on patient specific factors.

The use of general anaesthetic should be minimised. However, indications may include: — Patient is unable to tolerate biopsy under local anaesthetic — Biopsy involves multiple entry points — Repeat biopsy (e.g., following an inconclusive result) — Prostatic anatomical variation.

Visible lesions should be targeted. If there is a lesion, both targeted and systematic biopsies should be offered. Target biopsies should be performed initially, followed by systematic biopsies, and sent separately for histological analysis.

Please note, that this guidance is intended as a standard threshold for access. However, if you/ your patient falls outside of these criteria, the option to apply for an Individual Funding Request is still available to you.

Non-Visible Haematuria	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Non-visible haematuria is blood that is present but not visible in urine. It is usually found on the dipstick test and can indicate cancer (between 3- 9% of people with nonvisible haematuria go on to be shown to have cancer). It is also common in other, benign conditions such as infections or bladder / kidney stones.

Non-visible haematuria is common, with prevalence estimated at 2.5% of the population, rising to 18% in males of 70 years and older. The vast majority of patients (93.6-97%) will have no urological cancer found following secondary care investigation of non-visible haematuria.

Patients should be referred from primary care to secondary care for investigation of non-visible haematuria in line with guideline NG12 from the National Institute for Health and Care Excellence (NICE).

This guidance gives clear, agreed, evidence-based guidance on how it should be investigated in hospital.

Note - The policy should only be followed where the required service provision, equipment and commissioned pathways are in place.

Policy:

This guidance applies to those 18 years and over.

Patients should be referred from primary care to secondary care for investigation of nonvisible haematuria in line with guideline NG12 from the National Institute for Health and Care Excellence (NICE).

Refer patients from Primary to Secondary Care using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are:

- Aged 60 years and over.

AND

- Have unexplained non-visible haematuria.

AND

- Either dysuria OR a raised white cell count on a blood test

Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection.

The NICE guidance also includes recommendations on patient information and support, safety netting and the diagnostic process which are applicable both to patients who do and who do not meet the above referral criteria.

Secondary care urological investigation of non-visible haematuria should consist of:

— Imaging

— Ultrasound scan (USS) should be first line imaging modality.

— DO NOT routinely perform CT urography if USS is normal.

AND

— Cystoscopy

— Flexible cystoscopy under local anaesthesia should be the preferred approach unless patient choice or other factors make this inappropriate

AND

— A discussion regarding the rationale, risks, benefits, and likely outcomes of investigation with patients as part of a shared decision-making process.

Where, following investigation with imaging and cystoscopy, no cause for non-visible haematuria is found, patients should be discharged from secondary care follow up. They should not be referred or investigated again for future episodes of non-visible haematuria unless there is a change in their symptoms or signs (most notably the development of visible haematuria in the absence of urinary tract infection).

Please note that this guidance is intended as a standard threshold for access. However, if you/ your patient falls outside of these criteria, the option to apply for an Individual Funding Request is still available to you.

Penile Circumcision (for adults and children)	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI (adapted for NENC)**

Background:

Penile circumcision is the removal of the foreskin from the penis. This guidance does not focus on religious or cultural reasons for penile circumcision, which are not funded by the NHS. It refers only to the medical indications for penile circumcision in adults and children. Phimosis (where the foreskin is too tight to be pulled back over the head of the penis) is normal in babies and young children. The percentage that can fully retract the foreskin increases with age.

Evidence shows that there is a wide variation in numbers of penile circumcision performed across England. It is important to note that young children may be unable to give informed consent to penile circumcision, therefore clinicians should carefully consider the evidence-base and alternative options available.

Policy:

This policy applies to adults and children and is not funded for social, cultural, or religious reasons. This policy excludes adults, children, and young people with congenital penile conditions such as hypospadias.

Medical reasons for funding circumcision include:

- Carcinoma of the penis or suspicion of carcinoma (leukoplakia)

OR

- Prevention of urinary tract infection (UTI) in patients with recurrent UTIs or at high risk of UTI

OR

- Pathological phimosis/recurrent paraphimosis (balanitis xerotica obliterans /lichen sclerosus)

OR

- Persistent phimosis in children approaching puberty, following an attempted trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed.

OR

- Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis.

Relative indications for circumcision or other foreskin surgery:

Tight foreskin causing pain on arousal/interfering with physical function

Surgical Removal of Kidney Stones	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored 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.

Further information on the National EBI Policies can be found at www.aomrc.org.uk/ebi

Policy:

- Renal stones are 5-10mm and not suitable for watchful waiting, shockwave lithotripsy is to be offered as first-line treatment (unless contra-indicated or not targetable)

OR

- Renal Stones are 10-20mm shockwave lithotripsy can be considered as first-line treatment (if treatment can be given in a timely fashion)

OR

- Renal stones are 10-20mm and shockwave lithotripsy is contraindicated or ineffective,then ureteroscopy can be considered.

OR

- Renal stones are over 20mm (including staghorn), percutaneous nephrolithotomy (PCNL) can be offered as first-line treatment

Vascular

Asymptomatic Carotid Artery Stenosis Screening	**Category:** *(IFR / Prior Approval / Monitored Approval)*	**Monitored Approval**
	Local or National EBI (Evidence Based Interventions) Policy:	**National EBI**

Background:

Based on evidence, the EBI programme proposes that patients without relevant cardiovascular symptoms should not be referred for imaging. If a patient is found to have narrowed arteries, they do not require follow up if they continue to have no symptoms.

Policy:

- Patient is 18 years and over.

AND

- Patient can be referred when demonstrating relevant cardio symptoms, (input required from cardiovascular team)

OR

- Patient has evidence of an ischaemic event in the brain.

Asymptomatic carotid artery stenosis screening WILL NOT be offered to the following:

- Asymptomatic individuals should **NOT** be screened for carotid artery stenosis.

OR

- Patients with known peripheral vascular disease should not be asymptomatic screened.

OR

- Patients undergoing other forms of cardiac surgery do not qualify for asymptomatic screening.

OR

- Asymptomatic patients with carotid artery stenosis do not qualify for routine follow ups.

OR

- Peripheral vascular disease patients do not qualify for carotid artery stenosis screening

Document History

All amendments and updates to the Regional VBCC Policy prior to April 2019 have been archived and can be found in previous versions of the policy document. These can also be obtained upon request.

February 2019 – For Implementation from 1st April 2019		
Policy Area	**Notes**	**Contributors**
Bariatric Surgery – Revisional Procedures	Inclusion of policy relating to Revisional Bariatric Surgery following clarification queries. No change to previous NHSE policy – now ICB'S responsibility.	NE&C Clinical Leads and NHSE Commissioners
Breast – Prosthesis Replacement	Breast – Prosthesis Replacement previously not routinely commissioned will now be recognised as a commissioned procedure where a specific set of criteria are met, as detailed within the policy.	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Vagal Nerve Stimulation (Non-invasive) for Cluster Headache	Inclusion of Policy following NTAG Guidance published.	NE&C Clinical Leads and NTAG
Adult Snoring Surgery (in the absence of OSA)	National EBI Policy for inclusion in Regional Policy from April 2019. Adopted EBI Policy Title. Not previously included in NE&C Policy.	National EBI Guidance
Dilatation and curettage (D&C) for heavy menstrual bleeding in women	Minor changes to wording based on new NICE Guidelines. No changes to basis of policy. Adopted EBI Policy Title. Previously 'Dilatation and curettage (D&C) for treatment of heavy menstrual bleeding'.	National EBI Guidance

Knee arthroscopy	No changes to policy but reviewed in line with EBI guidance. Maintained current NE&C Policy title.	National EBI Guidance
Low Back Pain - Spinal injections	Minor additions suggested to policy for Non-Specific LBP. Maintained current NE&C policy title.	National EBI Guidance
Breast reduction	Some changes to wording of existing policy criteria. No change to Policy title.	National EBI Guidance
Removal of benign skin lesions	Minor changes to policy criteria in first criteria point. Adopted EBI Policy Title. Previously 'Minor Skin Lesions'.	National EBI Guidance
Grommets (and other ventilation devices) in Children	Some minor additions to policy as suggested by EBI Guidance. Maintain current NE&C policy title.	National EBI Guidance
Tonsillectomy for Recurrent Tonsillitis	Very minor additions to criteria wording included. Adopted EBI Policy title. Previously 'Tonsillectomy'.	National EBI Guidance
Haemorrhoid surgery	Very minor additions to criteria wording included.	National EBI Guidance

	Adopted EBI Policy title. Previously 'Haemorrhoidectomy surgical'.	
Hysterectomy for heavy menstrual bleeding	Very minor additions to criteria wording included. No change to Policy Title.	National EBI Guidance
Chalazia removal	Wider policy of 'Surgery for Minor Eyelid Lesions' which includes Chalazia already exists in NE&C. Chalazia Removal separated out to become standalone policy. Wider NE&C policy for all other minor eyelid lesions remains in place. Adopted EBI policy title.	National EBI Guidance
Arthroscopic shoulder decompression for subacromial shoulder pain	National EBI Policy for inclusion in Regional Policy from April 2019. Adopted EBI Policy Title. Not previously included in NE&C Policy.	National EBI Guidance
Carpal tunnel syndrome release	Inclusion of additional Background: text and minor amends to policy criteria. Adopted EBI Policy Title. Previously 'Carpal Tunnel Surgery'.	National EBI Guidance
Dupuytren's Contracture – Referral for Secondary Care Opinion	Inclusion of additional Background: text and minor amends to policy criteria. No changes proposed to Collagenase or Radiotherapy policies. Maintained current NE&C policy title	National EBI Guidance

Ganglion excision	Very minor additions to criteria wording included. Adopted EBI Policy title. Previously 'Ganglia'.	National EBI Guidance
Trigger finger release in adults	Inclusion of additional Background: text and further amends to policy criteria as suggested by EBI Guidance. Adopted EBI Policy Title. Previously 'Trigger Finger.	National EBI Guidance
Varicose vein interventions	Very minor amendments to policy wording included. Adopted EBI Policy Title. Previously 'Varicose Veins in the Leg'.	National EBI Guidance

January 2020 – For Implementation from 1st April 2020		
Policy Area	**Notes**	**Contributors**
Functional Electrical Stimulation (FES)	The title of this existing policy has been updated to reflect that it is specifically FES for Drop Foot due to the inclusion of a new policy for 'FES for issues other than drop foot'	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Invitro Fertilisation (IVF) and Intracytlopasmic Sperm Injection (ICSI)	Rename the title of the policy to the following: 'Assisted Reproduction Treatments' Policy content has been re-drafted to ensure the detail of the policy is clearer to understand as well as addresses position on same sex couples as surrogacy is not funded for male or females and Fertility Preservation	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT

Low Back Pain - Epidural and nerve root injections	Removed as a singular policy and replaced with the following two distinct policies, as recommended by local specialists; o Low Back Pain – Epidural and Nerve Root Injections for **Acute** Radicular Leg Pain o Low Back Pain – Epidural and Nerve Root Injections for **Chronic** Radicular Leg Pain	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Low Back Pain - Medial Branch Block (MBB) Low Back Pain - Radiofrequency Denervation (Rhizolysis)	Included a specific policy title for 'Medial Branch Block' and corresponding criteria that mirrors the criteria for Rhizolysis to clarify that a PAT can be obtained for this intervention, where criteria are satisfied. Minor update to Rhizolysis policy to add additional criteria point to note that a positive response to MBB diagnostic is required and to highlight that the MBB requires a separate PAT.	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Breast – Revisions of Breast Reconstruction Surgery and Repeated Courses of Nipple Tattooing	Some minor additional words added to the Background: information with minor formatting change to emphasise the words 'due to cancer treatment or prevention' in the Background: information.	NE&C ICB'S Clinical Leads
Hyperhidrosis – Referral Hyperhidrosis – Treatment with Botulinum Toxin	Hyperhidrosis – Referral; Additional criteria added in line with the criteria required for the treatment of hyperhidrosis, specifically, that any underlying anxiety has been identified and managed, and that 20% aluminium chloride hexahydrate has failed or is contraindicated. Hyperhidrosis – Treatment with Botulinum Toxin**;** Additional criteria added in line with the criteria required for the referral of a hyperhidrosis patient, specifically, that there must be evidence of medical complications such as skin macerations or secondary infections.	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Flash Glucose Monitoring	Policy criteria updated as detailed below to reflect the NHS England policy as already adopted and reflected in VBC Checker (now EBIcheck+).	NE&C ICB'S Clinical Leads

Breast – Breast Prosthesis Replacement	Clarity added to ensure marked asymmetry is included within the policy, provided criteria are met. Additional clarity added to note that this procedure will only be considered when the original procedure was provided by the NHS.	NE&C ICB'S Clinical Leads
Knee Replacement Surgery	Policy title updated to read 'Knee Replacement Surgery (Total)'	NE&C ICB'S Clinical Leads and Orthopaedic Alliance
Wigs & Hair Pieces	Inclusion of new policy	NE&C ICB'S Clinical Leads
Lycra Garments (for Children)	Inclusion of new policy	NE&C ICB'S Clinical Leads
Rhinophyma	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Continuous Positive Airway Pressure (CPAP) Device for Adults	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Newcastle Hospitals FT
Sacral Neuromodulation (SNM) for Faecal Incontinence	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from South Tees FT
Spinal Cord Stimulation (Adults only)	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from South Tees FT
Functional Electrical Stimulation (FES) for issues other than drop foot	Inclusion of new policy	NE&C ICB'S Clinical Leads and Clinical Teams from Northumbria FT
Open / Wide-Bore / Upright Magnetic Resonance Imaging (MRI) Scanning	Inclusion of new policy	NE&C ICB'S Clinical Leads
Ring External Fixator / Hexapod External Fixator	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance
Unicompartmental Knee Replacement (medial, lateral and patello femoral)	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance

Surgery to treat periprosthetic joint infection	Inclusion of new policy	NE&C ICB'S Clinical Leads and Orthopaedic Alliance

Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	Inclusion of new policy	NE&C ICB'S Clinical Leads and Gateshead Health FT
Continuous Sub-Cutaneous Insulin Infusion for Children under 12 years	Inclusion of new policy	NE&C ICB'S Clinical Leads and Gateshead Health FT

August 2021 – For Implementation from 1st October 2021		
Policy Area	**Notes**	**Contributors**
Gastric Neuromodulation	Removed from the policy document as confirmed as Specialised Commissioning responsibility.	NE&C ICB'S Clinical Leads
Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	Additional clarity to cover device, consumables, and any technical support requirements. Clarity added on the period a Prior Approval would be in place for. Change the word Omnipod to 'patch pumps'.	NE&C ICB'S Clinical Leads and Gateshead Health FT

Continuous Sub-Cutaneous Insulin Infusion in Children under 12	Additional criteria points added to bring in line with policy for Adults and Children > 12 yrs old. Clarity on the period a Prior Approval would be in place for. Clarity that patients should transition off an insulin pump to undergo a trial of MDI Therapy. MDI trial to be extended to age range 12-25 years. Additional clarity to ensure policy covers the device, consumables, and any technical support requirements. Change the word Omnipod to 'patch pumps'.	NE&C ICB'S Clinical Leads and Gateshead Health FT
Breast – Prosthesis Removal	Clarity that patients who have had PIP implants fitted on the NHS can have these removed.	NE&C ICB'S Clinical Leads
Breast – Prosthesis Replacement	Updated to take account of Gender Dysphoria patients and issues of PIP implants.	NE&C ICB'S Clinical Leads
Breast – Asymmetry	Clarification of policy to cover removal of a healthy breast to create symmetry following cancer treatment.	NE&C ICB'S Clinical Leads
Vasectomy under GA	Moved from an IFR based policy, to a criteria-led prior approval policy.	NE&C ICB'S Clinical Leads
Flash Glucose Monitoring	Updated policy criteria based on recent updates to national policy.	NE&C ICB'S Clinical Leads and South Tyneside & Sunderland FT
Assisted Reproduction Treatments	Clarification on policy to note IVF / ICSI carried out as part of pre-implantation genetic testing is commissioned directly by NHS England and therefore not covered by ICB'S commissioned policy.	NE&C ICB'S Clinical Leads

Various Policies as follows: - Groin Hernia - Low Back Pain – Spinal decompression & Discectomy - Low Back Pain - Radiofrequency denervation (rhizolysis) - Low Back Pain – Spinal Fusion - Cholecystectomy (for asymptomatic gallstones)	Policies all now fall under a National Evidence Based Interventions (EBI) Policy statement. Policies reviewed and no changes required to policy detail or criteria.	Updated due to National EBI Guidance
Bobath Therapy	Inclusion of new policy - Local	NE&C ICB'S Clinical Leads
Diabetes i-Ports	Inclusion of new policy - Local	NE&C ICB'S Clinical Leads and Gateshead Health FT
Diagnostic coronary angiography for low risk, stable chest pain	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Surgery for sinusitis - referral for specialist secondary care assessment	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Removal of adenoids for treatment of glue ear	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Arthroscopic surgery for meniscal tears	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Troponin test	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Surgical removal of kidney stones	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Cystoscopy for men with uncomplicated lower urinary tract symptoms	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Surgical intervention for benign prostatic hyperplasia	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Exercise ECG for screening for coronary heart disease	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Upper GI endoscopy	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Appropriate colonoscopy in the management of hereditary colorectal cancer	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Repeat Colonoscopy	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
ERCP in acute gallstone pancreatitis without cholangitis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Appendicectomy without confirmation of appendicitis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Low back pain imaging	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Knee MRI when symptoms are suggestive of osteoarthritis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Knee MRI for suspected meniscal tears	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Shoulder Radiology: Scans for Shoulder Pain and Guided Injections	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
MRI scan of the hip for arthritis	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Helmet therapy for treatment of positional plagiocephaly/ brachycephaly in children	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Pre-operative chest x-ray	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Pre-operative ECG	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Prostate-specific antigen (PSA) test	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

Liver function, creatinine kinase and lipid level tests – (Lipid lowering therapy)	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation
Blood transfusion	New Policy inclusion – National EBI policy	National EBI Programme – mandated policy following national consultation

January 2022 – For Implementation from 1st April 2022		
Policy Area	**Notes**	**Contributors**
Oculoplastic Eye Problems – Blepharitis	This policy has been agreed to be fully removed from the regional policy document.	NE&C ICB'S Clinical Leads
Dupuytren's Contracture – Collagenase Clostridium Histolyticum (CCH) Injections	Updated category of policy from Prior Approval to an IFR policy (ie: Not Routinely Funded) due to drug now being unlicensed. References to collagenase injections as a treatment option removed from linked policies, specifically: - Dupuytren's Contracture – Radiotherapy - Dupuytren's Contracture – Referral for Secondary Care Opinion	NE&C ICB'S Clinical Leads
Breast – Prosthesis Replacement	Additional criteria added to reflect a discussion has taken place between patient and treating clinician to confirm replacement of prosthesis is best outcome	NE&C ICB'S Clinical Leads
Wigs & Hair Pieces	Updated policy to move from Monitored Approval to Prior Approval to ensure suppliers have relevant documentation to back eligibility. Foot note added to policy to clarify value of free wigs (when satisfying criteria) is £465 per annum and not expected to pay NHS prescription charge. Allow funding requests for wigs to be eligible for a 3-year period, without needing to be re-referred	NE&C ICB'S Clinical Leads

Continuous Glucose Monitoring	Additional criteria added at request of Diabetes Clinical Network colleagues to take account of impending changes to NICE guidance on CGM.	Gateshead FT (Diabetes Clinical Network colleagues)
Liposuction for Chronic Lymphoedema	New Policy inclusion – In line with NTAG guidance	NE&C ICB'S Clinical Leads & regional NTAG colleagues

Liposuction for the Management of Lipoedema	New Policy inclusion	NE&C ICB'S Clinical Leads & regional NTAG colleagues
Surgery for Divarication of Recti	New Policy inclusion – In line with NTAG guidance	NE&C ICB'S Clinical Leads
Referral for Dry Eye Syndrome	New Policy inclusion - Local	NE&C ICB'S Clinical Leads and CDDFT Consultant colleagues.
General update made to policies which had a link to the NICE evidence search in relation to shared decision making.	Due to the closure of the NICE evidence search function on 31/03/22 NICE advised to utilise a different search function within the NHS Knowledge and Library Hub, as follows: https://library.nhs.uk/knowledgehub/ All previous references to the NICE search function have been updated throughout the VBC document with the above link.	NECS operational leads

February 2023 – For Implementation from 1st April 2023		
Policy Area	**Notes**	**Contributors**
Breast – Revisions of Breast Reduction Surgery & Repeated Courses of Nipple Tattooing	Wording Amendment – Change of wording from Reduction to Reconstruction	NE&C ICB'S Clinical Leads
Continuous Glucose Monitoring	To merge the Continuous Glucose Monitoring Policy with the Flash Glucose Monitoring policy to one policy. To re-name the Policy to Continuous Glucose Monitoring: real-time Continuous Glucose Monitoring (rtCGM) or intermittently scanned Continuous Glucose Monitoring (isCGM, commonly referred to as 'Flash') To move from Prior Approval to Monitored Approval	NE&C ICB'S Clinical Leads in line with NTAG guidelines

Flash Glucose Monitoring	To merge the Flash Glucose Monitoring Policy with the Continuous Monitoring Policy to one Policy To re-name the Policy to Continuous Glucose Monitoring: real-time Continuous Glucose Monitoring (rtCGM) or intermittently scanned Continuous Glucose Monitoring (isCGM, commonly referred to as 'Flash'**)** To move from Prior Approval to Monitored Approval	NE&C ICB'S Clinical Leads, in line with NTAG guidelines
i-Port Advance for use in Children and Adults with Type 1 Diabetes	Policy title amended to include Children and Adults with Type 2 Diabetes Updates within the policy eligibility criteria to include Type 2 Diabetes in Children and Adults and bring in line with NTAG guidelines.	NE&C ICB'S Clinical Leads, in line with NTAG guidelines
Tonsillectomy for Recurrent Tonsillitis	Referral eligibility criteria amended when there is a suspicion of malignancy or Recurrent episodes of quinsy	NE&C ICB'S Clinical Leads

June 2023 – For Implementation from 7th June 2023		
Policy Area	**Notes**	**Contributors**
Continuous Glucose Monitoring: real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM, commonly referred to as 'flash')	Criteria updated to CGM policy following NICE guidance update.	NICE guidance update

April 2024 – For Implementation from 25th April 2024		
Policy Area	**Notes**	**Contributors**
Bariatric Surgery	Change of wording within the policy to incorporate the EBI List 3 guidance. Title changes from Bariatric Surgery to Referral for Bariatric Surgery	EBI List 3 guidance
Breast Prothesis Removal	Change of wording within the policy to incorporate the EBI List 3 guidance.	EBI List 3 guidance
Penile Circumcision	Change of wording within the policy to incorporate the EBI List 3 guidance for adults and children.	EBI List 3 guidance

Removal of Benign Skin Lesions	The background section of the policy edited (in bold) stresses that the NHS does not remove benign skin lesions for cosmetic reasons and will only remove them if they are causing significant physical symptoms and if the PAT criteria are met. Amendment to Policy section regarding documented evidence of significant recurrent bleeding of 3 or more bleeds within a year of sufficient severity to require a dressing for 24 hours. Amendment to Policy Section, documented evidence of significant recurrent infection that has required 3 or more courses of oral antibiotics within a year OR hospital admission has been required and a course of IV antibiotics has been administered.	Update to existing policy following feedback from Dr Charlotte Goodhead, Lead Dermatologist NuTH
Angioplasty for PCI (percutaneous coronary intervention) Instable Angina	New Policy inclusion, EBI guidance	EBI List 3 guidance
Asymptomatic carotid artery stenosis screening	New Policy inclusion, EBI guidance	EBI List 3 guidance
Shared decision making for Cataract Surgery	New Policy inclusion, EBI guidance	EBI List 3 guidance
Optical Coherence Tomography use in Diabetic Retinopathy Referral	New Policy inclusion, EBI guidance	EBI List 3 guidance
Glaucoma referral criteria	New Policy inclusion, EBI guidance	EBI List 3 guidance
Needle Biopsy of Prostate	New Policy inclusion, EBI guidance	EBI List 3 guidance
Non-visible Haematuria	New Policy inclusion, EBI guidance	EBI List 3 guidance
Continuous Glucose Monitoring: real-time continuous glucose monitoring (rtCGM) or intermittently scanned continuous glucose monitoring (isCGM, commonly referred to as 'flash')	This policy has been agreed to be fully removed from the VBCCP document as these devices are part of standard diabetes care.	NE&C ICB'S Clinical Leads, in line with NTAG guidelines
Continuous Sub-Cutaneous Insulin Infusion for Adults and Children over 12 years	This policy has been agreed to be fully removed from the VBCCP document as these devices are part of standard diabetes care.	NE&C ICB'S Clinical Leads, in line with NTAG guidelines
Continuous Sub-Cutaneous Insulin Infusion in Children under 12	This policy has been agreed to be fully removed from the VBCCP document as these devices are part of standard diabetes care.	NE&C ICB'S Clinical Leads, in line with NTAG guidelines

Oculoplastic Eye Problems – Entropion	This policy has been agreed to be fully removed from the VBCCP document due to the high risks for patients	NE&C ICB'S Clinical Leads, in line with Ophthalmologist guidance

June 2025 – For Implementation from 2nd July 2025		
Policy Area	**Notes**	**Contributors**
Tonsillectomy for Recurrent Tonsillitis	Change of wording within the policy to incorporate guidance that recent evidence has emerged to suggest that tonsillectomy may also be clinically effective in adults.	NENC ICB's Clinical leads, in line with ENT guidance.
Low Back Pain – Medial Branch Block (MBB)	Change of wording within the policy to incorporate the EBI List 3 guidance.	NENC ICB's Clinical Leads, in line with Pain Aesthetics and Pain Management guidance.
Low Back Pain - Radiofrequency denervation (Rhizolysis)	Change of wording within the policy to incorporate the EBI List 3 guidance for adults and children.	NENC ICB's Clinical Leads, in line with Pain Aesthetics and Pain Management guidance.
Tirzepatide for overweight and obesity	New Policy inclusion, NICE guidance	NICE guidance – new national clinical guidance

Appendix A - Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion, and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Claire Wong
Job Title: Elective Services Lead
Organisation: NECS

Title of the service/project or policy: Value Based Clinical Commissioning Policy

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other N/A

What are the aim(s) and objectives of the service, project or policy:
This document sets out the corporate approach to how we manage policies relating to Value Based Clinical Commissioning. Procedures / treatments outlined within the Value Based Clinical Commissioning policy are reviewed on a twice-yearly basis. Where any changes are proposed, these are discussed at the VBCCP Steering Group, made up of Primary and Secondary care clinicians, Public Health and NECS colleagues. Policy changes are then ratified at ICB Executive Committee and are subsequently published. An EIA is completed / updated for each procedure / treatment within the policy to ensure consideration of equality, diversity and inclusion.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☒
- **Other Public Sector Organisations** ☐
- **Voluntary / Community groups / Trade Unions** ☐
- **Others, please specify** Not applicable.

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

This policy outlines the corporate framework for the approval and development of policies. No detrimental impact on any equality protected characteristics groups have been identified.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible- info-standard-overview-2017-18.pdf	☒	☐
If any of the above have not been implemented, please state the reason: Not applicable		

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
ICB Executive Committee	Approver	April 2025