NHS
North Central London
Integrated Care Board

NORTH CENTRAL LONDON INTEGRATED CARE BOARD (ICB)

EVIDENCE BASED INTERVENTIONS AND CLINICAL STANDARDS (EBICS)

Covering procedures not routinely funded or restricted and best practice guidance

This policy applies to patients 18 years of age and over unless specified in body text of sections.

Version 9.2

Document details

Approved by	NCL Strategy & Development Committee on 8th February 2023
For specific feedback on policy	Email scwcsu.hpsu@nhs.net for feedback Feedback should be submitted only using the NCL EBICS feedback form in Appendix 1.
For general/ commissioning queries	Email nclicb.enquiries@nhs.net

Document history

Date	Version	Summary of amendments
10/11/11	1.0	Policy issued
30/01/12	2.0	Partial Policy update issued
02/04/12	3.2	Entire Policy update issued
28/11/12	4.0	Entire Policy update issued
01/07/15	5.0	Entire Policy update issued
24/09/18	6.5	Entire Policy update
22/11/18	6.6	Incorporation of comments from Sept. 2018 feedback exercise
14/01/19	6.6	Policy issued
26/03/19	7.0	Partial Policy update
10/04/19	7.1	Minor grammatical changes. Inclusion of one additional statement in cataract management & tonsillectomy and minor edit in benign skin lesions and cholecystectomy Update of NCL PoLCE feedback form
16/09/19	7.2; issued with accompanying addendum	Name changed to Evidence Based Interventions and Clinical Standards. Accompanying addendum updated policies on vasectomy (under general anesthetic) and benign skin lesions.
08/02/23	9.0	Entire policy updated and approved at Strategy & Development Committee, including incorporation of EBI-2 guidance.
22/03/23	9.1	Policy update issued, for implementation from 1 April 2023. Minor tweaks made to non-policy aspects of the document.
01/02/24	9.2	Policy update issued, for use from 1 February 2024 to recognise closure of Referral Support Services (RSSs) in NCL. Individual AOMRC hyperlinks have been removed as they no longer work, with narrative included in the policy to reference the AOMRC EBI patient resources and guidance.

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Background

Just because we can do something doesn't always mean we should. Some treatments and procedures may not help in all circumstances. They can be painful and result in complications or harms that are greater than the benefits. Recovery from surgical procedures can take a long time and disrupt everyday life at home and work. Sometimes, a safer, simpler alternative could be tried instead.

As a result, NHS organisations across the country have developed criteria for accessing many common tests, treatments and procedures, to make sure that:

- patients receive the right treatment, at the right time, fairly and consistently (to reduce unwarranted variation)
- treatments with no, or very limited, evidence of benefits to health are not used

In North Central London, these criteria are listed in this document called the Evidence Based Interventions and Clinical Standards' policy (or EBICS for short)[1]. The EBICS policy explains when around 110 tests, treatments and procedures can and can't be used by clinicians to treat North Central London patients.

Exclusions to the EBICS policy

Unless otherwise specified, the following exclusions apply to all procedures listed within the EBICS policy:

- Surgery for suspected cancer, cancer related surgery and reconstruction surgery following treatment for cancer or its prevention
- Emergency or urgent care

The EBICS policy applies to adult patients aged over 18 only, unless specified otherwise in the body text of individual policies.

How to use the EBICS policy

The EBICS policy applies across the system to all providers in NCL, including primary care, community care, secondary care, tertiary care and the independent sector. It is a comprehensive resource containing all NCL clinical commissioning policies relating to non-pharmacological interventions.

The EBICS document includes policies on procedures not routinely funded, funded with criteria, and best practice guidance. Reflecting the new system-wide approach, it is for the use of secondary care clinicians as well as GPs and many sections of the document are relevant to both.

The policy follows the principle of self-regulation; all organisations within the system have a responsibility to ensure compliance with the policy.

Following the closures of the referral support services in NCL (Jan 2024), all providers must ensure they have necessary processes in place to ensure the EBICS policy is adhered to.

For GPs in primary care, the referrals that are subject to EBICS should include the relevant information and criteria that demonstrate adherence to the policy, in the referral letter.

For secondary care, those people deemed to need an EBICS procedure should be confirmed for adherence to the EBICS policy and documented by the treating / clinical team at the provider accordingly. People subject to EBICs procedures, should NOT be referred to primary care for EBICs checks or confirmation of policy adherence.

[1] The EBICS document was previously named 'Procedures of Limited Clinical Effectiveness (PoLCE)'.

The NCL EBICS policy includes clinical policies on about 110 tests, treatments and procedures agreed by North Central London Integrated Care Board (ICB). Policies for each intervention contained in the NCL EBICS policy will identify whether it is:

- **Not routinely funded** – The intervention is not routinely funded for people registered with a GP in North Central London. In some cases there may be exceptional reasons to fund a procedure not routinely funded and this would be through an individual funding request (IFR) (see below for more information)
- **Restricted** – The intervention is funded by North Central London ICB but only where a patient meets the eligibility criteria set out in the relevant policy and this is evidenced by their doctor / clinical team. When the referral originates in primary care, all information to demonstrate compliance with the NCL EBICS policy must be included in the referral. Policy compliance should also be checked and evidenced, by the treating clinician, at the point of decision making for the EBICS intervention. For patients not meeting the eligibility criteria, NCL ICB will only fund the intervention if an IFR application is successful (see below).
- **Guidance** – The intervention is funded by North Central London ICB. While it is not necessary to demonstrate compliance with the policy for these procedures, the NCL EBICS policy sets out best practice guidance on the circumstances in which they should be considered.

It is important to emphasise, that there is no blanket ban on any of the interventions covered by the NCL EBICS policy. Where a patient does not meet the eligibility criteria or the intervention is not routinely funded, clinicians can make an individual funding request (IFR) if they think that the patient meets the criteria for 'exceptionality' or 'rarity' – see below for more information.

The NCL EBICS policy is incorporated into all relevant NHS standard contracts agreed by North Central London ICB (for both NHS and independent sector providers). Procedures covered by the NCL EBICS policy may be subject to audits and/or casefile reviews to ensure adherence to this policy.

See Appendix 2 for flowchart of the process for procedures and interventions subject to the NCL EBICS policy.

Why are eligibility criteria for health care interventions necessary?

The NCL EBICS policy helps clinicians prevent avoidable harm, and to identify patients most likely to benefit from particular interventions, fairly and consistently across North Central London, based on the latest available evidence. Whilst the quality of care given to patients is the most important factor for these policies, they will also help to free up time and resources that can be reinvested in patient care. The NHS is committed to providing the most effective, fair and sustainable use of finite resources. NHS resources should be focused on treatments that have been proven to be effective and appropriate. Making sure that treatment and care is focused where it can make the biggest difference is a key part of getting the best use out of NHS resources.

The North Central London EBICS also takes account of the national Evidence-Based Interventions (EBI) Programme. The EBI programme is a joint enterprise between the following national partners: the Academy of Medical Royal Colleges, NHS Clinical Commissioners, the National Institute for Health and Care Excellence (NICE) and NHS England and Improvement. Consistent with the NCL EBICS policy, the aim of the EBI programme is to avoid needless harm to patients and to free up clinical time for performing evidence-based and appropriate interventions. A short video explaining the aims of the national EBI programme can be accessed here.

How have the EBICS policies been developed?

Policies included in the NCL EBICS policy have undergone a rigorous review process that is clinically led.

Individual clinical policies included in the EBICS document are developed and reviewed by a group of doctors, commissioners and community members from across North Central London.

The group uses evidence from clinical studies and clinical guidelines from national and professional organisations (such as NICE[2], the Academy of Medical Royal Colleges and the EBI programme), alongside expert opinion from clinical specialists to develop and review existing EBICS policies. Equality issues are also considered by the group during policy development[3].

All decisions made by the group are guided by a set of decision-making principles. These principles ensure:

- that all relevant current information and factors have been taken into account before decisions are made
- decisions are made fairly and consistently across NCL
- policy decisions are built on sound rationale that is clearly stated

The group issue their recommendations to the NCL Strategy & Commissioning Committee for their consideration. Once recommendations have been approved by the NCL Strategy & Commissioning Committee, they are added to the EBICS document when it is next reissued.

Each policy within the EBICS document will have reference to the evidence (where available) underpinning it. Where applicable, each policy will also include reference to supporting resources developed by the national EBI programme.

The clinical policies included in the EBICS document are kept under routine review to ensure that they are in-line with the evidence base and best practice.

Where existing clinical policies need to be amended, these changes will be incorporated when the EBICS document is next reissued. However, where an urgent issue with an existing clinical policy is identified in-year, this will be addressed by issuing an addendum to the existing EBICS document (which will be incorporated into the EBICS document when it is next reissued).

General comments on the EBICS document and specific comments on individual policies can be made by completing the feedback form found in Appendix 1 and returning it to scwcsu.hpsu@nhs.net.

EBI patient resources and guidance

The Academy of Medical Royal Colleges (AOMRC) website includes helpful patient resources (such as patient leaflets and videos) pertaining to specific EBI policies, as well as EBI guidance documents containing recommendations and supporting rationale.

[2] The National Institute for Health and Care Excellence (NICE) is a national advisory body. Its role is to improve outcomes for people using the NHS and other public health and social care services. NICE do this by producing robust evidence-based guidance and advice for health, public health and social care managers and practitioners.

[3] North Central London (NCL) ICB have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012. NCL ICB has committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NCL ICB will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

If a patient meets the eligibility criteria are they guaranteed treatment?

No. Eligibility for NHS funding is not the same as a guarantee of treatment. The treatment should only be considered if the eligibility criteria are met, but it is important that the final decision to treat is an informed decision between the responsible clinician and the patient.

Demonstrating compliance with the NCL EBICS policy for referrals from primary care

It is expected the referring primary care clinician will check the patient's eligibility for the EBICS treatment against the relevant criteria in the NCL EBICS policy.

The primary care clinician making the referral will undertake appropriate assessment to ensure that the referral meets the criteria set out in the NCL EBICS policy and demonstrates adherence to the policy in the referral.

There is no standard referral form for EBICS procedures. Clinicians should use their standard referral letters and can use the EBICS criteria within the policy to evidence compliance.

Demonstrating compliance with the NCL EBICS policy for referrals from or within community, secondary or tertiary care (including independent sector)

It is expected that the responsible clinician will check the patient's eligibility for treatment against the relevant criteria in the NCL EBICS policy.

Where a referral is originating in community, secondary or tertiary care (including independent sector) the clinician making the referral will undertake appropriate assessment to ensure that the referral meets any criteria set out in the NCL EBICS policy and demonstrates adherence to the policy in the referral.

In addition, regardless of route of entry, the treating clinician must undertake appropriate checks to ensure adherence with the NCL EBICS policy, at the point of decision making for proceeding with the EBICS intervention.

Process for Individual Funding Requests (IFR)

In NCL, if a patient does not meet the eligibility criteria for a particular EBICS policy that is not routinely funded or is restricted, then the intervention will not be funded. Of note, it is important to ensure that all the information that demonstrates compliance with the policy is included in referrals, clinical information records, etc., to minimise confusion for the patient and avoid causing delays or inappropriate use of clinical time and resources.

The individual funding request (IFR) route is an option for clinicians, if they think that their patient meets the criteria for 'clinical exceptionality' or 'rarity' based on their individual circumstances. Please refer to the NCL ICB IFR Policy and IFR section of the NCL ICB webpage for guidance on the IFR application process. Information can also be found on the NCL GP webpage. For queries on IFR please contact the NCL IFR team at nclicb.ifr@nhs.net.

Please note:

- If a clinician is unsure whether the EBICS criteria is met or not, they should consider using Clinical Advice and Guidance and / or ensure that they include all relevant information with the referral to support onward clinical decision making
- Not all EBICS policies with criteria are deemed as "restricted"; the policy will state if it is for guidance only

- If a condition/ intervention is not explicitly included within the EBICS policy, then demonstrating compliance with the NCL EBICS policy is not appropriate

Policy compliance monitoring arrangements

It is important that NCL ICB have appropriate processes in place to monitor and understand the impact of the EBICS policy, which includes monitoring activity across the system. NCL ICB and providers will work collectively to agree, maintain and review coding to support current versions of policies.

Procedures covered by EBICS may be subject to audits and/or casefile reviews in conjunction with provider partners to ensure adherence to this policy.

1 Anaesthetics

1.1 Pre-operative chest x-ray

Category	Guidance
Guidance	
Pre-operative chest radiographs should not be routinely performed in adult elective surgical patients. However, they may be appropriate in specific cohorts of patients, including when the following criteria apply: • Patients undergoing cardiac or thoracic surgery • Patients undergoing organ transplantation or live organ donation • At the request of the anaesthetist in: o 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 o Those with a recent history of chest trauma o Patients with a significant smoking history who have not had a chest radiograph in the previous 12 months, or those with malignancy and possible lung metastases o Those undergoing a major abdominal operation, who are at high risk of respiratory complications. Where pre-operative tests are completed outside the centre in which surgery will be completed, avoid unnecessarily repeating these tests on admission and ensure appropriate transfer of images takes place. **This guidance applies to adults aged 19 years and over.**	
Reference	
Evidence-based interventions guidance available on AOMRC website.	

1.2 Pre-operative electrocardiogram (ECG)

Category	Guidance
Guidance	
Pre-operative electrocardiograms should not be routinely performed in low risk, non-cardiac, adult elective surgical patients. However, they may be appropriately performed when the following criteria apply: • Patients with an American Society of Anaesthesiologists (ASA) physical classification status of 3 or greater and no ECG results available for review in the last 12 months • Patients with a history of cardiovascular or renal disease, or diabetes	

- Patients with any history of potential cardiac symptoms (e.g. cardiac chest pain, palpitations, unexplained syncope or breathlessness) or a new murmur, that has not previously been investigated
- Patients over the age of 65 attending for major surgery.

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

2 Cardiology

2.1 Coronary angiography (diagnostic) for low risk, stable chest pain

Category	Guidance

Guidance

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

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

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

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

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

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

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

2.2 Exercise ECG for screening for coronary heart disease

Category	Not routinely funded
Exercise ECG for the screening of asymptomatic and low risk patients for coronary heart disease is not routinely funded by NCL ICB.	
Reference	
Evidence-based interventions guidance available on AOMRC website.	

2.3 Liver function, creatinine kinase and lipid level tests (for patients taking lipid lowering therapy)

Category	Guidance

Guidance

Creatine Kinase Testing

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

Liver Function Testing

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

Lipid Testing

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

- Perform when clinically relevant an annual non-fasting blood test for non-HDL cholesterol to inform discussion at annual medication reviews.

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

2.4 Troponin blood test

Category	Guidance

Guidance

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

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

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

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

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

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

This guidance applies to adults and children.
Reference
Evidence-based interventions guidance available on AOMRC website.

3 Dermatology

3.1 Benign skin lesions (removal of)

Category	Restricted

Criteria

Exclusions to the policy

Any lesion suspicious of malignancy is not included within the scope of this policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of basal cell carcinoma).

In addition, the following lesions are excluded from the scope of this policy:

- Any lesion not listed in the 'scope of the policy' section below
- Malignant lesions – patients should be managed via the two-week wait pathway
- Pigmented lesions with malignant potential
- Lesions with diagnostic uncertainty
- Lesions undergoing rapid growth
- Actinic keratosis
- Café au lait patches – see policy on treatment of skin hyper-pigmentation
- Congenital naevi
- Genital warts – patients should be referred to sexual health clinic
- Naevus of Ota/ Naevus of Ito
- Scars (hypertrophic, keloid) – see policy on keloidectomy or revision of hypertrophic scars
- Vascular birth marks in children – see policy on treatment of vascular lesions

Note, this is not an exhaustive list. Please review relevant policies relating to these lesions to establish when/ if treatment is funded.

Procedures and interventions for benign skin lesions will not be commissioned for solely cosmetic reasons.

Scope of the policy

This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.

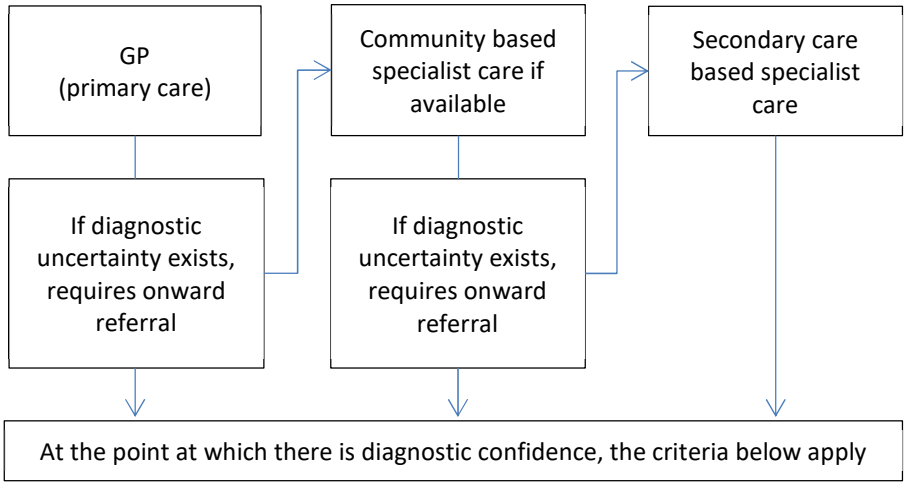
This policy relates to both adults and children aged 2+.

The following lesions are included within the scope of this policy:

- Benign pigmented moles/ melanocytic naevus
- Capilliary haemangioma/ Campbell de Morgan
- Comedones
- Corn/ callous
- Cysts (epidermal, pilar, trichodermal, sebaceous)
- Dermatofibroma

- Lipoma
- Milia
- Molluscum contagiosum
- Neurofibromata
- Seborrhoeic keratoses (basal cell papillomata)
- Skin tags including anal tags (acrochordon)
- Telangiectasia/ thread veins
- Warts including plantar warts, mosaic warts
- Xanthelasma

Commissioning criteria



- This policy only applies to the lesions included within the scope of this policy, at the point at which there is diagnostic confidence.
- Removal of benign skin lesions is not routinely funded by NCL ICB unless the following criteria are met and evidenced:
  - The lesion is unavoidably and significantly traumatised on a *regular* basis,

  AND

  - The location of the lesion obstructs an orifice **OR** impairs vision **OR** significantly restricts usual function **OR** causes *regular* pain **OR** has been significantly infected, requiring more than 2 courses of antibiotics (oral or IV)

  AND

  - Recurrence and complication rates have been discussed with the patient.
- Lipomas >5cms, or in a sub-fascial position, with rapid growth and/or pain should be referred as per local pathway.
- NCL ICB do not routinely fund secondary care procedures and interventions for warts unless conservative treatments have failed and warts are:
  - Extensive **OR** facial **OR** the patient is immunocompromised

This policy applies to people aged 2 years and over.

Advice for clinicians
Clinicians are expected to apply reason to the criteria which will always have an element of subjectivity: • e.g. catching on clothes daily, regularly disturbed by combing of hair, under the waistband or bra strap causing clothes to be unwearable. • Relevant to the patient e.g. lesions preventing children playing sport, lesions affecting ability to write/ type
Reference
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-2a-Benign-Skin-Lesions-Policy.pdf

3.2 Hair epilation (hair removal by electrolysis and/or laser)

Category	Restricted
Criteria	
Hair epilation is not routinely funded by NCL ICB unless one of the criteria below are met and evidenced: 1. Patient has undergone reconstructive surgery leading to abnormally located hair-bearing skin to the face, neck or upper chest (areas not covered by normal clothing), **OR** 2. Patient is undergoing treatment for pilonidal sinuses to reduce recurrence	

3.3 Hair loss – Correction of hair loss (including male pattern baldness and alopecia)

Category	Not routinely funded
Procedures to correct hair loss are not routinely funded by NCL ICB. This includes hair grafting, flaps with/without tissue expansions, non-NHS provided interlace system. In certain circumstances, people may be eligible for free or reduced cost wigs on the NHS. More information on buying wigs and NHS policy is available here.	

3.4 Hyperhidrosis – Treatment of

Category	Restricted

Criteria

Focal hyperhidrosis

Focal hyperhidrosis is where only certain parts of the body are affected, such as the armpits, hands, feet or face.

Treatments for focal hyperhidrosis are not routinely funded by NCL ICB unless all of the criteria below are met and evidenced:

- Excessive sweating has a significant impact on the patient's quality of life i.e. Hyperhidrosis Disease Severity Score (HDSS) 3 or 4 OR the patient has complications due to hyperhidrosis such as skin maceration with secondary skin infections. NB: details of the complications or the HDSS score will need to be provided on the application, **AND**
- The patient has failed a 6 month trial of conservative management including:
  - Lifestyle measures including avoiding crowded rooms, caffeine or spicy foods, using extra-strength antiperspirant (as opposed to deodorant), avoiding tight clothing, appropriate footwear, etc.
  - First line medication: Aluminium Chloride Hexahydrate 20% (OTC)
  - Treatment of underlying anxiety e.g. with CBT

Generalised hyperhidrosis

Generalised hyperhidrosis is where the entire body is affected.

Generalised hyperhidrosis is often the result of an underlying health condition, such as an overactive thyroid gland. Treatment to address underlying conditions must be attempted first.

Treatment for generalised hyperhidrosis is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Hyperhidrosis is severe and there is evidence of severe functional impairment including difficulties with daily living.

Treatments

Botulinum toxin injections will be funded where the eligibility criteria outlined above are met and evidenced. For patients in whom botulinum toxin injections fail or are contraindicated, surgical excision of sweat glands may be considered if the eligibility criteria outlined above are met and evidenced.

The following treatments will not be routinely funded for the treatment of hyperhidrosis:

- Iontophoresis (can be bought OTC)
- Surgical sympathectomy
- Laser surgery (transcutaneous microwave ablation for severe axilliary)

Note: Patients who smoke should be advised to attempt to stop smoking and referred to smoking cessation services.

References
NICE Guidance https://cks.nice.org.uk/hyperhidrosis 2013 https://www.nice.org.uk/guidance/ipg601 2017 (microwave ablation) https://www.nice.org.uk/guidance/ipg487 2017 (thoracic sympathectomy) https://www.nice.org.uk/advice/es10/chapter/Key-points 2017 (use of oxybutynin) https://www.nice.org.uk/advice/esuom16/chapter/Key-points-from-the-evidence 2013 (use of oral glycopyrronium)

3.5 Keloidectomy (keloid scars) or revision of hypertrophic scars

Category	Restricted

Criteria

Procedures to revise keloid scars or hypertrophic scars will not be routinely funded by NCL ICB for cosmetic purposes.

Patients should only be referred for surgical treatment once conservative approaches have been exhausted, including:

- Haelan tape (Fludroxycortide tape) – patient should be informed of the need to wear the tape for 12 hours per day
- Silicone gel
- Steroid injections

See the British Association of Dermatologists (BAD) website for more information: https://www.bad.org.uk/pils/keloids/.

Surgical intervention is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- The keloid has been present for at least 18 months (post injury or post-surgery) and has failed 6 months of conservative methods (defined above)

AND

- The keloid meets at least one of the following criteria:
  - Results in significant functional impairment; **OR**
  - Causes significant pain requiring chronic analgesic medication for at least six months; **OR**
  - Bleeds or is recurrently infected; **OR**
  - Obstructs orifice or vision; **OR**
  - Is a facial lesion causing disfigurement.

AND

- Patients should be informed that having surgery on a scar will in itself leave a new scar that will take up to two years to improve in appearance. If surgery is used to treat a hypertrophic scar,

there is a risk that the scarring may be worse after the surgery. In keloids, excision may result in a new keloid even larger than the original one.

Where appropriate, patients may be directed to Changing Faces (www.changingfaces.org.uk), a charity that supports people with a scar, mark or condition on their face or body that makes them look different.

Low-dose, superficial radiotherapy may reduce the recurrence rate of hypertrophic and keloid scars after surgery. Because of the possibility of long-term side effects, it is only reserved for the most serious cases.

Commissioning responsibility for the treatment of keloid scars under some circumstances is with NHS England. Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

This policy applies to people aged 2 years and over.

References

Best Practice with local NCL clinicians
https://patient.info/doctor/keloid-pro
http://www.bad.org.uk/shared/get-file.ashx?id=216&itemtype=document
http://journals.sagepub.com/doi/full/10.1177/2059513117690937
http://www.pcds.org.uk/clinical-guidance/scars

3.6 Skin hyper-pigmentation – Treatment of

(including laser therapy, chemical peels, and referrals for prescriptions for topical treatments etc.)

Category	Not routinely funded

Treatments for skin hyper-pigmentation are not routinely funded by NCL ICB.

3.7 Skin resurfacing and other surgical interventions for scarring

(including laser, dermabrasion and chemical peels)

Category	Not routinely funded

Skin resurfacing and other surgical interventions for scarring are not routinely funded by NCL ICB.

See also policy on keloidectomy (keloid scars) and revision of hypertrophic scars.

3.8 Tattoo removal

Category	Not routinely funded
Tattoo removal is not routinely funded by NCL ICB.	

3.9 Vascular lesions – Treatment of (port wine stains on the head and neck)

Category	Not routinely funded
Treatments for vascular lesions are not routinely funded by NCL ICB. See also policy on removal of benign skin lesions.	

4 Ear, Nose and Throat (ENT)

4.1 Adjuvant adenoidectomy for glue ear in children

Category	Restricted

Criteria

Adjuvant adenoidectomy for children undergoing grommet insertion for the treatment of otitis media with effusion is not routinely funded by NCL ICB unless one of the following criteria is met and evidenced:

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

This policy applies to children aged 18 years and under.

See also policies on grommets for glue ear in children, tonsillectomy (with or without adenoidectomy), chronic rhinosinusitis (surgical treatment of) and sleep related breathing disorder (surgery for).

Reference

Evidence-based interventions guidance available on AOMRC website.

4.2 Chronic rhinosinusitis – Surgical treatment of

Category	Restricted

Criteria

Referral Criteria

Referral for specialist secondary care assessment for surgery for chronic rhinosinusitis (CRS) is not routinely funded by NCL ICB unless the following criteria are met and evidenced*:

- A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance: with 2 or more persistent symptoms for at least 12 weeks, one of which should be nasal obstruction and/or discharge and/or must include: facial pain/pressure or anosmia) in primary care and patient still has moderate / severe symptoms** after a 3-month trial of intranasal steroids and nasal saline irrigation, AND
- In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg)

OR

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

OR

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

No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan).

There is no role for prolonged courses of antibiotics in primary care.

**Note – there maybe local community services in NCL which support GPs in managing patients with CRS which do not require the full criteria as set out above. Please refer to local community service criteria as appropriate. The above policy relates to patients who require assessment for surgical intervention for CRS.*

*** Assessment of severity of symptoms can be facilitated by using a 10cm Visual Analogue Scale (VAS) to categorise into mild (VAS 0 – 3) or moderate/severe (VAS >3).*

Surgical criteria

Endoscopic sinus surgery is not routinely funded by NCL ICB unless all of the following criteria are met and evidenced:

- A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and / or CT scan***
- Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms (e.g. Sinonasal Outcome Test [SNOT-22]) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway' (see Figure 1 overleaf).
- Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway.
- Patient and clinician have undertaken appropriate shared decision making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention.

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

This policy applies to adults and children.

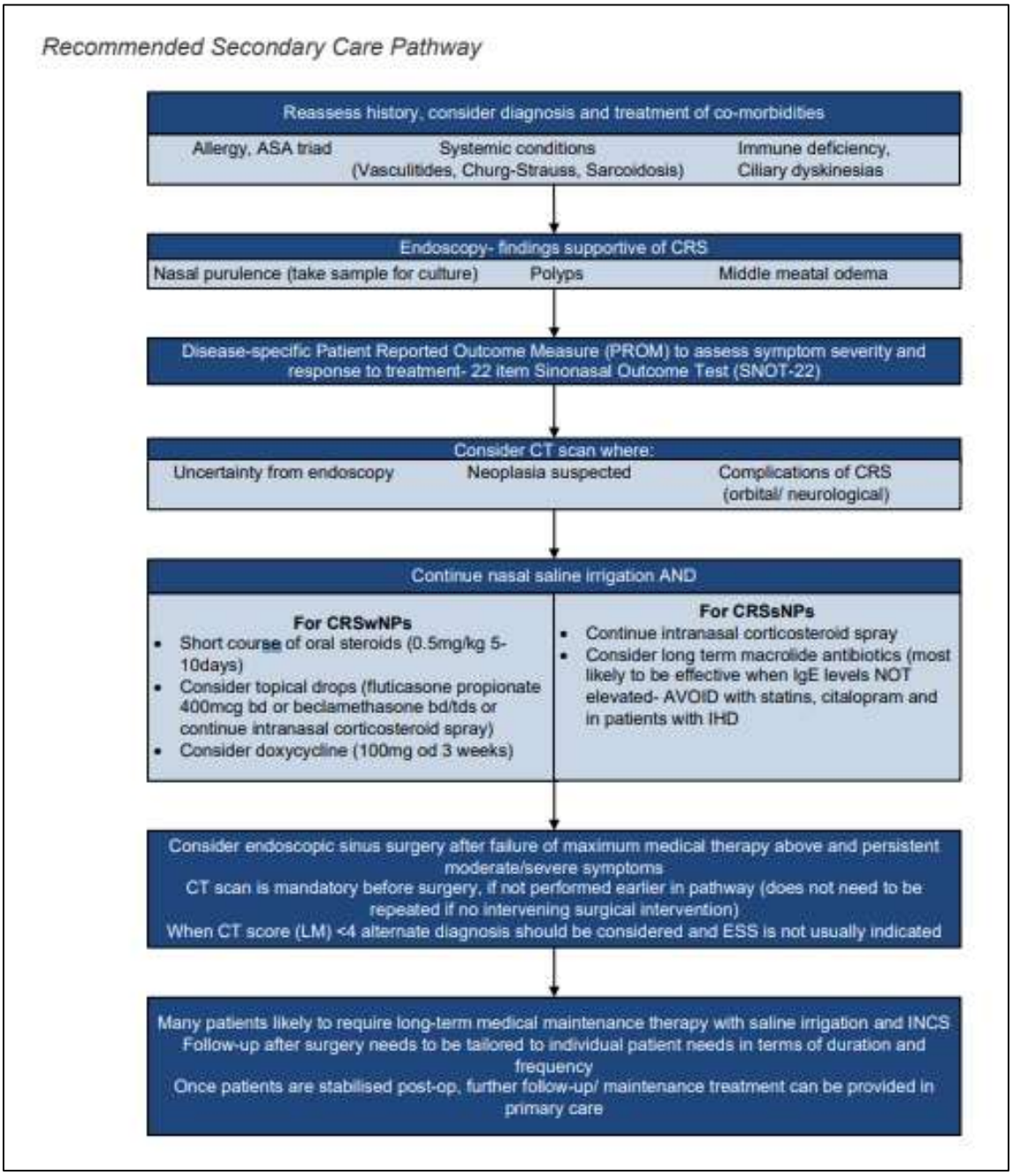
Exclusions to the policy

There are a number of medical conditions whereby endoscopic sinus surgery may be required outside the above criteria and in these cases they should not be subjected to the above criteria and continue to be routinely funded:

- Any suspected or confirmed neoplasia
- Emergency presentations with complications of sinusitis (e.g. orbital abscess, subdural or intracranial abscess)
- Patients with immunodeficiency
- Fungal Sinusitis
- Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (NSAID-ERD, Samter'sTriad Aspirin Sensitivity, Asthma, CRS)
- Treatment with topical and / or oral steroids contra-indicated.

- As part of surgical access or dissection to treat non-sinus disease (e.g. pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)

Figure 1



Source: RCS/ ENT Commissioning Guide on Chronic Rhinosinusitis (page 11).

References

Royal College of Surgeons and ENT-UK Commissioning Guide on Chronic Rhinosinusitis
https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/rhinosinusitis-commissioning-guide-for-republication.pdf

Evidence-based interventions guidance available on AOMRC website.

4.3 Grommets for glue ear in children

Category	Restricted

Criteria

Exclusions from the policy

This policy only relates to children with glue ear (otitis media with effusion [OME]) and should not be applied to other clinical conditions where grommet insertion should continue to be routinely funded, these include:

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

Commissioning criteria

NCL ICB do not routinely fund grommets for the treatment of glue ear in children unless the criteria set out in NICE Clinical Guideline 60 are met and evidenced:

- Children must have:
  - Had specialist audiology and ENT assessment
  - Persistent bilateral otitis media with effusion documented over a period of 3 months
  - Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4 kHz
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant.
- Healthcare professionals should also consider surgical intervention in 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.
- The guidance is different for children with Down's Syndrome and Cleft Palate; children with these conditions may be offered grommets after a specialist MDT assessment in line with recommendations made in NICE Clinical Guideline 60.
- It is good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

References

NICE Guidance
https://www.nice.org.uk/Guidance/CG60.

Evidence-based interventions guidance available on AOMRC website.

4.4 Rhinoplasty (surgery to reshape the nose)

Category	Restricted

Criteria

Rhinoplasty is not routinely funded by NCL ICB unless at least one of the criteria below are met and evidenced:

1. Nasal airway obstruction causing significant symptoms (e.g., difficulty breathing, post traumatic deformity), **OR**
2. Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids or immunotherapy as per local clinical/national guidelines, **OR**
3. Correction of complex congenital conditions unless the commissioning responsibility of NHS England*.

Septorhinoplasty will only be funded where septoplasty alone will not improve functional impairment. Septorhinoplasty is not funded for cosmetic reasons.

*Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

See also policy on surgical treatment for chronic rhinosinusitis.

4.5 Sleep related breathing disorder (SRBD) – Surgery for

Category	Restricted

Criteria

Surgical procedures to remove, refashion or stiffen the tissues of the soft palate in an attempt to improve the symptoms of simple snoring in the absence of obstructive sleep apnoea (OSA) is not routinely funded by NCL ICB.

Surgery for sleep related breathing disorders is not routinely funded by NCL ICB unless the patient has OSA and all six of the criteria below are met and evidenced:

1. Before consideration for surgery all of the following have been tried where appropriate:
    - Trial of weight loss (failure to lose weight should not prevent access to treatment)
    - Alcohol consumption is within recommended safe limits and patterns and avoided late at night
    - Exclude and treat appropriately: rhinitis, nasal polyposis, hypothyroidism and anaemia
2. Sleep study result
    - AHI greater than FIVE, **OR**
    - AHI less than 5 but flow limitation index* greater than 15 AND Epworth sleepiness score greater than 12

3. CPAP failure (minimum three month trial)
    - All patients who use CPAP should be reassessed in a CPAP clinic where a smart card can give information on parameters such as reduction of AHI, mask leak and pressure requirements, allowing for analysis of efficacy and compliance of CPAP, **OR**
    - Obvious obstructive upper airway pathology compromising CPAP use, **OR**
    - Claustrophobia
4. Failed use of Mandibular Advancement Device (MAD)
    - Repeat sleep study with use of MAD has failed to demonstrate a reduction in AHI, **OR**
    - The patient begins to encounter dental problems or TMJ dysfunction
5. Sleep nasendoscopy demonstrates significant anatomical problem:
    - Nasal, oropharyngeal or hypopharyngeal
6. The aim of surgery is to:
    - Partially improve upper airway obstruction to facilitate CPAP use, **OR**
    - Completely resolve upper airway obstruction

Cautious consideration for surgery in those with a BMI greater than 35 unless significant anatomical abnormality is present compromising CPAP use.

*Where equipment does not provide a reliable flow limitation index, the following should be demonstrated instead: evidence on polysomnography that there are respiratory effort related arousals and snoring related arousals contributing to reduction in sleep quality.

NCL ICB do not routinely fund the following interventions for the treatment of OSA:

- Soft-palate implants
- Hypoglossal nerve stimulation

References

NICE guidance
https://www.nice.org.uk/guidance/ipg241/chapter/1-Guidance (soft palate implants)
https://www.nice.org.uk/guidance/ipg598/chapter/1-Recommendations (hypoglossal nerve stimulation)

Evidence-based interventions guidance available on AOMRC website.

4.6 Tonsillectomy (with or without adenoidectomy)

Category	Restricted

Criteria

Tonsillectomy is not routinely funded by NCL ICB unless the criteria below are met and evidenced. This policy refers to tonsillectomy with or without adenoidectomy. Adenoidectomy alone, for clinical reasons, is routinely funded.

Criteria for eligibility

A. Tonsillectomy for recurrent acute tonsillitis:

Tonsillectomy for recurrent acute tonsillitis is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year

OR

- Five or more such episodes in each of the preceding two years

OR

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

AND

- Sore throats are due to acute tonsillitis and episodes are disabling and prevent normal functioning.

B. Tonsillectomy for sleep disordered breathing in children (<16 years):

Tonsillectomy for sleep disordered breathing is not routinely funded by NCL ICB unless there is evidence that the patient has been diagnosed with obstructive sleep apnoea (OSA) by an accepted method of diagnosis according to Royal College of Surgeons (RCS)/ENT-UK guidance (see below for advice for primary care practitioners). This is because children with simple snoring without symptoms or signs of apnoea are unlikely to benefit from adeno-tonsillectomy.

Tonsillectomy will also be funded if there is evidence that the patient has habitual snoring with laboured breathing and falls into one of the following complex high-risk categories for sleep apnoea:

- Down's syndrome
- Cerebral palsy
- Craniofacial disorders
- Chronic lung disease
- Sickle cell disease
- Neuromuscular disorders
- Genetic/ metabolic/ storage disease
- Central hyperventilation syndromes

C. Tonsillectomy for quinsy/ other tonsillitis

Tonsillectomy is not routinely funded by NCL ICB for quinsy or for tonsillitis (in patients who do not fulfil criteria for tonsillectomy for recurrent acute tonsillitis [criteria A]), unless the criteria below are met and evidenced:

1. The patient has had ONE episode of quinsy or ONE or more episodes of tonsillitis requiring admission to hospital where there has been a previous history of recurrent tonsillitis

OR

2. The patient has had one year or more of chronic tonsillitis with tonsoliths causing halitosis and significant social embarrassment

OR

3. The patient has a medical condition where specialist assessment determins that episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of on-going management:

- Acute and chronic renal disease resulting from acute bacterial tonsillitis.
- As part of the treatment of severe guttate psoriasis.
- Metabolic disorders where periods of reduced oral intake could be dangerous to health.
- PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Suspected tonsil neoplasms should be referred via the agreed urgent pathway.

This policy applies to people aged 2 years and over.

Advice for primary care practitioners

According to the RCS/ ENT-UK commissioning guide on tonsillectomy, primary care assessment of obstructive sleep disordered breathing in children aged <16 should include:

- Obstructive sleep disordered breathing ranges from simple snoring to obstructive sleep apnoea. Carefully assess (history and examination) children presenting with symptoms of snoring to distinguish between simple snoring and disruptive breathing patterns whilst asleep.
- Make note of nasal obstruction and size of tonsils (consider photo documentation)
- Carefully assess and document impact on growth and development, behaviour and quality of life e.g., height and weight, hyperactivity, daytime somnolence, school performance.
- Consider asking parents to bring a recording (smartphone video) of their child sleeping.
- Consider the role of obesity as a cause of obstructive sleep disordered breathing and referral to a weight management service. Obese children achieve poorer PSG outcomes than those of a healthy weight.
- Children with simple snoring without symptoms or signs of apnoea are unlikely to benefit from adeno-tonsillectomy.
- In older children >3 years with mild/moderate symptoms of obstructive sleep disordered breathing consider a trial of nasal saline irrigation and/or intranasal steroids for 6-8 weeks.
- If available consider allergy testing/treatment.

References

Royal College of Surgeons/ ENT-UK commissioning guide on tonsillectomy
https://www.entuk.org/sites/default/files/files/Revised ENT UK Tonsillectomy commissioning guide edit to final (002).pdf

Evidence-based interventions guidance available on AOMRC website.

5 Gastroenterology

5.1 Colonoscopy in the management of hereditary colorectal cancer

Category	Guidance

Guidance

Follow the British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer (CRC):

Family history of CRC

For individuals with moderate familial CRC risk:

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

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

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

Lynch Syndrome (LS) and Lynch-like Syndrome

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

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

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

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

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

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

Early Onset CRC (EOCRC)

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

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

Serrated Polyposis Syndrome (SPS)

For individuals with SPS:

- Offer colonoscopic surveillance every year from diagnosis once the colon has been cleared of all lesions >5mm in size

- If no polyps ≥ 10mm in size are identified at subsequent surveillance examinations, the interval can be extended to every 2 years.

For first degree relatives of patients with SPS:

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

Multiple Colorectal Adenoma (MCRA)

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

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

Familial Adenomatous Polyposis (FAP)

For individuals confirmed to have FAP on predictive genetic testing:

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

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

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

MUTYH-associated Polyposis (MAP)

For individuals with MAP:

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

For monoallelic MUTYH pathogenic variant carriers:

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

Peutz-Jeghers Syndrome (PJS)

For asymptomatic individuals with PJS:

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

For symptomatic patients, investigate earlier.

Juvenile Polyposis Syndrome (JPS)

For asymptomatic individuals with JPS:

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

For symptomatic patients, investigate earlier.

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

References

British Society of Gastroenterology guidelines for colonoscopy in the management of hereditary colorectal cancer
https://www.bsg.org.uk/clinical-resource/guidelines-for-the-management-of-hereditary-colorectal-cancer-from-the-bsg-acpgbi-ukcgg/

Evidence-based interventions guidance available on AOMRC website.

5.2 Colonoscopy (surveillance)

Category	Guidance

Guidance

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

Risk Surveillance Criteria for Colonoscopy

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

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

Surveillance colonoscopy after polypectomy

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

- Offer one-off surveillance colonoscopy at 3 years.

For individuals with **no high-risk** findings:

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

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

Surveillance colonoscopy after potentially curative CRC resection:

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

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

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

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

- Site-checks at 2-6 months and 18 months from the original resection.

Once no recurrence is confirmed, patients should undergo post-polypectomy surveillance after 3 years

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

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

- Site-check should be considered within 2-6 months
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria

Ongoing colonoscopic surveillance:

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

References

British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection
BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines - The British Society of Gastroenterology

Evidence-based interventions guidance available on AOMRC website.

5.3 Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis

Category	Guidance

Guidance

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.

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

5.4 Upper gastrointestinal (GI) endoscopy

Category	Guidance

Guidance

Upper GI endoscopy should only be performed if the patient meets the following criteria:

Urgent: (Within two weeks)

- Any dysphagia (difficulty in swallowing), to prioritise urgent assessment of dysphagia please refer to the Edinburgh Dysphagia Score OR
- Aged 55 and over with weight loss and any of the following:
  - Upper abdominal pain
  - Reflux
  - Dyspepsia (4 weeks of upper abdominal pain or discomfort)
  - Heartburn
  - Nausea or vomiting
- Those aged 55 or over who have one or more of the following:
  - Treatment resistant dyspepsia (as above), upper abdominal pain with low haemoglobin level (blood level) OR
  - Raised platelet count with any of the following: nausea, vomiting, weight loss, reflux, dyspepsia, upper abdominal pain OR
  - Nausea and vomiting with any of the following: weight loss, reflux, dyspepsia, upper abdominal pain.

For the assessment of upper GI bleeding:

- For patients with haematemesis, calculate Glasgow Blatchford Score at presentation and any high-risk patients should be referred

- Endoscopy should be performed for unstable patients with severe acute upper gastrointestinal bleeding immediately after resuscitation
- Endoscopy should be performed within 24 hours of admission for all other patients with upper gastrointestinal bleeding.

For the investigation of symptoms:

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

For management of specific cases

H. pylori and peptic ulcer:

- Eradication can be confirmed with a urea breath test, however if peptic ulcer is present repeat endoscopy should be considered 6-8 weeks after beginning treatment for *H. pylori* and the associated peptic ulcer.

Barrett's oesophagus:

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

Coeliac disease:

- Patients aged 55 and under with suspected coeliac disease and anti-TTG >10x reference range should be treated for coeliac disease on the basis of positive serology and without endoscopy or biopsy. The essential practice points of using a non-biopsy protocol in adults can be found here. This interim guidance is specific to the COVID-19 environment pending the publication of new guidance on coeliac disease by the British Society of Gastroenterology (expected to be published in 2022).

Surveillance endoscopy:

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

Screening endoscopy can be considered in:

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

Post excision of adenoma:

- Following complete endoscopic excision of adenomas, gastroscopy should be performed at 12 months and then annually thereafter when appropriate.

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

6 Gender dysphoria (treatments for)

6.1 Stand-alone surgical procedures (hysterectomy, bi-lateral salpingo-oophorectomy, orchidectomy or penectomy) for adults with gender dysphoria

Category	Restricted

Context

NHS England commissions Gender Dysphoria Clinics which assess and diagnose individuals, directly provide some interventions and arrange for referrals to other services, including for medical and surgical treatments.

Access to NHS funded surgical intervention is only by referral from a specialist Gender Dysphoria Clinic that is commissioned by NHS England.

The majority of surgical interventions are the commissioning responsibility of NHS England, however ICBs are responsible for commissioning hysterectomy, bilateral salpingo-oophorectomy, penectomy and orchidectomy when they are performed as 'stand-alone' procedures for gender dysphoria.

Criteria

Standalone hysterectomy, bi-lateral salpingo-oophorectomy, orchidectomy or penectomy are not routinely funded by NCL ICB for the treatment of adults with gender dysphoria unless both of the following criteria are met and evidenced:

- The patient has followed the appropriate NHS England care pathway for gender dysphoria, AND
- The patient meets the NHS England eligibility criteria for masculinising or feminising genital surgery as set out in their service specification for gender identity services for adults

The patient should be advised to stop smoking* and lose weight** (if appropriate).

*NHS England has received advice that patients should not smoke for six weeks prior to surgery and for at least six weeks after surgery as smoking increases risk of perioperative complications but also of major skin and tissue loss.

**NHS England note that a patient being significantly overweight increases their risk of peri-operative complication and may compromise the outcome of their surgery. Consensus opinion amongst surgeons who advised NHS England on their service specification is that patients with a BMI of 30 or more should lose weight before having genital surgery. Referral to a surgeon may still be made and an individualised discussion of risk and likely outcome included in the pre-operative counselling and consent process.

Reference

NHS England service specification for gender identity services for adults (surgical interventions) https://www.england.nhs.uk/wp-content/uploads/2019/12/nhs-england-service-specification-gender-identity-surgical-services.pdf

7 General surgery

7.1 Appendicectomy without confirmation of appendicitis

Category	Guidance

Guidance

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

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

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

This guidance applies to adults and children.

Reference

Evidence-based interventions guidance available on AOMRC website.

7.2 Cholecystectomy for gallstones

Category	Restricted Guidance regarding timing of surgery following acute admission

Criteria

Cholecystectomy for gallstones is not routinely funded by NCL ICB unless one of the criteria below is met and evidenced:

- Confirmed episode of gallstone induced pancreatitis, **OR**
- Confirmed recurrent episodes of abdominal pain typical of biliary colic, **OR**
- Confirmed episode of obstructive jaundice in the presence of gallstones where the gallstones are thought to be the cause, **OR**
- Confirmed acute cholecystitis, **OR**
- Where there is clear evidence from an ultrasound scan that the patient is at risk of gall bladder carcinoma.

NCL ICB will not routinely fund cholecystectomy for asymptomatic gallstones found in a normal gallbladder and normal biliary tree. An exception to this would be where the patient is asymptomatic

but also has diabetes, chronic liver disease or cirrhosis or is a transplant recipient; a secondary care opinion should be sought.

This policy does not apply to bile duct stones. NICE CG188 recommends offering bile duct clearance and laparoscopic cholecystectomy to people with symptomatic or asymptomatic common bile duct stones.

Guidance on timing of cholecystectomy following acute admission

For patients who are admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, index laparoscopic cholecystectomy should be performed within that admission. These patients should have their gallbladders removed, ideally before discharge, to avoid further delay and prevent further potentially fatal attacks. If the patient is fit enough for surgery and same admission cholecystectomy will be delayed for more than 24 hours, it may be reasonable to make use of a virtual ward, where the patient can return home under close monitoring prior to undergoing surgery as soon as possible.

Otherwise patients diagnosed with acute cholecystitis should have their laparoscopic cholecystectomy on the same admission within 72 hours (NICE guidelines published in October 2014 state one week, but 72 hours is preferable). This guidance may not be applicable in patients with severe acute pancreatitis.

Surgery for these patients may be challenging and can be associated with a higher incidence of complications (particularly beyond 96 hours) and a higher conversion rate from laparoscopic surgery to open surgery. These patients should be operated on by surgeons with experience of operating on patients with acute cholecystitis, or if not available locally, transfer to a specialist unit should be considered. Timely intervention is preferable to a delayed procedure, and, if the operation cannot be performed during the index admission it should be performed within two weeks of discharge.

This guidance applies to adults aged 19 years and over.

References

NICE guidance
https://www.nice.org.uk/guidance/cg188

Royal College of Surgeons and Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) commissioning guide on gallstone disease
https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/gallstone-disease-commissioning-guide-for-republication.pdf

Evidence-based interventions guidance available on AOMRC website.

7.3 Divarication of recti – Surgical repair of

Category	Not routinely funded

Surgical repair of recti divarication is not routinely funded by NCL ICB.

7.4 Haemorrhoid surgery

Category	Restricted

Criteria

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

Surgical treatment for haemorrhoids is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- The haemorrhoids do not respond to non-operative measures, **OR**
- The haemorrhoids are severe, specifically:
  - Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding, **OR**
  - Irreducible and large external haemorrhoids

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

Reference

Evidence-based interventions guidance available on AOMRC website.

7.5 Hernia – Management of

Category	Restricted for abdominal hernia repair, including recurrent and bilateral Guidance for inguinal hernia repair, including recurrent and bilateral

Criteria

Femoral hernia

Femoral hernia repair does not fall under the scope of this policy.

Inguinal hernia repair – Guidance

Minimally symptomatic inguinal hernia can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients.

In women, all suspected groin hernias should be urgent referrals.

This guidance applies to adults aged 19 years and over.

Groin pain with clinical suspicion of hernia (obscure pain or swelling)

Patients with groin pain with clinical suspicion of hernia may undergo diagnostic testing (e.g. ultrasound scan) to assess whether hernia or other pathology and managed accordingly. Funding criteria for hernia surgery (where applicable) are then applied as laid out in this policy.

Recurrent and bilateral hernia repair

Recurrent and bilateral hernia are considered in the same way as primary hernias and funding criteria (where applicable) for surgery will be applied as described in this policy. In order for the patient to access bilateral hernia repair, the relevant eligibility criteria (where applicable) will need to be met and evidenced for each hernia separately. Referral should be made to appropriate specialists with expertise in open and laparoscopic surgery.

Abdominal (including incisional and umbilical) hernia repair – Restricted

Abdominal hernia repair is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- there is pain/discomfort significantly interfering with activities of daily living (this must be documented and described), **OR**
- there is a documented increase in hernia size month on month.

  AND
- for patients with a BMI of 35kg/m^2 or above, there have been attempts at weight reduction for 6 months and these have not resolved the pain/discomfort.

References

Evidence-based interventions guidance available on AOMRC website.

European Hernia Society Guideline
https://www.europeanherniasociety.eu/sites/www.europeanherniasociety.eu/files/medias/PDF/HerniaSurgeGuidelinesPART1TREATMENT.pdf

BMJ Best Practice
https://bestpractice.bmj.com/topics/en-gb/723?q=Inguinal%20hernia%20in%20adults&c=suggested
https://emedicine.medscape.com/article/189563-overview#a0104

NICE guidance
https://www.nice.org.uk/guidance/ta83

McIntosh, Hutchinson, Roberts, Withers (2000). Evidence based management of groin hernia in primary care - a systematic review. Family Practice; 17:442-447
https://www.ncbi.nlm.nih.gov/pubmed/11021907

Friedrich, Muller-Riemenschneider, Roll, Kulp, Vauth, Greiner, Willich and von der Schulenbury (2008). Health Technology Assessment of laparoscopic compared to conventional surgery with and without mesh for incisional hernia repair regarding safety, efficacy and cost-effectiveness. GMS Health Technology Assessment ; 7/4: Doc 01
https://www.ncbi.nlm.nih.gov/pubmed/21289907

Dabbas (2011) Frequency of abdominal wall hernias: is classical teaching out of date. JRSM Short Reports: 2/5; 5
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3031184/

Fitzgibbons (2006) Watchful waiting versus repair of inguinal hernia in minimally symptomatic men, a randomised controlled trial. JAMA: 295; 285-292
https://www.ncbi.nlm.nih.gov/pubmed/16418463

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Rosenberg (2011). Danish hernia database recommendations for management of inguinal and femoral hernias in adults. Danish Medical Bulletin; 58/2: C4243
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https://www.ncbi.nlm.nih.gov/pubmed/8921464

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https://www.ncbi.nlm.nih.gov/pubmed/12612798

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https://www.ncbi.nlm.nih.gov/pubmed/15115007; http://www.ssat.com/

Surgical repair of incisional hernia. Journal of Gastrointestinal surgery; 8/3: 369-70
https://www.sciencedirect.com/science/article/abs/pii/S1091255X0300310X

8 Gynaecology

8.1 Bartholin's cysts – Treatment for

Category	Restricted

Criteria

Acute Bartholin's cyst presentations should be referred via agreed urgent pathways.

Surgical treatment of non-acute Bartholin's cysts is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

1. Cyst is larger than 3cm in diameter, **OR**
2. Cyst of any size causing significant discomfort, which have become infected requiring anti-biotic treatment on at least two separate occasions.

8.2 Dilatation and curettage for heavy menstrual bleeding (HMB)

Category	Not routinely funded

Dilatation and curettage for the diagnosis or treatment of HMB is not routinely funded by NCL ICB.

Reference

Evidence-based interventions guidance available on AOMRC website.

8.3 Hysterectomy for heavy menstrual bleeding (HMB)

Category	Restricted

Criteria

NCL ICB advise it is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Criteria for access to treatments for HMB should be in line with NICE NG88.

Information should be provided about all possible treatment options for HMB and discussed with the women. Discussions should cover:

- The benefits and risks of the various options, including information detailed in NG88 about what discussions should cover for specific interventions
- Suitable treatments if she is trying to conceive
- Whether she wants to retain her fertility and/or her uterus

Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.

When agreeing treatment options for HMB with women, take into account:

- the woman's preferences
- any comorbidities
- the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis
- other symptoms such as pressure and pain

Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis

- Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with:
  - no identified pathology, **OR**
  - fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity, **OR**
  - suspected or diagnosed adenomyosis.
- If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments:
  - non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs)
  - hormonal: combined hormonal contraception, cyclical oral progestogens.
- Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.
- If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for:
  - investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had, **AND**
  - alternative treatment choices, including:
    - pharmacological options not already tried (see above)
    - surgical options: second-generation endometrial ablation, hysterectomy.
- For women with submucosal fibroids, consider hysteroscopic removal.

Treatments for women with fibroids of 3 cm or more in diameter

- Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.
- If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.
- Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.
- For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments:
  - pharmacological:
    - non-hormonal: tranexamic acid, NSAIDs

- hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens
- uterine artery embolization
- surgical: myomectomy, hysterectomy

- Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.
- Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered.
- Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.
- If treatment is unsuccessful:
  - consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations, **AND**
  - offer alternative treatment with a choice of the options described above.
- Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

References

NICE Guidance
https://www.nice.org.uk/guidance/ng88

Evidence-based interventions guidance available on AOMRC website.

8.4 Labiaplasty

Category	Not routinely funded

Labiaplasty is not routinely funded by NCL ICB.

Exclusions from the policy

Surgery to the labia in relation to a malignancy.

8.5 Pelvic organ prolapse - Surgery for

Category	Restricted

Criteria

Criteria for referral:

Referral for consideration of surgery for pelvic organ prolapse (POP) is not routinely funded by NCL ICB unless both of the following criteria are met and evidenced:

- The prolapse is symptomatic

AND

- Failure of management in primary care; prior to referral to secondary care, all non-surgical management options (outlined below) should have been considered, where these are available locally, and either failed or deemed unsuitable/ not clinically appropriate or declined after documented discussion with clinician:
  - lifestyle interventions including information on: losing weight, minimising heavy lifting and preventing/ treating constipation
  - topical oestrogen for women with POP and signs of vaginal atrophy
  - programme of supervised pelvic floor muscle training (PFMT) for at least 16 weeks for women with symptomatic POP-Q (Pelvic Organ Prolapse Quantification) stage 1 or stage 2 pelvic organ prolapse.
  - vaginal pessary

Asymptomatic patients (e.g. those where prolapse is detected incidentally) should not be referred to secondary care (once pelvic mass or other pathology ruled out).

Criteria for surgery:

Surgery for pelvic organ prolapse is not routinely funded by NCL ICB unless all of the following criteria are met and evidenced:

- The patient has moderate to severe symptoms; surgery for POP is not routinely funded for asymptomatic patients or those with mild symptoms

AND

- Failure of non-surgical management; all non-surgical management options (outlined below) should have been considered, where these are available locally, and either failed or deemed unsuitable/ not clinically appropriate or declined after documented discussion with clinician:
  - programme of supervised PFMT for at least 16 weeks for women with symptomatic POP-Q stage 1 or 2 POP
  - vaginal pessary (alone or in conjunction with supervised PFMT)

AND

- The woman indicates their preference and willingness to have surgery following an informed discussion and shared decision-making (consider using the NICE patient decision aids on surgery for uterine prolapse and surgery for vaginal vault prolapse where appropriate and they apply, or the NHS England leaflet on surgical procedures for pelvic organ prolapse in women; a simple guide for patients to the pros and cons of different treatments for POP is also available on NHS.uk). NICE NG123 details what information discussions with women should cover.
- In line with NICE guidance (NG123), surgery to prevent incontinence should not be offered in women having surgery for prolapse who do not have incontinence.
- Providers must ensure that data on surgical procedures for POP are recorded in a national registry, as outlined in the section on collecting data on surgery and surgical complications in NICE NG123, following patient consent.

Reference

NICE guidance
https://www.nice.org.uk/guidance/NG123

8.6 Reversal of female sterilisation

Category	Restricted

Criteria

Reversal of sterilisation is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Death of only existing child
- Remarriage following death of spouse

9 Ophthalmology

9.1 Cataract surgery

Category	Restricted

Criteria

Exclusions from the policy

- Patients with confirmed or suspected malignancy.
- Patients with acute trauma or suspected infection.
- Paediatric patients.

Commissioning criteria

Cataract surgery is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye

AND

- Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls.

All patients should be given the opportunity to engage with shared decision making at each point in the pathway to cataract surgery (e.g. optometrists, GPs, secondary care), to ensure they are well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration.

- Surgery is also indicated for management of cataract with co-existing ocular comorbidities*.
- Where patients have a best corrected visual acuity better than 6/9, specialist assessment should still be considered where there is a clear clinical indication or the patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, or risk of falls
- For NHS treatment to be provided, there needs to be mutual agreement between the provider and the **responsible** (i.e. paying) commissioner about the rationale for cataract surgery **prior to undertaking the procedure** (i.e. demonstration of compliance with the policy is recorded).

*List of ocular comorbidities:

- Glaucoma
- Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening
- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitis)
- Severe anisometropia in patients who wear glasses

• Posterior subcapsular cataracts
Reference
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-9a-Cataract-Surgery-Policy.pdf

9.2 Chalazia removal

Category	Restricted

Criteria

Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia is not routinely funded by NCL ICB unless at least one of the criteria below is met and evidenced:

- The chalazion has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks, **OR**
- The chalazion interferes significantly with vision, **OR**
- The chalazion interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy, **OR**
- The chalazion is a source of infection that has required medical attention twice or more within a six month time frame, **OR**
- The chalazion is a source of infection causing an abscess which requires drainage, **OR**
- If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features, in which case the lesion should be removed and sent for histology as for all suspicious lesions

Consider management of co-existing risk factors:

- Chronic blepharitis
- Seborrhoeic dermatitis
- Acne rosacea

This policy applies to people aged 13 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

9.3 Eyelid surgeries

Category	Restricted

Criteria

Blepharoplasty and ptosis correction

- Surgical repair of blepharoptosis or dermatochalasis (as a primary or recurrent condition) is not routinely funded by NCL ICB unless either Criteria A or B below are met and evidenced:

  A. Patients must meet all of the following criteria:

  - Visual field test (by optometrist in primary care) reports that the binocular visual field (using an Estermann test or equivalent) is reduced to 120 degrees or less laterally or 40 degrees or less vertically in the superior visual field, **AND**
  - There is clinical evidence of chronic compensation through elevation of the brow, **AND**
  - All other causes of visual field defect have been excluded

  B. Patients must meet all of the following criteria:

  - Patients are unable to perform visual field tests due to either physical or cognitive impairment preventing full assessment, or poor visual acuity inhibiting accurate visual fields assessment (defined as corrected visual acuity of 6/36 or less). Reasonable adjustments must be made by the optometrist to facilitate patients being able to undergo visual field testing and these must be detailed within the referral, **AND**
  - Specialist assessment confirms both of the following:
    - There is clinical evidence of chronic compensation through elevation of the brow, **AND**
    - In the resting position (with eyebrows not raised) the affected eyelid causes significant visual field obstruction leading to functional impairment.
- Revision of blepharoplasty undertaken privately for cosmetic purposes will not be routinely funded unless there is a threat to visual function. Referrals may be made for specialist assessment under routine commissioning arrangements.
- The following are excluded from the scope of this policy:
  - Congenital conditions
  - Paediatric presentations
  - Trauma
  - Reconstructive surgery after cancer
  - Correction of prosthesis difficulties for an anophthalmic socket
  - Thyroid eye disease
  - Infiltration due to other systemic conditions (e.g. histiocytosis, amyloidosis, sphenoid wing meningioma)
  - Oculomotor nerve palsy
  - Myasthenia gravis
  - Blepharospasm/ hemifacial spasm
  - Myopathy

Correction of ectropion and entropion

- Minor ectropion or entropion may be managed conservatively. If there is concern about significant entropion or ectropion, patients should be referred for specialist assessment and surgical treatment (where appropriate) under routine commissioning arrangements.

References

Bartalena L, Baldeschi L, Dickinson AJ et al. Consensus statement of the European Group on Graves' Oribitopathy (EUGOGO) on management of Graves' orbitopathy. *Eur J Endocrinol*. 2008;158:273-85. https://www.ncbi.nlm.nih.gov/pubmed/18299459

Goel R, Sanoria A, Kumar S et al. Comparison of polypropylene sling with combined transconjunctival retractor plication and lateral tarsal strip for correction of involutional lower eye lid ectropion. *Open Ophthalmol J*. 2017;11:285-297. https://www.ncbi.nlm.nih.gov/pubmed/29081868

Hollander MHJ, Contini M, Pott JW et al (2019) Functional outcomes of upper eyelid blepharoplasty: a systematic review. *J Plast Reconstr Aesthet Surg*. 2019;72:294-309. https://www.ncbi.nlm.nih.gov/pubmed/30528286

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10 Oral surgery

10.1 Temporo-Mandibular Joint (TMJ) surgery

Category	Restricted

Criteria

Temporo-mandibular joint surgery is not routinely funded by NCL ICB unless there is evidence that all of the following treatments have been tried and failed:

1. Jaw rest, **AND**
2. Medications: non-steroidal anti-inflammatory medications such as aspirin, ibuprofen to control inflammation. Muscle relaxants, such as diazepam may decrease muscle spasms, **AND**
3. Physiotherapy, **AND**
4. Local anaesthetic, **AND**
5. Occlusal therapy: a custom made acrylic appliance which fits over the teeth prescribed for night and day to balance the bite, reduce and eliminate teeth grinding or clenching (bruxism), **AND**
6. Botulinum toxin injections.

TMJ ligament tightening, joint restructuring, and joint replacement are only considered in the most severe cases of joint damage or deterioration.

TMJ surgery referred to in this policy excludes arthroscopy as it may be performed for diagnostic reason.

It is suggested that before any dentist or surgeon commences any plan or approach involving surgery, a thorough search for inciting para-functional jaw habits have been performed with the correction of any discrepancies from normal as the primary goal.

Absolute contraindications to surgery are:

- Active or chronic infection
- Insufficient quantity or quality of bone to support the components
- Systemic disease with increased susceptibility to infection
- Patients with extensive perforations in the mandibular fossa and/or bony deficiencies in the articular eminence or zygomatic arch that would severely comprise support for the artificial fossa component
- Partial TMJ joint reconstruction
- Known allergic reaction to any materials used in the components
- Patients with mental or neurological conditions who are unwilling or unable to follow post-operative care instructions
- Skeletally immature patients
- Patients with severe hyper-functional habits (e.g. clenching, grinding etc.)

Reference

NICE Guidance
https://www.nice.org.uk/guidance/ipg500/

11 Orthopaedics

11.1 Autologous Chondrocyte Implantation (ACI)

Commissioning responsibility for autologous chondrocyte implantation (ACI) of the knee is with NHS England. Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

11.2 Bunions (hallux valgus) – Surgery for

Category	Restricted

Criteria

Patients with bunions should NOT be referred for prophylactic or cosmetic reasons.

Surgery for bunion (hallux valgus) is not routinely funded by NCL ICB unless all of the criteria below have been met and evidenced:

- The patient experiences persistent pain and significant disturbance to lifestyle or activities of daily living and/or the second toe is involved, **AND**
- Appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: evidence based non-surgical treatments, i.e. analgesia, bunion pads, footwear modifications (e.g. accommodative footwear and orthoses), **AND**
- The patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car), **AND**
- Patient understands that surgery may relieve pain and improve the alignment of the toe in most people; however, there is no guarantee that the foot will be perfectly straight or pain-free after surgery.

NCL ICB will not routinely fund bunion surgery for prophylactic or cosmetic reasons for asymptomatic bunions.

There is a higher risk of ulceration or other complications, in patients with neuropathy or diabetes. Such patients should be referred for an early assessment.

This policy does not cover hallux rigidus (osteoarthritis of the first metatarsophalangeal joint) because the management is different to that of a bunion.

References

NICE Guidelines
https://www.nice.org.uk/guidance/ipg332

Royal College of Surgeons (RCS) and British Orthopaedic Association (BOA) commissioning guide on painful deformed great toe in adults
https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-deformed-great-toe-guide-2017.pdf

11.3 Carpal tunnel syndrome release

Category	Restricted

Criteria

- 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:
  - Corticosteroid injection(s)* **OR** nocturnal splinting**
- Surgery for carpal tunnel syndrome is not routinely funded by NCL ICB unless one of the following criteria is met and evidenced:
  - Symptoms significantly interfere with daily activities and sleep and have not settled to a manageable level with either one local corticosteroid injection and/ or nocturnal splinting for a minimum of 8 weeks, **OR**
  - There is either:
    - a permanent reduction in sensation in the median nerve distribution, **OR**
    - muscle wasting or weakness of thenar abduction.
- Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

* There is good evidence for the short term effectiveness (8-12 weeks) of steroid injections.

** Wrist splints worn at night are less effective than steroid injections.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.4 Dupuytren's contracture release

Category	Restricted

Criteria

- Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contracture, or one which is not progressing and does not impair function.
- Surgical treatment (needle fasciotomy, fasciectomy and dermofasciectomy) for Dupuytren's contracture is not routinely funded by NCL ICB unless the criteria below are met and evidenced:
  - finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint, **OR**
  - severe thumb contractures which interfere with function
- Radiation therapy will not be funded due to a lack of evidence of clinical effectiveness.

References
Evidence-based interventions guidance available on AOMRC website. NICE Guidance https://www.nice.org.uk/guidance/ipg573 (radiation therapy)

11.5 Ganglion excision

Category	Restricted

Criteria

Wrist ganglia:

- No treatment is required unless the ganglion is causing pain or tingling/ numbness or concern (worried it is a cancer)
- First line treatment is aspiration if the ganglion is causing pain, tingling/ numbness or concern
- Surgical excision of wrist ganglia is not routinely funded by NCL ICB unless aspiration has failed to resolve the pain or tingling/ numbness and there is restricted hand function

Seed ganglia that are painful:

- First line treatment is puncture/ aspiration of the ganglion using a hypodermic needle
- Surgical excision of seed ganglia that are painful is not routinely funded by NCL ICB unless the ganglia persists or recurs after puncture/ aspiration

Mucous cysts:

- Surgical excision of mucous cysts is not routinely funded by NCL ICB unless there is recurrent spontaneous discharge of fluid or significant nail deformity

Reference

Evidence-based interventions guidance available on AOMRC website.

11.6 (Primary) Hip arthroplasty

Category	Restricted

Criteria

Exclusions from the policy

- Children.
- Patients with confirmed or suspected malignancy, acute trauma, suspected infection and inflammatory arthropathy.
- Patients with underlying disease (such as haemophilia or sickle cell) related hip disease.
- Young adults with abnormal hip anatomy.

Commissioning criteria

Total hip replacement is not routinely funded by NCL ICB unless **ALL** of the criteria below are met and evidenced:

- The patient has osteoarthritis with joint symptoms (pain, stiffness and reduced function) that have a substantial impact on quality of life as agreed with the patient and/ or the patient's representative, referring clinicians and surgeons, **AND**
- The symptoms are refractory to non-surgical treatment (including analgesia, exercise, physiotherapy and weight loss, where appropriate), **AND**
- The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this, **AND**
- The patient has been engaged in shared decision making regarding treatment options.

Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- Osteoarthritis (OA) is the most common form of arthritis in the United Kingdom and the hip is a commonly affected site. Important consequences are pain, limitation of daily activities and reduction in quality of life.
- It is important to recognise that OA may not be progressive and most patients may be successfully managed with non-surgical measures in primary or intermediate care.
- Patients should be encouraged to engage in conservative treatments, which include education and lifestyle modifications, exercise and weight loss (where appropriate).
- Primary care practitioners should encourage smoking cessation and weight reduction, offering referral to appropriate services, where required.
- An earlier referral to secondary care for those with suspected end stage hip OA may be appropriate as conservative measures are unlikely to improve the patient's pain or quality of life.
- Primary care practitioners should ensure that the patient has meaningfully engaged with conservative management, where appropriate, prior to referral for hip replacement surgery. These lifestyle changes have the potential to improve general health and wellbeing, as well as intervention success rates and enhance recovery times from surgery.

- Clinical judgement should be used to assess severity of symptoms and consideration of referral for surgical opinion, as there are currently no scoring systems validated for clinical use.
- In conjunction with this, patients should be given the opportunity to engage with shared decision making prior to referral for surgery. This may occur in primary care or interface services, such as Musculoskeletal Clinical Assessment and Treatment Service (MCATS), where applicable.
- At referral, primary care practitioners must ensure that they supply all the relevant information to secondary care, particularly concerning conservative treatments.

Decision aids

In line with best practice, shared decision making should involve the use of a decision-making aid. These tools can be accessed online at: https://www.england.nhs.uk/rightcare/shared-decision-making/

Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-3a-Hip-Arthroplasty-Policy.pdf

11.7 Hip MRI for arthritis

Category	Guidance

Guidance

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

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

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

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

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

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

- Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis
- Trauma

- History or family history of an inflammatory arthropathy
- Mechanical, impingement type symptoms
- Prolonged and morning stiffness
- History of cancer or corresponding risk factors
- Suspected Osteonecrosis / Avascular necrosis of the hip
- Suspected transient osteoporosis
- Suspected periarticular soft tissue pathology e.g. abductor tendinopathy

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.8 Interventional treatments for back pain – Overview

Overarching criteria

For many patients, consideration of interventional treatments for back pain only arises after conservative management in primary care or specialist musculoskeletal services.

The following exclusions apply to policies on interventional treatments for back pain:

- Children*.
- Patients thought to have/ have cancer (including metastatic spinal cord compression).
- Patients with neurological deficit (spinal cord compression or cauda equina symptoms), fracture or infection.

*Eligibility criteria for interventional treatments for back pain relate to people aged over 16 years unless otherwise stated.

Advice for primary care practitioners

- Low back pain is a very common presentation, especially to General Practice. It is a soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. Some people also get back symptoms radiating down one or both legs (radicular symptoms/ sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg.
- This pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management. Conservative management may include reassurance, advice and guidance with a holistic assessment (where tools such as STarT Back can be helpful) and/or simple analgesia with safety netting. Patients with “red flag” pathologies should be treated on alternative pathways.
- **The commissioning criteria set out in this document should not delay referral for assessment of patients with uncontrollable pain despite conventional treatment.**

• Primary care practitioners must ensure that patients have engaged in shared decision making for potential further intervention and that they supply all the relevant information to secondary care, particularly concerning conservative treatments. • Primary care should ensure that, where appropriate, the patient has meaningfully engaged with conservative management. These include education and lifestyle modifications, exercise and physiotherapy. Primary care practitioners should encourage smoking cessation and weight reduction (where appropriate), offering referral to appropriate services, where required. These lifestyle changes have the potential to improve general health and wellbeing, as well as, intervention success rates and enhance recovery times from surgery.
Reference
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

11.9 Interventional treatments for back pain – Acupuncture

Category	Not routinely funded
Acupuncture for back pain is not routinely funded by NCL ICB.	
Reference	
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf	

11.10 Interventional treatments for back pain – Discectomy (lumbar)

Category	Restricted
Criteria	
Lumbar discectomy is not routinely funded by NCL ICB unless all of the following criteria are met and evidenced: • Patient has compressive nerve root signs and symptoms lasting at least three months (or are severe cases) • Non-operative management has failed to resolve symptoms • Concordant MRI changes are present ***Exclusions to the policy*** This policy is not intended to cover patients who demonstrate deterioration in neurological function (e.g. objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent	

referral to an acute spinal centre for further evaluation and imaging, as nonoperative treatment may lead to irreversible harm.

This policy applies to adults aged 19 years and over.

Advice for clinicians

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

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

Some patients may benefit from a discectomy – a shared decision-making framework has been used with the patient to determine the appropriateness of the discectomy.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.11 Interventional treatments for back pain – Epidurals

Category	Restricted

Criteria

- Epidural injections for neurogenic claudication in people who have central spinal canal stenosis are not routinely funded by NCL ICB.
- Epidural injections of local anaesthetic and steroid are not routinely funded by NCL ICB unless the criteria below are met and evidenced:
  - The patient has spinal pain associated with radicular pain/ myotomal pain consistent with the level of spinal involvement

    AND
  - The patient has shown no sign of improvement despite conventional therapy such as advice, reassurance, reasonable and acceptable doses of conventional oral analgesia and manual therapy

    AND
  - The patient has moderate-severe symptoms

    AND
  - MRI scan shows pathology concordant with the clinical diagnosis.

A maximum of 3 epidural injections will be permitted per pain episode. Epidural injections should only be repeated if 6 months of significant pain relief (using a visual analogue scale or equivalent) and functional improvement is achieved, which is clearly documented in the patent's notes*.

If patients have persisting symptoms after 3 injections, reasons for additional treatment with epidural injections should be clearly documented in the patient notes, including reasons why alternative

treatments are inappropriate. This may be an older/ frailer patient who derives medium term benefit but are unsuitable or unwilling to have surgery. **Consider repeat MRI according to clinical judgement.*
References
Evidence-based interventions guidance available on AOMRC website. London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf NICE Guidance https://www.nice.org.uk/guidance/ng59

11.12 Interventional treatments for back pain – Epidural lysis

Category	Not routinely funded
Epidural lysis is not routinely funded by NCL ICB.	
Reference	
NICE guidance https://www.nice.org.uk/guidance/ipg333	

11.13 Interventional treatments for back pain – Lumbar disc replacement

Category	Not routinely funded
Lumbar disc replacement surgery is not routinely funded by NCL ICB.	
Reference	
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf	

11.14 Interventional treatments for back pain – Ozone discectomy

Category	Not routinely funded

Ozone discectomy is not routinely funded by NCL ICB.

Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

11.15 Interventional treatments for back pain – Radiofrequency denervation

(including non-anterior radicular cervical, thoracic and lumbar areas)

Category	Restricted

Criteria

Radiofrequency denervation is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Patient has chronic 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**
- Conservative management including physiotherapy and multidisciplinary input has failed to achieve meaningful relief of pain, **AND**
- The main source of pain is thought to come from structures supplied by the medial branch nerve*, **AND**
- The patient has had a significant reduction in pain from a diagnostic medial branch block, which is clearly documented in the patient's notes using a visual analogue scale or equivalent.

Consistent with NICE guideline (NG) 59, imaging should not be offered for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation (see also policy on low back pain imaging).

For each affected nerve level, the patient should have one diagnostic medial branch block followed by one therapeutic radiofrequency denervation procedure.

Referral for repeat radiofrequency denervation procedures after relapse are not routinely funded by NCL ICB unless a patient reported outcome measure has demonstrated significant improvement in pain relief and function at 12 months post the initial denervation procedure. A maximum of 2 procedures for each affected nerve level will be funded.

**** Clinical features suggestive of a facet joint pain component***

Although no reliable clinical features or physical signs identify 'facet joint pain' accurately, the NICE NG59 guideline development group (GDG) agreed that the features identified by a UK based consensus group might be helpful in identifying those patients who may benefit from a radiofrequency denervation. The features include:

- Increased pain unilaterally or bilaterally on lumbar para-spinal palpation
- Increased back pain on 1 or more of the following:
  - extension (more than flexion)
  - rotation
  - extension/ side flexion
  - extension/ rotation

AND

- No radicular symptoms

AND

- No sacroiliac joint pain elicited using a provocation test.

References

Evidence-based interventions guidance available on AOMRC website.

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

NICE guidance
https://www.nice.org.uk/guidance/ng59

Spinal surgery GIRFT report
https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/01/Spinal-Services-Report-Mar19-L1.pdf

11.16 Interventional treatments for back pain – Sacroiliac joint injections (diagnostic and therapeutic)

Category	Restricted

Criteria

- Therapeutic sacroiliac joint injections are not routinely funded by NCL ICB
- Diagnostic sacroiliac joint injections are not routinely funded by NCL ICB unless the criteria below are met and evidenced:
  - Patient is under the care of a specialist, **AND**
  - Patient has persistent pain for 12 weeks or longer despite conservative management*

  The patient may have up to two diagnostic injections (if both short and long acting injections are being used) within a two-week period.

  The second diagnostic injection may only be given if the first elicits 80% improvement in pain and this is clearly documented in the notes.

*This eligibility criterion is intended to reduce avoidable harm to patients considering that: (1) Non-specific low back pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management, and (2) more invasive treatments carry the risk, even if small, of harm to patients.
Reference
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

11.17 Interventional treatments for back pain – Spinal cord stimulation

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

11.18 Interventional treatments for back pain – Spinal decompression

Category	**Restricted**
Criteria	
Spinal decompression is not routinely funded by NCL ICB unless the criteria below are met and evidenced: • The patient has spinal pain associated with radicular pain/ myotomal pain consistent with the level of spinal involvement, **AND** • The MRI scan (unless contraindicated) shows one or more areas of spinal stenosis whereby the pathology is concordant with the clinical diagnosis, **AND** • The patient has shown no sign of improvement despite conventional therapy for 1 year.	
Reference	
London Choosing Wisely https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf	

11.19 Interventional treatments for back pain – Spinal fusion for mechanical axial low back pain

Category	Not routinely funded (exclusions apply)

Spinal fusion for non-specific, mechanical low back pain is not routinely funded by NCL ICB.

Exclusions to the policy

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

Spinal fusion is usually reserved for:

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

NHS England may be the responsible commissioner for fusion surgery in some circumstances.

This policy applies to adults aged 19 years and over.

Advice for clinicians

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

Reference

Evidence-based interventions guidance available on AOMRC website.

11.20 Interventional treatments for back pain – Spinal injections (diagnostic and therapeutic)

Category	Diagnostic medial branch blocks are funded provided criteria are met; Therapeutic spinal injections for low back pain are not routinely funded

- The following injections for non-specific low back pain are not routinely funded by NCL ICB:
  - Facet joint injections
  - Medial branch blocks (applies to therapeutic medial branch blocks only; see below for diagnostic medial branch blocks)
  - Intradiscal therapy
  - Prolotherapy
  - Trigger point injections with any agent, including botulinum toxin
  - Epidural steroid injections (see also separate section on epidurals for other indications)
  - Any other spinal injections not specifically covered above
- Diagnostic medial branch blocks are not routinely funded by NCL ICB unless the criteria below are met and evidenced:
  - It is being used as a diagnostic tool to establish whether the patient is likely to respond to radiofrequency denervation, **AND**
  - Patient is under the care of a specialist, **AND**
  - Patient has persistent pain for 12 weeks or longer despite conservative management*

Patients who experience positive responses to diagnostic medial branch blocks (as defined in the section relating to radiofrequency denervation) should be offered radiofrequency denervation rather than repeated medial branch blocks when seeking further treatment.

*This eligibility criterion is intended to reduce avoidable harm to patients considering that: (1) Non-specific low back pain is usually self-limiting and the majority of patients will find their symptoms resolve without treatment or with conservative management, and (2) more invasive treatments carry the risk, even if small, of harm to patients.

References

Evidence-based interventions guidance available on AOMRC website.

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-6a-Low-Back-Pain-Policy-Updated.pdf

NICE guidance
https://www.nice.org.uk/guidance/ng59

11.21 Knee arthroplasty

Category	Restricted

Criteria

Exclusions from the policy

- Patients with joint failure from causes other than degenerative disease/ osteoarthritis
- Patients with confirmed or suspected malignancy
- Patients with acute trauma or suspected infection
- Patients with inflammatory arthropathies
- Paediatric patients

Commissioning criteria

Total or partial knee replacement surgery is not routinely funded by NCL ICB unless **ALL** of the criteria below are met and evidenced:

- Osteoarthritis with joint symptoms (pain, stiffness, reduced function, joint instability) that have a substantial impact on quality of life as agreed with the patient and/ or the patient's representative, referring clinicians and surgeons, **AND**
- The symptoms are refractory to non-surgical treatment (including pain relief, exercise, physiotherapy and weight loss where appropriate), **AND**
- The patient's symptoms are consistent with degenerative disease, and prior to arthroplasty there is radiological confirmation of this, **AND**
- The patient has been engaged in shared decision making regarding treatment options.

Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- It is important to note that osteoarthritis (OA) may not be progressive and many patients can be successfully managed with non-surgical measures in primary care.
- Patients should be encouraged to be involved in self-management of core (non-surgical) treatments, which includes education and lifestyle modifications, exercise and weight loss (where appropriate).
- Patients who smoke should be advised to attempt to stop smoking at least 12 weeks before surgery and should be offered support with smoking cessation services.
- Patients with raised BMI should be supported to lose weight and, where appropriate, offered access to local weight loss services (where these services are available).
- Clinical judgement should be used with regards to assessing severity of symptoms and considering referral for surgical opinion, as there are currently no classification scores validated for clinical use.
- Prior to referral, primary care practitioners should ensure that patients have meaningfully engaged with non-surgical management.
- Referrals to secondary care should be via the MSK interface services (where such pathways are in place).

- Consider earlier referral to secondary care for patients with suspected end-stage OA.

Decision aids

To support with informed decision making, patients should be given the opportunity in primary care to complete the Decision Aid tools on knee osteoarthritis and knee replacement surgery. These tools can be accessed online at: https://www.england.nhs.uk/rightcare/shared-decision-making/

Reference

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-4a-Knee-Arthroplasty-Policy.pdf

11.22 Knee arthroscopy for suspected meniscal tears

Category	Guidance

Guidance

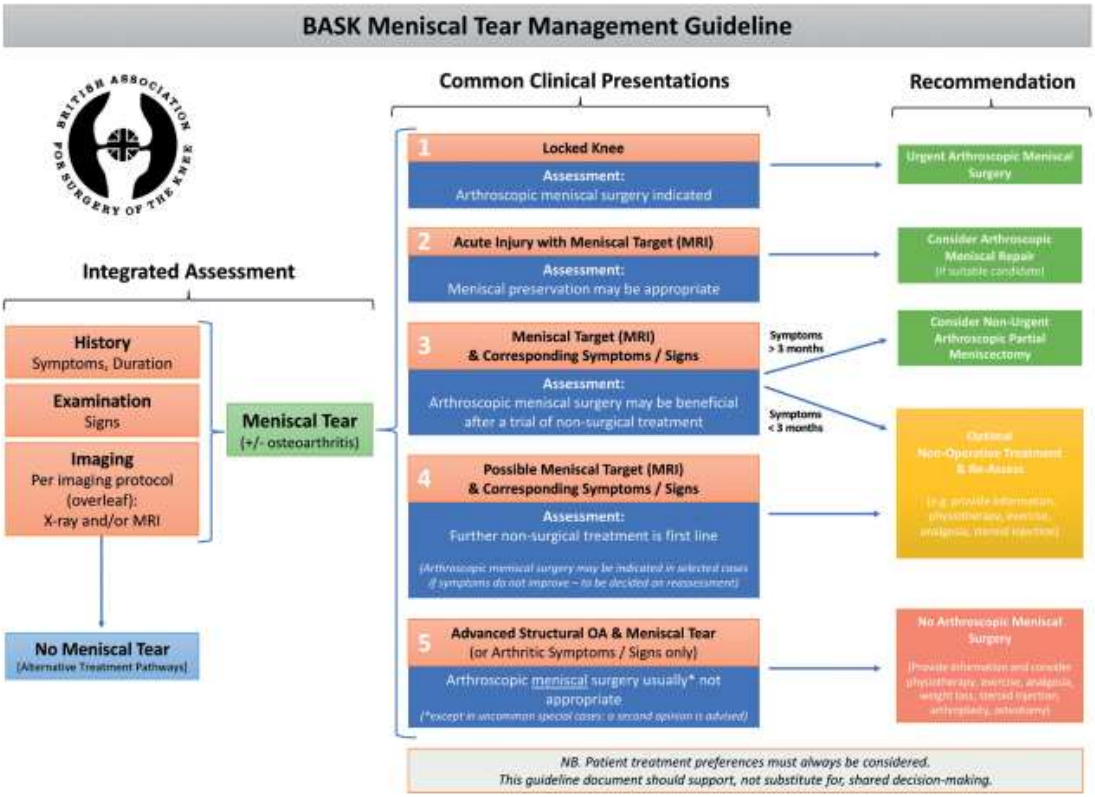
The use of arthroscopic surgery to treat degenerate meniscal tears should follow British Association for Surgery of the Knee (BASK) Guidelines on Arthroscopic Meniscal Surgery (see page 655 of Guidelines and Figure 2 below).

See also policy on knee arthroscopy for osteoarthritis.

This guidance applies to adults and children.

Note – in NCL, this guidance will mainly be for determining which patients should be referred into secondary care following an MRI – it is not designed to address the pre-MRI pathway comprehensively. In NCL direct access for MRI of the knee varies; GPs should follow their local pathways.

Figure 2



Source: BASK Guideline on Arthroscopic Meniscal Surgery (page 655).

Advice for clinicians

Meniscal tears in the knee are a common finding and in many cases are not related to any significant symptoms. They are often associated with degenerative articular cartilage change and osteoarthritis within the knee. A significant number of patients who present with persistent and often mechanical symptoms within the knee have a meniscal tear, which may be noted with an MRI scan.

The vast majority of patients with a meniscal tear should be initially treated non-operatively and should not have arthroscopic meniscectomy as a first-line treatment. Non-operative treatment is highly effective with patient education using verbal and written materials, physiotherapy and weight loss interventions. Exercise should comprise both local muscle strengthening and general aerobic fitness. Paracetamol and topical NSAIDs should be first-line pharmacological pain management strategies. Many patients treated this way will improve and do not require surgery.

There are a number of occasions when arthroscopic meniscal surgery can be considered as a first-line treatment. Firstly, patients who have a locked knee need urgent assessment. If a bucket handle tear of the meniscus is present, most cases need arthroscopic repair or resection of the meniscus.

Secondly where the patient has had an acute injury and an MRI scan reveals a potentially repairable meniscus tear, an arthroscopic meniscal repair should be considered.

Where symptoms have not settled after three months of non-operative treatment an MRI scan should be considered. In these cases with an unstable meniscal tear on MRI, arthroscopic meniscal surgery may be indicated. Recent systematic review evidence has suggested that in these cases where there are persistent symptoms, there can be improvement with this procedure.

Patients considering arthroscopic knee surgery should go through a shared decision-making process and have a good understanding of the risks of surgery. The procedure is a relatively safe intervention but does carry a low a low risk of infection and deep vein thrombosis, both of which are serious complications.

Routine use of arthroscopy for degenerative knee disease, where no specific target pathology has been identified (e.g. proven meniscal tear and persistent symptoms), is not recommended. Use of arthroscopy in patients with generic degenerative knee disease and no specific target pathology has not been found to be clinically beneficial and is unlikely to be cost-effective. Using agreed guidelines for employing arthroscopic surgery to treat meniscal tear pathology and avoiding indiscriminative use will reduce unwarranted variation in clinical care.

References

British Association for surgery of the Knee (BASK) Guidelines on Arthroscopic Meniscal Surgery https://online.boneandjoint.org.uk/doi/pdf/10.1302/0301-620X.101B6.BJJ-2019-0126.R1

Evidence-based interventions guidance available on AOMRC website.

11.23 Knee arthroscopy for osteoarthritis

Category	Not routinely funded (exclusions apply)

Exclusions from the policy

- Patients receiving an arthroscopic procedure as part of another surgical procedure e.g. high tibial osteotomy or unicompartmental arthroplasty
- Patients with acute trauma/ injury
- Patients with ligament rupture
- Patients with a meniscal surgical target. See policy on knee arthroscopy for suspected meniscal tears.
- Patients with suspected infection
- Patients with suspected avascular necrosis
- Patients with confirmed or suspected malignancy
- Patients with inflammatory arthropathies
- Paediatric patients
- Patients requiring chondroplasty
- Patients requiring synovial biopsy and synovectomy
- Patients requiring excision synovial plica

Those few patients with osteoarthritis who also have a clear history of a truly locked knee (i.e. inability of knee extension on clinical examination, as opposed to morning joint stiffness [aka gelling], 'giving way' or X-ray evidence of loose bodies) will need therapeutic arthroscopic intervention.

Commissioning criteria

Arthroscopic lavage and debridement for the treatment of knee osteoarthritis is not routinely funded by NCL ICB.

See also policy on knee arthroscopy for suspected meniscal tears.

Advice to primary care practitioners

The following section is designed to aid decision making in primary care and does not form part of the commissioning criteria.

- High quality evidence does not support the use of knee arthroscopic surgery in most patients with degenerative disease (with or without osteoartiritis [OA]).
- Asymptomatic meniscal tears are very common in middle and older aged patients and are often an incidental finding on MRI. There is mixed opinion regarding the clinical identification of those tears for which arthroscopic treatment is clinically effective.
- The diagnosis of OA can be made clinically without imaging if a person is 45 or over and has activity-related joint pain and has either no morning joint-related stiffness, or morning stiffness that lasts no longer than 30 minutes. (If requesting X-rays for degenerative disease, weight-bearing standing films should be requested).
- For patients who are symptomatic with degenerative disease including OA, first-line treatment should ideally be with a comprehensive programme of non-surgical measures, including education, exercise, physiotherapy, simple analgesia and steroid injection (where acceptable to the patient).
- Corticosteroid injections can be offered in primary care or community care (where acceptable to the patient); they can provide pain relief and may allow patients to better engage with physiotherapy.
- Referrals to secondary care should be triaged via the MSK interface services (where such pathways are in place).
- Patients who smoke should be offered support with smoking cessation at least 12 weeks prior to surgery.
- Patients with raised BMI should be supported to lose weight and, where appropriate, offered access to local weight loss services (where available).
- Patients should be offered the opportunity to engage with shared decision making either in primary or secondary care. There are decision tools available online for the treatment of knee OA (available at https://www.england.nhs.uk/rightcare/shared-decision-making/) and a non-validated aid for arthroscopy treatment of degenerative disease (available at https://www.bmj.com/content/357/bmj.j1982).

References

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-5a-Knee-Arthroscopy-Policy.pdf

Evidence-based interventions guidance available on AOMRC website.

11.24 Knee MRI for suspected meniscal tears

Category	Guidance

Guidance

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

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.25 Knee MRI when symptoms are suggestive of osteoarthritis

Category	Guidance

Guidance

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

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

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

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

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

This guidance applies to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.26 Low back pain imaging

Category	Guidance

Guidance

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

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

Further information can be accessed at the relevant NICE guideline for these conditions.

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

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

Consider a combined physical and psychological programme for management of sub-acute and chronic low back pain (greater than 3 to 6 months duration) e.g. Back Skills Training (BeST). Consider referral to a specialist centre for further assessment and management if required. Imaging within specialist centres is indicated only if the result will change management.

This guidance applies to adults aged 19 years and over.

References

Evidence-based interventions guidance available on AOMRC website.

National Pathway of Care for Low Back and Radicular Pain
https://www.nice.org.uk/guidance/ng59/resources/endorsed-resource-nationalpathway-of-care-for-low-back-and-radicular-pain-4486348909

NICE guidance
https://www.nice.org.uk/guidance/ng59
https://www.nice.org.uk/guidance/qs155

11.27 Shoulder radiology – Image guided injections for shoulder pain

Category	Image guided injections for subacromial shoulder pain are not routinely funded; Image guided injections for non-subacromial shoulder pain are restricted

Image guided injections for subacromial shoulder pain – Not routinely funded

Image guided injections for subacromial shoulder pain are not routinely funded by NCL ICB in primary, intermediate or secondary care.

Image guided injections for non-subacromial shoulder pain – Restricted

Image guided injections for non-subacromial shoulder pain is not routinely funded by NCL ICB unless one of the following criteria is met and evidenced:

- The cause of shoulder pain is not subacromial – (i.e. glenohumeral joint and acromioclacicular joint problems)
- Injections are offered under the guidance of a secondary care shoulder service.

These policies apply to adults aged 19 years and over.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.28 Shoulder radiology – Scans for shoulder pain

Category	Guidance

Guidance

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

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

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

- Any history or suspicion of malignancy

- Any mass or swelling
- Suggestions of infection, e.g. red skin, fever or systemically unwell
- Trauma, pain and weakness
- Trauma, epileptic fit or electric shock leading to loss of rotation and abnormal shape.

This guidance applies to adults aged 19 years and over.

References

British Elbow and Shoulder Society (BESS) treatment and referral guidelines for routine shoulder conditions
https://bess.ac.uk/national-guidelines/

Evidence-based interventions guidance available on AOMRC website.

11.29 Subacromial decompression in the treatment of subacromial shoulder pain

Category	Restricted

Criteria

Exclusions from the policy

- Emergency referral (same day):
  - Acutely painful red warm joint – e.g. suspected infected joint
  - Trauma leading to loss of rotation and abnormal shape – unreduced shoulder dislocation
- Urgent referral (<2 weeks) to secondary care:
  - Shoulder mass or swelling – suspected malignancy
  - Sudden onset of acute pain and/ or loss of ability to actively raise the arm (with or without trauma) – acute rotator cuff tear
  - New symptoms of inflammation in several joints – systemic inflammatory joint disease (refer to rheumatology)
- Paediatric patients are excluded from the policy.

Commissioning criteria

Subacromial decompression surgery is not routinely funded by NCL ICB unless all of the criteria below are met and evidenced:

- The patient has had symptoms for at least 3 months from the start of treatment, **AND**
- Symptoms are intrusive and debilitating (for example waking several times a night, pain when putting on a coat), **AND**
- The patient has been compliant with conservative management (education, rest, nonsteroidal anti-inflammatory drugs [NSAIDs], simple analgesia, appropriate physiotherapy) for at least 6 weeks, **AND**
- A bursal injection has been considered* (if acceptable to the patient), **AND**

- Following bursal injection (where given) above symptoms have returned**

* This may be done in primary, community or secondary care as appropriate. Image guided subacromial injections should NOT be used. See policy on shoulder radiology – Image-guided injections for shoulder pain.

** Where symptoms recur following bursal injection, this will usually be apparent by 8 weeks after injection.

Advice to primary care practitioners

- Subacromial pain and impingement syndrome are most typically seen in relatively active patients between 35-60 years of age.
- Shoulder impingement syndrome is an uncommon diagnosis in patients under 30 years or over 80 years and consideration should be given to alternative causes of symptoms.
- Assessment and diagnosis of subacromial shoulder pain should be clinically guided and imaging is not usually an essential component of assessment in primary care. However, where patients present with traumatic or sudden change to subacromial pain, referral and imaging are advisable. See also policy on shoulder radiology – Scans for shoulder pain.
- First-line management of most patients should be with conservative measures, including rest, education, simple analgesia, physiotherapy and a bursal injection (where locally available and acceptable to the patient). Image guided subacromial injections should NOT be used. 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 or secondary care during routine management of patients with subacromial shoulder pain. See policy on shoulder radiology – Image-guided injections for shoulder pain.
- The majority of patients will not require a surgical procedure and can be successfully managed with conservative treatment in primary care.
- Many patients with subacromial shoulder pain will have pathology amenable to improvements with appropriate structured physiotherapy which should start to show benefits over a course of six weeks e.g. through postural correction and strengthening of the rotator cuff and scapula muscles.
- If patients have improved following six weeks of appropriate physiotherapy, it is reasonable to consider a second six week (or longer) course of physiotherapy.
- A bursal injection of steroid or local anaesthetic may provide pain relief for up to three months and allow patients to better engage with physiotherapy and rehabilitation (a maximum of two bursal injections can be offered). Image guided subacromial injections should NOT be used. See policy on shoulder radiology – Image-guided injections for shoulder pain.
- Prior to referral to secondary care, the primary care practitioner should ensure that patient wishes to discuss surgical treatment options.
- When making a referral for patients with subacromial pain, it is expected that this should be via the MSK interface services (where such pathways are in place).
- Evidence regarding the effectiveness of surgical management of subacromial pain is conflicting, however the procedure can be effective in certain circumstances and patient selection is key.
- Patients undergoing surgery for subacromial pain and shoulder impingement can expect a period of recovery and rehabilitation of up to six months. As neither conservative nor operative pathways seem to offer a faster restoration of function, patient involvement in decision making is crucial.
- The risk profile of subacromial decompression is low and similar to other shoulder arthroscopy procedures; the commonest adverse events are:
    - pain and stiffness: around 5 to 20 people in 100 will have some degree of ongoing pain and/ or stiffness (including frozen shoulder),

- Infection: most commonly a superficial infection and occurs in <1 in 100 people; deep infection is rare (c. 0.02%)
- Primary care practitioners should encourage smoking cessation and weight reduction (where appropriate), offering referral to appropriate services where required. These lifestyle changes have the potential to improve general health and wellbeing, as well as intervention success rates and enhance recovery times from surgery.
- Consider earlier referral to secondary care services in certain situations (for example patients who are wheelchair bound and/ or patients with lower limb amputations).
- Patients must have the opportunity to engage with a shared decision making process prior to surgical intervention.

References

Evidence-based interventions guidance available on AOMRC website.

London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-8a-Subacromial-Shoulder-Pain-Policy.pdf

11.30 Trigger finger release in adults

Category	Restricted

Criteria

- Mild cases of trigger finger which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.
- Cases interfering with activities or causing pain should first be treated with:
  - one or two steroid injections* **OR** splinting of the affected finger for 3-12 weeks**
- Surgery for trigger finger is not routinely funded by NCL ICB unless the criteria below are met and evidenced:
  - the triggering persists or recurs after one of the above measures, **OR**
  - the finger is permanaently locked in the palm, **OR**
  - the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods, **OR**
  - the patient has diabetes.
- Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

*There is strong evidence to indicate one or two steroid injections are likely to be successful, however trigger finger may recur, especially in people with diabetes.

**There is weak evidence to support the use of splinting.

Reference

Evidence-based interventions guidance available on AOMRC website.

11.31 Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures

Category	Restricted

Criteria

Vertibral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures is not routinely funded by NCL ICB unless all of the following criteria are met and evidenced:

- Patient has severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management
- The acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination
- Multidisciplinary team discussions have taken place
- The procedure will take place at a facility with access to spinal surgery services
- Processes for audit and clinical governance are in place
- Vertebroplasty/ kyphoplasty must be performed in conjunction with additional measures to improve bone health

This policy applies to adults aged 19 years and over.

Advice for clinicians

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

References

Evidence-based interventions guidance available on AOMRC website.

NICE guidance
https://www.nice.org.uk/guidance/ta279

12 Other

12.1 Blood transfusion

Category	Guidance

Guidance

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

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

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

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

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

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

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

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

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

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

Reference

Evidence-based interventions guidance available on AOMRC website.

12.2 Complementary and alternative medicines

Category	Restricted

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

Some complementary and alternative medicines or treatments are based on principles and an evidence base that are not recognised by the majority of independent scientists. Others have been proven to work for a limited number of health conditions. When a person uses any health treatment, including a CAM, and experiences an improvement, this may be due to the placebo effect.

The availability of CAMs on the NHS is limited, and in most cases the NHS will not offer such treatments. NICE provides guidance to the NHS on effective treatments that are value for money. NICE has recommended the use of CAMs in a limited number of circumstances.

Complementary and alternative medicines are not routinely funded by NCL ICB unless they are recommended by current NICE guidance to treat the relevant indication. The specific reference and supporting section of the NICE guidance must be included in the referral and/or clinical information record.

Referrals must also include the patient's diagnosis, the treatment for which is being applied for, the duration of treatment, the expected outcomes and total cost of the treatment. The number of treatments/ course of treatment given should not exceed that recommended by NICE.

See also separate policy on acupuncture for the treatment of back pain.

12.3 Helmet therapy for positional plagiocephaly/ brachycephaly in children

Category	Not routinely funded

Helmet therapy for the treatment of positional plagiocephaly/ brachycephaly in children is not routinely funded by NCL ICB.

This policy applies to children aged 2 years and under.

Advice for clinicians

The flattened area of the head usually self-corrects naturally, as a baby grows, develops and becomes more mobile with increased muscle strength, and spends less time lying in one position.

To reduce pressure on the flattened part of the head and encourage remoulding, the following simple interventions are suggested:

- 'Tummy time' - Allow baby to spend time lying on their front while awake, supervised and playing.
- Change the position of toys/ mobiles/ cot in the room to encourage baby to move their head away from the flattened side
- Use a sling or a front carrier to reduce the amount of time baby spends lying on a firm flat surface

- Modify parental lap “nursing” position to promote contact with less flattened side to parental chest.

All babies including those with non-synostotic/ positional plagiocephaly or brachycephaly must be laid to sleep on their back. Sleeping in positions other than this is associated with an increased risk of Sudden Infant Death Syndrome or SIDS (formerly known as Cot Death). For the same reason, no pillows or props should be used to change a baby’s sleeping position.

Reference

Evidence-based interventions guidance available on AOMRC website.

12.4 Massage – Manual lymphatic drainage (MLD)

Category	Not routinely funded

Manual lymphatic drainage (MLD) on its own or as part of Decongestive Lymphoedema Treatment (DLT) is not routinely funded by NCL ICB.

12.5 Open MRI/ bariatric MRI

See NCL ICB GP website for eligibility criteria and contact details for enquiries.

13 Plastic surgery

13.1 Cosmetic surgery (aesthetic) – Overview

Definition

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

General principles

NCL ICB will not normally fund aesthetic surgery for cosmetic purposes. All applications need to be approved via an Individual Funding Request (IFR) where exceptional circumstances are clearly demonstrated.

Prior to making an IFR application for aesthetic surgery for cosmetic purposes clinicians should advise patients:

- About the complications of surgery and the potential risk of scarring, infection and potential recurrence.
- That psychological distress will not be accepted as a reason to fund surgery.

Note: Removal of benign skin lesions are covered in a separate section of this document.

13.2 Body contouring – Apronectomy or abdominoplasty (tummy tuck)

Category	Restricted

Criteria

Apronectomy and abdominoplasty are not routinely funded by NCL ICB unless Criteria A or Criteria B are met and evidenced:

Criteria A (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patients smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. At the time of the application the patient has a BMI of between 18 to 30 kg/m^2; the patient must have maintained a BMI in this range for at least two years
5. BMI has been stable for at least 12 months
6. The patient has severe functional problems (as defined below)

Criteria B – applies to patients who have had very significant weight loss but are unable to reduce their BMI to 30 or less (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. The patient has lost at least 75% of their original excess weight at the time of the application*
5. The patient should have a BMI of between 30 to 40 kg/m^2; the patient must have maintained a BMI in this range for at least two years
6. BMI has been stable for at least 12 months
7. Further weight loss is unlikely
8. The patient has severe functional problems (as defined below)

Severe functional problems

Severe functional problems must include at least one of the following:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed and for which abdominoplasty or apronectomy will provide a clear resolution.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.
- The flap (panniculus) hangs at below the level of symphysis pubis.
- Poorly fitting stoma bags.
- Surgery is required as part of an abdominal hernia correction or other abdominal wall surgery.

Where patients have an active psychiatric or psychological condition that would contraindicate surgery, consider treatment for this condition prior to referral for surgery.

*Percent excess body weight loss is calculated as follows: initial weight – current weight/initial weight – (25xheight^2) x100.

Reference

Royal College of Surgeons and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) commissioning guide on massive weight loss body contouring (2017) http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

13.3 Body contouring – Arm lift (brachioplasty)

Category	Restricted

Criteria

Brachioplasty is not routinely funded by NCL ICB unless Criteria A or Criteria B are met and evidenced:

Criteria A (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. At the time of the application the patient has a BMI of between 18 to 30 kg/m^2; the patient must have maintained a BMI in this range for at least two years
5. BMI has been stable for at least 12 months
6. The patient has severe functional problems (as defined below)

Criteria B – applies to patients who have had very significant weight loss but are unable to reduce their BMI to 30 or less (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. The patient has lost at least 75% of their original excess weight at the time of the application*
5. The patient should have a BMI of between 30 to 40 kg/m^2; the patient must have maintained a BMI in this range for at least two years
6. BMI has been stable for at least 12 months
7. Further weight loss is unlikely
8. The patient has severe functional problems (as defined below)

Severe functional problems

Severe functional problems must include at least one of the following:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.

Where patients have an active psychiatric or psychological condition that would contraindicate surgery, consider treatment for this condition prior to referral for surgery.

*Percent excess body weight loss is calculated as follows: initial weight – current weight/initial weight – (25xheight^2) x100.

Reference
Royal College of Surgeons and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) commissioning guide on massive weight loss body contouring (2017) http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

13.4 Body contouring – Buttock lift

Category	Restricted

Criteria

Buttock lift surgery is not routinely funded by NCL ICB unless Criteria A or Criteria B are met and evidenced:

Criteria A (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. At the time of the application the patient has a BMI of between 18 to 30 kg/m^2; the patient must have maintained a BMI in this range for at least two years
5. BMI has been stable for at least 12 months
6. The patient has severe functional problems (as defined below)

Criteria B – applies to patients who have had very significant weight loss but are unable to reduce their BMI to 30 or less (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. The patient has lost at least 75% of their original excess weight at the time of the application*
5. The patient should have a BMI of between 30 to 40 kg/m^2; the patient must have maintained a BMI in this range for at least two years
6. BMI has been stable for at least 12 months
7. Further weight loss is unlikely
8. The patient has severe functional problems (as defined below)

Severe functional problems

Severe functional problems must include at least one of the following:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.

Where patients have an active psychiatric or psychological condition that would contraindicate surgery, consider treatment for this condition prior to referral for surgery.

*Percent excess body weight loss is calculated as follows: initial weight – current weight/initial weight – (25xheight^2) x100.

Reference

Royal College of Surgeons and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) commissioning guide on massive weight loss body contouring (2017) http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

13.5 Body contouring – Thigh lift

Category	Restricted

Criteria

Thigh lift surgery is not routinely funded by NCL ICB unless Criteria A or Criteria B are met and evidenced:

Criteria A (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. At the time of the application the patient has a BMI of between 18 to 30 kg/m^2; the patient must have maintained a BMI in this range for at least two years
5. BMI has been stable for at least 12 months
6. The patient has severe functional problems (as defined below)

Criteria B – applies to patients who have had very significant weight loss but are unable to reduce their BMI to 30 or less (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. The patient has lost at least 75% of their original excess weight at the time of the application*

5. The patient should have a BMI of between 30 to 40 kg/m^2; the patient must have maintained a BMI in this range for at least two years
6. BMI has been stable for at least 12 months
7. Further weight loss is unlikely
8. The patient has severe functional problems (as defined below)

Severe functional problems

Severe functional problems must include at least one of the following:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.

Where patients have an active psychiatric or psychological condition that would contraindicate surgery, consider treatment for this condition prior to referral for surgery.

*Percent excess body weight loss is calculated as follows: initial weight – current weight/initial weight – (25xheight^2) x100.

Reference

Royal College of Surgeons and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) commissioning guide on massive weight loss body contouring (2017) http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

13.6 Body contouring – Total body lift

Category	Restricted

Criteria

Total body lift is not routinely funded by NCL ICB unless Criteria A or Criteria B are met and evidenced:

Criteria A (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. At the time of the application the patient has a BMI of between 18 to 30 kg/m^2; the patient must have maintained a BMI in this range for at least two years
5. BMI has been stable for at least 12 months
6. The patient has severe functional problems (as defined below)

Criteria B – applies to patients who have had very significant weight loss but are unable to reduce their BMI to 30 or less (all criteria must be met and evidenced)

1. The patients starting BMI (prior to weight loss) was above 40kg/m^2 OR above 35kg/m^2 with co-morbidities
2. The patient is 18 or over at the time of application
3. If the patient smokes, they have been counselled on the benefits of stopping smoking at least 8 weeks prior to surgery
4. The patient has lost at least 75% of their original excess weight at the time of the application*
5. The patient should have a BMI of between 30 to 40 kg/m^2; the patient must have maintained a BMI in this range for at least two years
6. BMI has been stable for at least 12 months
7. Further weight loss is unlikely
8. The patient has severe functional problems (as defined below)

Severe functional problems

Severe functional problems must include at least one of the following:

- Severe difficulties with daily living (i.e. walking, dressing and ambulatory restrictions), which has been formally assessed.
- Documented record of recurrent intertrigo beneath the skin folds that recurs or fails to respond despite appropriate medical therapy for at least six months.

Where patients have an active psychiatric or psychological condition that would contraindicate surgery, consider treatment for this condition prior to referral for surgery.

*Percent excess body weight loss is calculated as follows: initial weight – current weight/initial weight – (25xheight^2) x100.

Reference

Royal College of Surgeons and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS) commissioning guide on massive weight loss body contouring (2017) http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/rewrite-for-2017--final-version.pdf?sfvrsn=4

13.7 Breast procedures – Breast augmentation (bilateral and unilateral)

Category	Restricted

Criteria

- Breast augmentation (bilateral or unilateral) is not routinely funded by NCL ICB unless one of the following criteria are met and evidenced:
  - The patient is undergoing reconstruction following surgery to treat or prevent breast cancer, **OR**

- The patient is undergoing reconstruction following trauma or burns

- Unilateral breast reduction should be considered for asymmetric breasts as opposed to breast augmentation
- Lipofilling of the breast is not routinely funded unless the patient is undergoing reconstruction following surgery to treat or prevent breast cancer

References

Association of Breast Surgery (ABS), British Association of Plastic, Reconstructive & Aesthetic Surgeons (BAPRAS) and Breast Cancer Now (BCN) Guidance for the Commissioning of Oncoplastic Breast Surgery (2018)
https://breastcancernow.org/sites/default/files/guidance_for_the_commissioning_of_oncoplastic_breast_surgery_-_ccg_guidelines_2018.pdf

NICE guidance
https://www.nice.org.uk/guidance/ng101
https://www.nice.org.uk/guidance/cg164
https://www.nice.org.uk/guidance/ipg417/chapter/1-Guidance (reconstruction using lipomodelling)

13.8 Breast procedures – Breast augmentation (revision of)

Category	Restricted

Criteria

Removal of breast implants

- Removal of breast implants is not routinely funded by NCL ICB unless one of the following criteria is met and evidenced:
  - Rupture of silicone-filled gel implants, **OR**
  - Implants complicated by recurrent infection, **OR**
  - Extrusion of implant through skin, **OR**
  - Baker Class IV capsular contracture associated with severe pain, **OR**
  - Implants with severe contracture that interferes with mammography, **OR**
  - The patient has PIP implants and the decision has been made to remove them informed by an assessment of clinical need, risk or the impact of unresolved concerns and the original procedure was either:
    - funded by the NHS, **OR**
    - funded privately but the clinic involved has either closed or is unwilling to help
- Where the above criteria are met by only one breast, both implants can be removed to ensure symmetry.

Replacement of breast implants

- Replacement of breast implants is not routinely funded by NCL ICB unless either criteria A or B below is met and evidenced:

  A. The patient fulfils all of the following criteria:

- The patient meets the criteria for removal of breast implants, **AND**
- The original procedure was funded by the NHS, **AND**
- The patient meets the criteria for breast augmentation under the existing policy

B. The patient fulfils both of the following criteria:

- The patient has PIP implants and the decision has been made to remove them informed by an assessment of clinical need, risk or the impact of unresolved concerns, **AND**
- The original procedure was funded by the NHS.

- Patients who are eligible for removal but not replacement of breast implants will not be able to self-fund the replacement implant for use during NHS surgery to remove the original implant as this is inconsistent with Department of Health guidance.

Reference

DH guidance on PIP implants (2012)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215231/dh_132102.pdf

13.9 Breast procedures – Breast reduction (bilateral and unilateral)

Category	Restricted

Criteria

Breast reduction – Overarching criteria (applicable to both bilateral and unilateral breast reduction)

Breast reduction is not routinely funded by NCL ICB unless all of the following criteria are met and evidenced (see also additional criteria for bilateral and unilateral breast reduction below):

- Breast size results in functional symptoms with at least two of the following for at least one year:
  - Pain in the neck
  - Pain in the upper back
  - Pain in the shoulders
  - Painful kyphosis documented by X-rays
  - Pain/ discomfort/ ulceration from bra straps cutting into shoulders

  There should be documented evidence of GP visits for these problems.
- Pain symptoms persist despite a six month trial of therapeutic measures including all of the following:
  - Supportive devices (e.g. proper bra/ support bra fitted by a trained bra fitter, wide bra straps)
  - Analgesic/ non-steroidal anti-inflammatory drugs (NSAIDs) interventions
  - Physical therapy/ exercises/ posturing manoeuvres

  The above should be documented by the clinician.

- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
- Body mass index (BMI) is <27 and stable for at least twelve months.
- The patient must be provided with written information to allow her to balance the risks and benefits of breast surgery.
- The patient should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking.
- The patient should be informed that breast reduction can cause permanent loss of lactation.

Surgery will not be funded for cosmetic reasons.

Exclusions to the policy

This policy does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral surgery following breast cancer surgery.

Bilateral breast reduction – Additional criterion

In addition to the above overarching criteria, women undergoing bilateral breast reduction must also meet the following criterion in order to be eligible for surgery:

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

Resection weights should be recorded for audit purposes.

Unilateral breast reduction – Additional criterion

In addition to the above overarching criteria, women undergoing unilateral breast reduction must also meet the following criterion in order to be eligible for surgery:

- There is breast asymmetry leading to a difference of 150 -200 gms size between breasts, as measured by a specialist.

Resection weight should be recorded for audit purposes.

Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation.

Reference

Evidence-based interventions guidance available on AOMRC website.

13.10 Breast procedures – Mastopexy (breast lift)

Category	Not routinely funded (exclusions apply)

Mastopexy (bilateral or unilateral) is not routinely funded by NCL ICB unless the patient is undergoing reconstruction following surgery to treat or prevent breast cancer.

References

Association of Breast Surgery (ABS), British Association of Plastic, Reconstructive & Aesthetic Surgeons (BAPRAS) and Breast Cancer Now (BCN) Guidance for the Commissioning of Oncoplastic Breast Surgery (2018)

https://breastcancernow.org/sites/default/files/guidance_for_the_commissioning_of_oncoplastic_breast_surgery_-_ccg_guidelines_2018.pdf NICE guidance https://www.nice.org.uk/guidance/ng101 https://www.nice.org.uk/guidance/cg164

13.11 Breast procedures – Surgery for gynaecomastia

Category	Not routinely funded (exclusions apply)
Gynaecomastia is not routinely funded by NCL ICB. This policy does not apply to surgery for gynaecomastia caused by medical treatments (e.g. treatments for prostate cancer).	
Reference	
Evidence-based interventions guidance available on AOMRC website.	

13.12 Breast procedures – Surgical correction of nipple inversion

Category	Not routinely funded
Surgical correction of nipple inversion is not routinely funded by NCL ICB.	

13.13 Ear procedures – Pinnaplasty

Category	Restricted
Criteria	

Pinnaplasty is not routinely funded by NCL ICB unless either criteria A or B are met and evidenced.

Patients should not be referred to secondary care unless they meet these criteria.

Criteria A (all criteria must be met)

- The patient should be aged above 5 years of age and under 18 years of age, AND
- The child is experiencing significant psychological distress due to prominent ears, which will be resolved by surgery, AND
- The child (rather than the parents alone) desires surgical correction – referrals should not be made for children who appear indifferent or opposed to the idea of surgery*

Criteria B

• Correction of prominence will help in retaining hearing aids securely in children (aged under 18) in whom they are required * Parents requesting surgery for their child in order to prevent psychological distress when their child starts school or at some time in the future should be advised that referral should wait until their child specifically requests treatment.
Reference
Royal College of Surgeons, British Association of Plastic, Reconstructive and Aesthetic Surgeons and ENT-UK commissioning guide on pinnaplasty (2013) https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/pinnaplasty-commisioning-guide/

13.14 Ear procedures – Repair of external ear lobes

Category	Not routinely funded
Repair of external ear lobe is not routinely funded by NCL ICB.	

13.15 Facial procedures – Brow lift

Category	Restricted
Criteria	
Brow lift is not routinely funded by NCL ICB unless the criteria below are met and evidenced. After assessment by a specialist; evidence must be provided demonstrating the severity and clinical need for surgery in these instances: • Impairment of vision. • To correct impairment of the visual field.	

13.16 Facial procedures – Injection of botulinum toxin

Category	Not routinely funded
Botulinum toxin injections for the improvement of appearance of facial lines are not routinely funded by NCL ICB.	

13.17 Facial procedures – Rhytidectomy (face lift)	
Category	**Not routinely funded**
Rhytidectomy is not routinely funded by NCL ICB.	

13.18 Liposuction	
Category	**Not routinely funded**
Liposuction is not routinely funded by NCL ICB.	

14 Urology

14.1 Benign prostatic hyperplasia – Surgical intervention for

Category	Guidance

Guidance

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

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

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

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

Following a discussion about whether to intervene surgically, men should be counselled about their preferred and most suitable surgical modality, incorporating reference to available evidence. Practical concerns, including the distance required to travel to pursue a given modality of surgical treatment are also important.

Appropriate support should be provided to make shared decisions pertinent to physical, emotional, psychological and sexual health. If appropriate, carers should be informed and involved. With respect to surgical modality:

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

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

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

References

European Association of Urology guidelines on management of non-neurogenic male lower urinary track symptoms (LUTS), including benign prostatic obstruction (BPO)
https://uroweb.org/wp-content/uploads/EAU-Guidelines-on-the-Management-of-Non-neurogenic-Male-LUTS-2018-large-text.pdf

Evidence-based interventions guidance available on AOMRC website.

NICE guidance
https://www.nice.org.uk/guidance/cg97

14.2 Circumcision (applies to all ages)

Category	Restricted

Criteria

- NCL ICB will not fund circumcisions for social, religious or cultural reasons
- NCL ICB will not routinely fund circumcision unless one of the below criteria are met and evidenced:
  - Pathological phimosis (the commonest cause is lichen sclerosus; balanitis xerotica obliterans [BXO] is an old fashioned descriptive term), **OR**
  - Recurrent (more than one episode) or persistent balanoposthitis not responding to management in primary care, **OR**
  - Recurrent (more than one episode) paraphimosis, **OR**
  - Prevention of urinary tract infection in patients with an abnormal urinary tract, **OR**
  - Traumatic foreskin injury where it cannot be salvaged (e.g. zipper injury), **OR**
  - Tight foreskin causing pain on arousal/ interfering with sexual function not responding to management in primary care, **OR**
  - Congenital abnormalities, **OR**
  - Malignant or pre-malignant preputial lesion that is confined to the foreskin, **OR**
  - For biopsy if there is suspicion of pathology other than lichen sclerosus

This policy refers to circumcision (the surgical removal of the penile foreskin) in males only. Female circumcision (female genital mutilation) is illegal in England (Female Genital Mutilation Act 2003).

Advice to primary care practitioners

Definitions

- Phimosis is a condition where the foreskin cannot be retracted over the glans penis; it may be physiological or pathological.
- Physiological phimosis refers to a normal foreskin where non-retractability is due to 'physiological' congenital adherence of the inner prepuce to the glans penis. There is no evidence of scarring.
- Pathological phimosis is a condition associated with scarring of the foreskin opening leading to symptoms and non-retractability of the prepuce. The commonest cause of pathological phimosis is lichen sclerosus (balanitis xerotica obliterans [BXO] is an old fashioned descriptive term).

Natural history of the foreskin

- Almost all boys have a non-retractile foreskin at birth. The inner foreskin is attached to the glans. Foreskin adhesions break down and form smegma pearls (white cysts under the foreskin) which are then extruded. The foreskin does not start to retract before the age of 2 years. The process of retractility is spontaneous and does not require manipulation.
- Physiologic phimosis is common in boys up to 3 years of age, but often extends into older age groups. The majority of boys will have a retractile foreskin by 10 years of age and nearly all will have a retractile foreskin by 16-17 years of age.

Presentation of phimosis

- In physiological phimosis, parents may bring their son in for consultation, concerned that his foreskin may not yet be retracting. They may have noticed the naturally occurring adhesions or may be anxious about ballooning during micturition. Problems relating to physiological phimosis may include recurrent balanoposthitis and recurrent urinary tract infections.
- Pathological phimosis may present as painful erections, haematuria, recurrent urinary tract infections, preputial pain and weak urinary stream.
- There may be swelling, redness and tenderness of the prepuce with purulent discharge. Adhesions may be seen between the inner surface of the prepuce and the glans or the frenulum. The frenulum itself may be shortened and retraction of the foreskin may lead to ventral distortion of the glans. In physiological phimosis the meatus will appear healthy and unscarred. In pathological phimosis the meatus may appear scarred, with a fibrous white ring forming around the preputial orifice.

Lichen sclerosus

Lichen sclerosus is a chronic, progressive, scarring, inflammatory skin condition. In uncircumcised men, there may be itchy, painful, atrophic white patches or plaques on the glans penis and foreskin, possible telangiectasia, haemorrhagic vesicles, blisters, erosions, or ulceration. Repeated chronic inflammation causes white, firm scarring of the foreskin tip which may lead to inability to retract the foreskin, meatal stenosis, and urethral stricture.

Management

- In children up to an including 18 years of age, pathological phimosis must be distinguished from physiological adherence of the foreskin to the glans, which is normal
- When physiological phimosis is diagnosed in a primary care assessment of foreskin condition, consultation should focus on reassurance and education of parents and child. If there is concern that any pathology is evident, or if there is diagnostic uncertainty, referral is indicated.
- For advice on management of phimosis and balanitis in primary care, see: NICE CKS; Royal College of Surgeons (RCS) Commissioning guide: Foreskin conditions

Resources for patients and carers

NHS.uk on tight foreskin and balanitis

References

Royal College of Surgeons, British Association of Urological Surgeons (BAUS), British Association of Paediatric Surgeons (BAPS), British Association of Paediatric Urologists (BAPU) commissioning guide on foreskin conditions (2013)
https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/foreskin-conditions/

NICE CKS
https://cks.nice.org.uk/balanitis#!management

Patient.info
https://patient.info/doctor/phimosis-and-paraphimosis

14.3 Cystoscopy for men with uncomplicated lower urinary tract symptoms

Category	Guidance

Guidance

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

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

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

- Recurrent infection
- Sterile pyuria
- Haematuria
- Profound symptoms
- Pain

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

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

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

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

References
Evidence-based interventions guidance available on AOMRC website. NICE guidance https://www.nice.org.uk/guidance/cg97

14.4 Kidney stones – Surgical removal

Category	Guidance

Guidance

Please refer to NICE NG118 (recommendation 1.5) for full details on the assessment and management of renal and ureteric stones.

Adult renal stones

- <5mm: If asymptomatic consider watchful waiting
- 5-10mm: If not suitable for watchful waiting offer SWL as first-line treatment (unless contra-indicated or not targetable)
- 10-20mm: Consider SWL as first-line treatment if treatment can be given in a timely fashion. URS can also be considered if SWL is contraindicated or ineffective
- Over 20mm (including staghorn): Offer PCNL as first-line treatment

Adult ureteric stones

- <5mm: If asymptomatic consider watchful waiting with medical therapy e.g. Alpha blocker for use with distal ureteric stones
- 5-10mm: Offer SWL as first-line treatment where it can be given in a timely fashion (unless contra-indicated or not targetable)
- 10-20mm: Offer URS but consider SWL if local facilities allow stone clearance within 4 weeks

This guidance applies to adults aged 19 years and over

References

Evidence-based interventions guidance available on AOMRC website.

NICE guidance
https://www.nice.org.uk/guidance/ng118

14.5 Penile procedures (penile implants)

Commissioning responsibility for penile implants is with NHS England. Queries around treatment availability and eligibility, as well as referrals and applications for funding should be directed to NHS England.

14.6 Prostate-specific antigen (PSA) test

Category	Guidance

Guidance

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

PSA testing should be considered in asymptomatic men over age 40 who are at higher risk of prostate cancer because they are Black and/or have a family history of prostate cancer (including the presence of cancer-predisposing *BRCA2* variants).

PSA testing should be considered when clinically indicated (ideally after counselling on the potential risks and benefits of testing) in men when there is clinical suspicion of prostate cancer, which may include the following symptoms:

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

PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history, including the presence of cancer-predisposing *BRCA2* variants). This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend.

Note: PSA testing for prostate cancer should be avoided if the 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 which are likely to raise PSA and give a false positive result.

Relevant Resources:

Public Health England (PHE) patient information sheet - PSA testing and prostate cancer: advice for well men aged 50 and over.

Prostate Cancer Research Foundation - SWOP Risk Calculator. Choosing Wisely UK - Patient education and shared decision-making resources. Prostate Cancer UK - Patient education and shared decision-making resources. **This guidance applies to male adults aged 19 years and over.**
Reference
Evidence-based interventions guidance available on AOMRC website.

14.7 Reversal of vasectomy

Category	Restricted

Criteria

Reversal of vasectomy is not routinely funded by NCL ICB unless the criteria below are met and evidenced:

- Death of only existing child
- Remarriage following death of spouse

14.8 Varicocele (surgical repair of)

Category	Restricted

Criteria

Varicocele repair surgery is not routinely funded by NCL ICB unless one of the criteria below are met and evidenced:

- Documented evidence of persistent discomfort or pain despite adequate conservative management, **OR**
- Where 2 documented semen analysis reports indicate abnormalities are present, varicocele repair should be considered.

References

BMJ Best Practice (2018)
https://bestpractice.bmj.com/topics/en-gb/1103

Practice Committee of the American Society for Reproductive Medicine; Society for Male Reproduction and Urology. Report on varicocele and infertility: a committee opinion (2014)
https://www.ncbi.nlm.nih.gov/pubmed/25458620

14.9 Vasectomy under general anaesthetic

Category	Not routinely funded

Vasectomies carried out under general anaesthetic will not be routinely funded by NCL ICB.

References

Faculty of Sexual & Reproductive Healthcare Clinical Guidance for male and female in sterilisation September 2014 (Review Date September 2019)
https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-sterilisation-summary-sep-2014/

World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Geneva: WHO; 3rd edition 2004. (Section on Surgical sterilization procedures pp13-15)
http://apps.who.int/iris/handle/10665/42907

NICE Clinical Knowledge Summaries. Contraception – sterilization
https://cks.nice.org.uk/contraception-sterilization

Cook LA, Pun A, van Vliet H, Gallo MF, Lopez LM. Scalpel versus no-scalpel incision for vasectomy. Cochrane Database Syst Rev. 2007 Apr 18;(2):CD004112
https://www.cochrane.org/CD004112/FERTILREG_scalpel-or-no-scalpel-approach-vas

15 Vascular surgery

15.1 Varicose vein interventions

Category	Restricted

Criteria

Referral to a vascular service for assessment and treatment of varicose veins* is not routinely funded by NCL ICB unless one of the following criteria are met and evidenced:

- Symptomatic** primary or recurrent varicose veins, **OR**
- Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency, **OR**
- Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence, **OR**
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks), **OR**
- A healed venous leg ulcer.

* Referral for assessment does not guarantee the patient will receive treatment.

**Symptomatic: Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).

For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment.

Refer people with bleeding varicose veins to a vascular service immediately.

Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

The following interventions are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery: endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy and open surgery (ligation and stripping).

For truncal ablation there is a treatment hierarchy based on cost effectiveness and suitability, which is as follows:

- First choice is endothermal ablation
- If endothermal ablation is unsuitable, offer ultrasound-guided foam sclerotherapy
- If ultrasound-guided foam sclerotherapy is unsuitable, offer conventional surgery.

For further information, see: https://www.nice.org.uk/guidance/cg168.

Advice to primary care practitioners

Give people who present with varicose veins information that includes:

- An explanation of what varicose veins are.
- Possible causes of varicose veins.

- The likelihood of progression and possible complications, including deep vein thrombosis, skin changes, leg ulcers, bleeding and thrombophlebitis. Address any misconceptions the person may have about the risks of developing complications.
- Treatment options, including symptom relief, an overview of interventional treatments and the role of compression.

The following lifestyle advice should be offered to all patients with varicose veins:

- Weight loss (if appropriate)
- Light to moderate physical exercise
- Avoiding factors that are known to make their symptoms worse if possible
- Smoking cessation

Pregnant women presenting with varicose vein should be given information on the effect of pregnancy on varicose veins. Interventional treatment for varicose veins during pregnancy should not be carried out other than in exceptional circumstances. Compression hosiery should be considered for symptom relief of leg swelling associated with varicose veins during pregnancy.

References

Evidence-based interventions guidance available on AOMRC website.

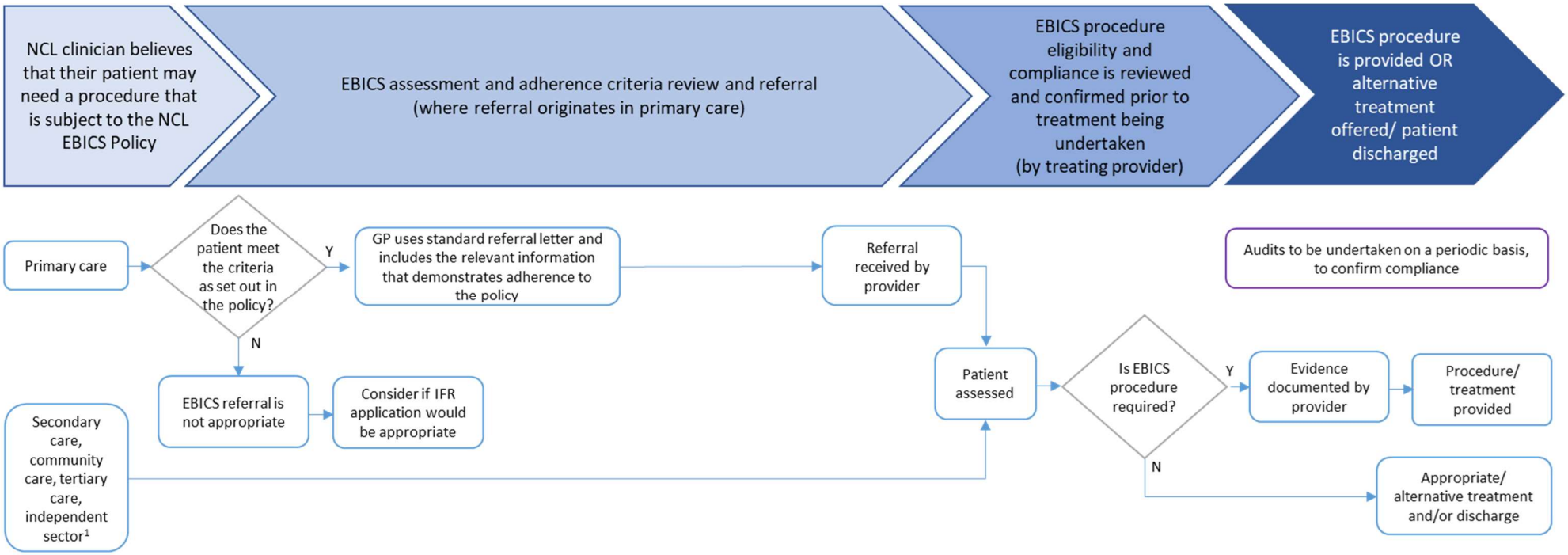
London Choosing Wisely
https://www.healthylondon.org/wp-content/uploads/2018/10/Appendix-7a-Varicose-Veins-Policy.pdf

NICE guidance
https://www.nice.org.uk/guidance/cg168

Appendix 1: EBICS feedback form

NCL EBICS Policy Feedback Form	
1	**In what capacity are you responding? Are you responding on behalf of an organisation or as an individual clinician?**
2	**Please confirm the issue date and version of the North Central London EBICS policy you are providing feedback on**
3	**Which of the Policy Areas relates to your feedback?**
4	**Are you proposing an amendment to the wording for the policy? If yes, please insert proposed rewording. If no, are you providing a general comment?**
5	**Please state the rationale for any suggested amendments or comments**
6	**Are you providing additional evidence to substantiate your amendments or comments?**
7	**Please provide contact details if you are happy to be contacted in relation to your submission**
8	**Date of submission**
Please submit your comments using this feedback form to **scwcsu.hpsu@nhs.net** **It is suggested that individual feedback forms are submitted for individual policy areas.**	

Appendix 2: Flowchart of process for a procedure subject to EBICS



Notes:

1. Patients in secondary care, who are subject to EBICS procedures, should NOT be referred to primary care or the ICB for EBICS checks / adherence. Secondary care providers should ensure patients meet the necessary eligibility criteria (and document accordingly) before commencing treatment.

It is impossible to cover every eventuality. Any questions about EBICS should be directed to NCL ICB via nclicb.ebics-policy@nhs.net