NHS
Cornwall and Isles of Scilly

Commissioning policies and evidence-based interventions

Each commissioning policy has an individual review date – if the review date has passed, the policy remains in effect until a new version is published

Document control sheet

Title of document: Commissioning policies and evidence-based interventions
Originating directorate: Delivery
Originating team: Planned care and cancer programme of care
Document type: Policy
Subject category: Individual funding requests
Author(s) name: Planned care and cancer team programme of care
Date ratified: See individual policy for approved date
Ratified by:

- Cornwall and Isles of Scilly ICB Quality, equality and performance committee 22 April 2025

Review frequency: Except for evidence-based interventions, each policy will be reviewed every 3 years or earlier if new guidance is issued. For evidence-based interventions, they will only be reviewed if updated EBI guidelines are issued.
To be reviewed by date: See individual policy for review date
Target audience: Service providers, referrers and members of the public
Can this policy be released under FOI? Yes

Version control

The version history of this policy shown below represents changes made since 2025. History, prior to this time, is available on request via the NHS Cornwall and Isles of Scilly Integrated Care Board planned care team.

	15/01/2025	Nicola Hughes	Policies clearly marked where national evidence-based intervention Updated to include all evidence-based interventions Review dates updated for evidence-based interventions in line with national policy Policies clearly marked where prior approval is required for criteria-based access procedures
	10/04/2025	Tracey Coles	EBI policy updates following clinical review
	25/04/2025	Tracey Coles	Published in line with QEPOC sign off
	09/06/2025	Tracey Coles	Published final version
	05/12/2025	Planned care team administrator	Embedded weight loss drugs policy

	14/01/2026	Planned care team administrator	Updated Referral for bariatric surgery policy confirmed ratified by the Deputy Chief medical officer on 22 October 2025 Confirmed weight loss drugs policy was ratified at Execs by the Chief medical officer on 12 November 2025 and at CPAG by the Deputy Chief medical officer on 26 November 2025 Final version sent to be published WEF 08 February 2026
	21/04/2026	Planned care team administrator	Replacement aid policy pricing removed and replacement hearing aid policy under review. Final version sent to be published 21/04/2026

Contents

Introduction

The purpose of this policy is to ensure that NHS Cornwall and Isles of Scilly Integrated Care Board (ICB), the commissioner for Cornwall and Isles of Scilly fund treatment only for clinically effective interventions delivered to the right patients. It sets out the treatments deemed to be of insufficient priority to justify funding from the available fixed budget.

Approved prescribing of medicines falls outside the scope of this document and is covered in the guidelines and protocols produced by the Cornwall area prescribing committee. Further information can be obtained from the prescribing team or the Cornwall and Isles of Scilly Joint Formulary.

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness.

Purpose

This policy sets out those procedures which are not normally commissioned due to their low clinical priority, and some others for which strict criteria apply.

Policy development is an on-going process, and future policy will be produced and published periodically.

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

Definitions

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

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

Responsibilities

NHS funds

The ICB buys healthcare on behalf of the local population of Cornwall and Isles of Scilly. The money for this comes from a fixed budget. By law, we are required to keep within this budget.

Demand for healthcare is greater than can be funded from this fixed budget.

Unfortunately, this means that some healthcare which patients might wish to receive, and which professionals might wish to offer cannot be funded.

This has always been the situation since the start of the NHS.

Assessing what the overall population most needs

Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed.

This assessment of need is made across the whole population and wherever possible, based on best evidence about what works. We aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services. We also aim to ensure that treatments which research shows are not effective, and may not even cause harm, are not offered to our population.

This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations.

One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and treatments which do not work well enough to justify any use within the local NHS. A similar list has been drawn up for medications, to ensure that the local NHS gets the greatest possible value for the local population. We aim to review these lists to ensure that they reflect the best available evidence and are affordable and fair.

Implications for you

This may mean that your doctor is not able to offer you a certain treatment because it would not be funded by the local NHS.

Although most doctors recognise the need for some kind of policy like this, she or he may be uncomfortable because of its implications for you as an individual.

Even so, your doctor must observe the policy because it is the policy of the local NHS and is the best way to ensure that local NHS funds are spent on the things that will bring greatest overall benefit to local people in a way that is affordable and fair.

For a full list of all treatments and applicable exclusions and criteria, please refer to the NHS Cornwall and Isles of Scilly Integrated Care Board commissioning policy covering access to procedures of limited clinical priority and other treatments (this document).

Exceptionality

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

Prior approval

Prior approval applications are required for procedures listed as criteria-based access with prior approval (CBA + PA) within this document. These have been based upon those procedures or interventions that providers in our system have been identified as an outlier when benchmarked against our peers. A prior approvals process will be adopted by all our providers over time, but phase one will focus the implementation of this with our two largest providers, Royal Cornwall Hospitals Trust (RCHT) and University Hospital Plymouth (UHP). These interventions/ procedures will be clearly identifiable in this document, including which provider needs to submit prior approval for which procedure. **Please note that the prior approval process does not apply to urgent care presentations and cancer, in these cases a retrospective audit will be undertaken.**

The ICBs prior approval process applies to treatments that are considered appropriate in some circumstances, but where funding is granted on an individual case by case basis when the ICB is assured that specific predetermined and evidence-based access criteria have been met.

The prior approval process should not be confused with the ICBs individual funding request (IFR) process which deals with requests for individuals who are ‘exceptional’ (i.e., there is something about the patient’s condition or circumstances that differentiate them on the basis of need from other patients with a similar diagnosis or condition and would justify funding being provide in an individual case when it is not routinely funded for others).

Assessment of the patient against the relevant CBA + PA criteria can be made at any point in the patient’s pathway prior to treatment but should be undertaken at the earliest possible stage in the pathway once the need for CBA + PA procedure has been identified. This means that an assessment against the CBA +PA criteria will either be made by the referrer prior to the referral, or by the secondary care clinician following

triage or initial assessment in secondary care. Further details on prior approval can be found here Prior approvals process standard operating procedure

Implementation plans and monitoring effectiveness

Commissioners, general practitioners, service providers and clinical staff treating residents of Cornwall and Isle of Scilly will implement this policy. When interventions are undertaken based on meeting criteria specified within the policy, this should be clearly documented within the clinical notes.

Criteria based access applies to treatments that are considered appropriate for patients in certain circumstances provided that specific pre-determined and evidence-based access criteria have been met. Assessment of the patient against the relevant criteria can be made at any point in the patient pathway prior to treatment but should be undertaken at the earliest possible stage in the pathway once the need for a criteria-based access procedure has been identified. This means that assessment against the criteria will either be made by the referrer prior to referral, or by the secondary care clinician following triage or initial assessment in secondary care.

Where the responsible clinician believes that a patient demonstrably meets the criteria set out in the policy, the patient can proceed for treatment unless it is a treatment that requires prior approval. If the assessment is undertaken by a referring general practitioner, that general practitioner must ensure that details of this are included within their referral. Secondary care providers must ensure that evidence that the patient meets the criteria is included within the patient's medical record for audit purposes.

Responsibility for adherence to the commissioning policy lies with the referring and treating clinicians. On any occasion where a provider undertakes procedures which are not routinely funded or criteria-based access activity where the patient does not meet the relevant criteria, that provider will not be paid for the associated activity. This policy is formally incorporated into contracts and will be subject to routine monitoring for compliance.

Update and review

All policies and similar documents must be dated when approved and a review date also included. This will usually be 3 years unless there is an indication to the contrary. It is the responsibility of the author (or nominated officer) to be aware of influencing factors and to initiate reviews promptly within the 3 years if appropriate.

For national evidence-based interventions the review period is as defined on the AoMRC website

Schedule of procedures

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

This policy should be read in conjunction with other policies published by the ICB.

Private funding

If patients choose to privately fund an intervention that is not normally funded by the ICB, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by the ICB they will retain their entitlement to all the other elements of cancer care that other residents of Cornwall and Isle of Scilly receive free of charge.

However, when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and the ICB's funded care within the same appointment or intervention. They cannot top-up the ICB's funded appointment or intervention by paying for an additional intervention to be provided or monitored during the same consultation.

National Institute for Health and Care Excellence guidance and recommendations

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

Commissioners do not routinely fund interventions identified in the NICE do not do recommendations

Commissioning policies

Aesthetic surgery

General guidelines

1. NHS Cornwall and Isles of Scilly Integrated Care Board considers all lives of all patients whom they serve to be of equal value and, in making decisions about funding

treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability save where a difference in the treatment options made available to patients is directly related to the patient's clinical condition
2. Aesthetic surgery in patients who are within the normal morphological range will be considered as purely cosmetic and therefore not funded on the NHS and referrals from GPs for these reasons will not be accepted
3. Patients requiring reconstructive surgery to restore normal or near normal appearance or function following cancer treatment or post trauma are eligible for NHS funding and therefore not included in this policy
4. Aesthetic surgery will not be routinely funded to alleviate psychological distress alone. Where there is concern that a patient presenting with an apparently simple aesthetic problem may have an underlying medical or severe psychiatric problem the GP should consider referring the patient for an appropriate opinion relating to that problem
5. Referrals for the revision of treatments originally performed outside the NHS will not normally be supported and should be referred to the practitioner who originally carried out the procedure. Where there is a complication of treatment originally undertaken outside of the NHS for example, breast capsulotomy following breast augmentation, these will be considered through NHS Cornwall and Isles of Scilly Integrated Care Board individual funding request (IFR) process. Such cases will not however be automatically eligible for repeat surgery under the NHS for example. defective breast implants may be removed but not replaced

Abdominoplasty or apronectomy

Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.

Criteria

Abdominoplasty and apronectomy are not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: S021, S022, S028, S029

Diagnoses challenged in this policy
ICD10 code: L98.7 Excessive and redundant skin and subcutaneous tissue

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

Date approved: August 2016, November 2018 and July 2021

Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Annual MRI breast screening

Criteria

Annual MRI breast screening is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

MRI scans are not normally offered to patients before their 20th birthday.

MRI surveillance should be considered for the following women with no personal history of breast cancer.

Patients aged 20 to 29

MRI scans are available for those at exceptionally high risk, for example women:

- with a known TP53 mutation
- who have not been tested but have a greater than 30% probability of carrying a TP53 mutation

Patients aged 30 to 49

- Women with a known TP53 mutation
- Women who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier
- Women with a known BRCA1 or BRCA2 mutation
- Women who have not had a genetic test but have a greater than 30% probability of being a BRCA carrier

Patients aged 50 to 69

- Women with a known TP53 mutation
- Women with a known BRCA1 or BRCA2 mutation AND have dense breast pattern on mammography
- Women who have not had a genetic test but have a greater than 30% probability of being a BRCA carrier AND have a dense breast pattern on mammography

Aged 70 and above

Not normally offered.

MRI surveillance

MRI surveillance should be considered for the following women with a personal history and family history of breast cancer.

Women aged 20 to 29:
- with a known TP53 mutation
- who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier

Women aged 30 to 49:
- at high risk of breast cancer*

*Women with a known BRCA1, BRCA 2 and/or TP53 mutations or greater than 30% probability of being carriers. Rare conditions that carry and increased risk of breast cancer such as Peutz-Jegher syndrome, Cowden and familial diffuse gastric cancer.

Women aged 50 to 69:
- with a dense breast pattern on mammography
- with a known TP53 mutation
- who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier

Not normally offered to women aged 70 and above.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
Z803

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018
Review date: April 2020 or earlier if new guidance is issued
JCIA: Yes, completed

Blepharoplasty

Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision.

Criteria

Blepharoplasty is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- impairment of visual fields in the relaxed, non-compensated state (evidence will be required that eyelids impinge on visual fields, reducing field to 120 degrees laterally and 40 degrees vertically (20 above and 20 below)
- correction of ectropion or entropion with ocular irritation and causing functional implications (evidence of functional implications must be supplied with the referral documentation)

Codes

Procedures challenged in this policy
C131, C132, C133, C134, C138, C139

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: February 2019 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Botox injection for the ageing face

Criteria

Botox Injection for the ageing face is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code:
- S53.2 - Injection of therapeutic substance into skin
- Z60.1 - Muscle of face or if injected into skin:
- Z47.1 - Skin of forehead
- Z47.2 - Skin of temple
- Z47.3 - Skin of cheek
- Z47.4 - Skin of nasolabial area
- Z47.5 - Skin of chin
- Z47.8 - Specified skin of face NEC
- Z47.9 - Skin of face NEC

Diagnoses challenged in this policy
ICD10 Code: None

Diagnoses for which the above procedures are permitted
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Breast asymmetry

Criteria

Cosmetic breast surgery is not routinely commissioned.

Exclusions

This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances.

Codes

Procedures challenged in this policy
B301, B302, B304, B308, B309, B312, B314, B375
B30.1 - Insertion of prosthesis for breast
B30.2 - Revision of prosthesis for breast
B30.4 - Renewal of prosthesis for breast
B30.8 - Other specified prosthesis for breast
B30.9 - Unspecified prosthesis for breast
B31.2 - Augmentation mammoplasty
B31.4 - Revision of mammoplasty
B37.5 - Lipofilling of breast

Relevant diagnoses for this policy
Z41.1 - Other plastic surgery for unacceptable cosmetic appearance

Diagnoses for which the above procedures are permitted
C500, C509, C501, C502, C503, C504, C505, C506, , C508, C509D, Z853
D05.0 - Lobular carcinoma in situ
D05.1 - Intraductal carcinoma in situ
D05.7 - Other carcinoma in situ of breast
D05.9 - Carcinoma in situ of breast, unspecified
Z40.0 - Prophylactic surgery for risk-factors related to malignant neoplasms

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Breast augmentation

Breast augmentation or enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

Criteria

Cosmetic breast augmentation or enlargement is not routinely commissioned.

Codes

Procedures challenged in this policy
B301, B302, B304, B308, B309, B312, B314, B375

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C590D, Z853
D05.0 - Lobular carcinoma in situ
D05.1 - Intraductal carcinoma in situ
D05.7 - Other carcinoma in situ of breast
D05.9 - Carcinoma in situ of breast, unspecified

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Breast lift (mastopexy)

This is included as part of the treatment of breast asymmetry but will not be available for purely cosmetic reasons, for example post lactation or age-related breast ptosis (drooping).

Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.

Criteria

Breast lift (mastopexy) is not routinely commissioned.

Exclusions

This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances.

Codes

Procedures challenged in this policy
B313, (B314 is also included in breast asymmetry and breast augmentation above)

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016; November 2018 and November 2025
Review date: November 2027 or earlier if new guidance is published
JCIA: Yes, completed

Breast prosthesis removal (National Evidence Based Intervention)

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

Criteria

This guidance applies to those 18 years and over.

This proposal does not cover the following:

- Gender reassignment surgery
- Implants inserted following surgery for breast cancer or breast cancer prevention performed under the NHS. In these cases, please refer to the Association of Breast Surgery (ABS) Guidance for the Commissioning of Oncoplastic Breast Surgery

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

- After implant leakage or rupture

OR

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

OR

- Implants are complicated by recurrent implant infection or seroma

OR

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

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

Patients whose initial procedure was privately funded should seek assurance from their private provider in the first instance.

If, however, the patient meets one of the above clinical indications, and the private provider is unable to offer the patient surgery, the patient can be offered an NHS referral for breast implant removal but not for replacement.

Where a patient is eligible for implant removal due to a problem associated with a single implant, bilateral implant removal should be offered.

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

The removal of breast implants due to symptoms termed as Breast Implant Illness (BII) or Autoimmune Syndrome Induced by Adjuvants (ASIA) on social media, or due to the risk of developing Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is not currently recommended.

Only patients whose initial procedure was funded by the NHS should be considered for both implant removal and replacement. In line with current guidance, patients eligible to have their implant replaced must be informed of the potential risk of BIA-ALCL.
As per guidance NG180 from the National Institute for Health and Care Excellence (NICE), discuss lifestyle modifications with people having surgery — for example stopping smoking and reducing alcohol consumption — in order to reduce the risk of post-operative complications. See NICE guidance NG180 on Perioperative care in adults for more information.

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('B303', 'B307')
AND (Any_Spell_Diagnosis LIKE '%Z421%')
AND (NOT( Any_Spell_Diagnosis LIKE '%T85[487]%'
OR Any_Spell_Diagnosis LIKE '%N60[0123489]%'
OR Any_Spell_Diagnosis LIKE '%N61%'
OR Any_Spell_Diagnosis LIKE '%N63%'
OR Any_Spell_Diagnosis LIKE '%N64[01234589]%'
OR Any_Spell_Diagnosis LIKE '%C84[6789]%'
OR Any_Spell_Diagnosis LIKE '%Y812%'
)
OR Any_Spell_Diagnosis IS NULL
)
```

```
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3A_Breast_Prosthesis_Removal'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Outpatient

WHEN Any_Appointment_Procedure LIKE '%B30[37]%'
AND ( Any_Appointment_Diagnosis LIKE '%Z421%')
AND (NOT( Any_Appointment_Diagnosis LIKE '%T85[487]%'
OR Any_Appointment_Diagnosis LIKE '%N60[0123489]%'
OR Any_Appointment_Diagnosis LIKE '%N61%'
OR Any_Appointment_Diagnosis LIKE '%N63%'
OR Any_Appointment_Diagnosis LIKE '%N64[01234589]%'
OR Any_Appointment_Diagnosis LIKE '%C84[6789]%'
OR Any_Appointment_Diagnosis LIKE '%Y812%'
)
OR Any_Appointment_Diagnosis IS NULL
)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3A_Breast_Prosthesis_Removal'

Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
```

OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Breast reduction (National Evidence Based Intervention locally adapted)

Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape.

Criteria

Breast reduction is not routinely commissioned.

Codes

Procedures challenged in this policy
B311

Relevant diagnoses for this policy
Diagnosis code (any position) is not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Breast reduction surgery in males for gynaecomastia

Most cases of gynaecomastia are idiopathic. It can also occur during puberty, when it tends to resolve as the post-pubertal fat distribution is complete. It can also occur secondary to medication such as oestrogens, gonadotrophins, digoxin, spironolactone

and cimetidine, as well as anabolic steroids. More rarely it can be due to endocrinological disorders and malignancy.

Criteria

Male breast reduction surgery for gynaecomastia is not routinely commissioned.

Note this policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected malignancy.

Codes

Procedures challenged in this policy
B311

Relevant diagnoses for this policy
N62.X - Hypertrophy of breast

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Closure of patent foramen ovale for migraine

The foramen ovale is hole in the wall that divides the 2 upper chambers of the heart. The hole is present in the heart of a developing fetus but normally closes up soon after the baby is born. If it fails to close it is known as a patent foramen ovale (PFO). In most people, this does not cause any problems, but some studies have suggested that there could be a link between having a PFO and recurrent migraines. This procedure involves passing a device through a large vessel in the groin up into the heart and closing or blocking the hole in the wall of the heart.

Criteria

Closure of patent foramen ovale for migraine is not routinely commissioned.

Use of this procedure should be restricted to patients who are severely affected by recurrent, refractory migraine.

This policy does not apply to closure of patent foramen for stroke prevention.

Codes

Procedures challenged in this policy
OPCS Code: K165

Diagnoses challenged in this policy
Q21.1 - Atrial septal defect
ICD10 Code: G430, G431, G432, G433, G438, G439

Date approved: April 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Cosmetic genital procedures

Criteria

Cosmetic genital procedures are not routinely commissioned.

Codes

Procedures challenged in this policy
P055, P056, P057
P05.5 - Excision of excess labial tissue
P05.6 - Reduction labia minor
P05.7 - Reduction labia major
P01.2 - Reduction of clitoris

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018, March 2019 – rename of policy and updated OPCS codes approved only and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Dermatology: acne and psoriasis

Criteria

Acne pulse-dye laser treatment is not routinely commissioned.

Psoriasis care pathway for the use of Fumaderm is criteria-based access.

Commissioned for the treatment of severe psoriasis for patients who are resistant to or have contra-indications to the standard treatments.

Codes

Procedures challenged in this policy
S071, S072, S078, S079

Relevant diagnoses for this policy
L700, L701, L702, L703, L704, L705, L708, L709, L730, L400, L401, L402, L403, L404, L405, L408, L409, L410, L411, L412, L413, L414, L415, L418, L419

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and February 2021
Review date: February 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Desensitising light therapy in the management of severe polymorphic light eruption

Polymorphic light eruption (PMLE) is a common skin rash trigged by exposure to sunlight or artificial ultraviolet (UV) light. An itchy or burning rash appears within hours, or up to 2 to 3 days after exposure to sunlight. It lasts for up to 2 weeks, healing without scarring. The rash appears on the parts of the skin exposes to sunlight, typically the head and neck, chest and arms (the face is not always affected). PMLE is thought to affect about 10% to15% of the UK population (nhs.uk, 2015).

Photosensitivity, including PMLE, is usually managed conservatively by reducing exposure to sunlight and where this brings insufficient improvement, by use of topical or systematic therapies. Patients should be advised to follow the top sun safety tips as advised by the British Association of Dermatologists (BAD) to manage their condition.

Criteria

A defined course of desensitizing light therapy in the management of severe polymorphic light eruption using UVB or PUVA is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

1. The diagnosis of PMLE has been confirmed by a consultant dermatologist.
2. A consultant dermatologist assessment considers light therapy likely to significantly improve the impact of the patient's PMLE
3. The patient's PMLE is judged severe, for example the patient has recurrent, extensive, itchy rash for most of the UK summer
4. Symptoms remain severe despite comprehensive use of prevention, first- and second-line treatments in line with the BAD guidance including:
    - the patient is using protective clothing and broad-spectrum sun protection factor 30+ semi-opaque sunscreen frequently to all uncovered skin

- the patient has been advised and tried gradually increasing exposure to sunlight without relief
- the patient has tried recommended drug therapies for PMLE (*please include a detailed history of this treatment within this application)

5. Symptoms from PMLE rash are causing significant functional impairment*

* Significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Note being unable to sunbathe, swim or take part in other recreational activities due to the impact of PMLE is unlikely to satisfy the commissioner that the patient is suffering from significant functional impairment.

Codes

Procedures challenged in this policy
S121, S122, S123, S124

Relevant diagnoses for this policy
L564

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018, November 2018 – significant functional impairment definition amended only and February 2021
Review date: February 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Epididymal cysts

An epididymal cyst is a fluid filled sac which grows at the top end of the testicle. It is benign not caused by cancer. Some men only get one; others get several on both testicles. Rarely, they can be associated with illness that causes cysts in other parts of the body. Small cysts do not need treatment. Larger ones can be removed by a surgeon, especially if painful. Drainage using a needle (aspiration) is another option, but it is not done very often.

Men are more likely to get an epididymal cyst around the age of 40. Children rarely get them before they become teenagers (Patient Info, 2014).

Criteria

If there is any uncertainty whether the cyst may be malignant in nature, refer the patient via the 2-week wait referral route.

The removal of benign epididymal cysts is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- it is large enough to cause a change to the shape and size of the scrotum
- the cyst is putting pressure on other structures in the testes
- there is documented clinical evidence that the cyst has been continuously present for more than 6 months
- the cyst is causing significant functional impairment*

* Significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Codes

Procedures challenged in this policy
N153, N15.6

Relevant diagnoses for this policy
N50.8 epididymal cyst (please note this code is not exclusive to this condition and may be assigned for another diagnosis).

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018, November 2018 – significant functional impairment definition amended only and March 2021
Review date: March 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Face lift or brow lift

These surgical procedures are performed to lift the loose skin of face and forehead to get a firm and smoother appearance of the face.

Criteria

Cosmetic face lift or brow lift are not routinely commissioned.

Codes
Procedures challenged in this policy

OPCS Code: S011, S012, S013, S014, S015, S016, S018, S019

Diagnoses challenged in this policy
ICD10 Code: L98.7 - Excessive and redundant skin and subcutaneous tissue

Diagnoses for which the above procedures are permitted

ICD10 Code Q183, Q189, Q670, Q671, Q672, Q673, Q674, G51, G510, Q828, Q85, Q850

Q18.3 - Webbing of neck
Q18.9 - Congenital malformation of face and neck, unspecified
Q67.0 - Facial asymmetry
Q67.1 - Compression facies
Q67.2 - Dolichocephaly
Q67.3 - Plagiocephaly
Q67.4 - Other congenital deformities of skull, face and jaw
G51.0 - Bell palsy
Q82.8 - Other specified congenital malformations of skin
Q85.0 - Neurofibromatosis (nonmalignant)
G51.1 - Geniculate ganglionitis
G51.2 - Melkersson syndrome
G51.3 - Clonic hemifacial spasm
G51.4 - Facial myokymia
G51.8 - Other disorders of facial nerve
G51.9 - Disorder of facial nerve, unspecified
Q85.0 - Neurofibromatosis (nonmalignant)
Q85.1 - Tuberous sclerosis
Q85.8 - Other phakomatoses, not elsewhere classified
Q85.9 - Phakomatosis, unspecified

Date approved: August 2016, November 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Hair depilation (hair removal)

Hair depilation can be used for excess hair in a normal distribution pattern, or for abnormally placed hair. It is usually achieved permanently by electrolysis or laser therapy.

Criteria

Hair depilation is not routinely commissioned.

Exclusion

Post hair bearing flap reconstructions

Codes

Procedures challenged in this policy

S606, S607 or S608 with Y089

Relevant diagnoses for this policy
L68, L68X, L680, Q842

Diagnoses for which the above procedures are permitted
Polycystic ovaries E282, Pilonidal cyst L05, L050, L059, and burns T20, T200, T201, T202, T203, T310, T311, T312, T313, T314, T315, T316, T317, T318, T318

Date approved: August 2017 and November 2018
Review date: November 2021 or earlier if new guidance is issued
JCIA: Yes, completed

Hymenorrhaphy

Criteria

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely commissioned.

Codes

Procedures challenged in this policy
P15.8 - Other specified other operations on introitus of vagina + Y25.9 - Unspecified suture of organ NOC

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Inverted nipple correction

Nipple inversion may occur as a result of an underlying breast malignancy, and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.

Criteria

Inverted nipple correction is not routinely commissioned. This policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected malignancy.

Codes

Procedures challenged in this policy
B35.6 - Eversion of nipple

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016; November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Labiaplasty

Criteria

Labiaplasty is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate codes for this procedure.

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Laser hair removal for pilonidal disease

Pilonidal disease is a skin disease usually found in the midline of the natal cleft. Active pilonidal disease can progress to chronic or recurrent disease, and approximately 50% of acute pilonidal abscesses may develop into chronic discharging pilonidal disease despite treatment of the acute abscess (CKS, 2015). Pilonidal disease may recur after surgical treatment, depending on the surgical method used (CKS, 2015).

Criteria

Laser hair removal for pilonidal disease is not routinely commissioned. As studies show similar results to other conservative treatment.

Exclusion

Where the pilonidal disease has occurred on a post hair bearing flap reconstruction, laser hair removal will be commissioned.

Codes

Procedures challenged in this policy
H60.8 + Y08.8 (where diagnosis contains pilonidal cyst codes L05.0, L05.9)

Relevant diagnoses for this policy
If in the primary position:
- L05.0 Pilonidal cyst with abscess
- L05.9 Pilonidal cyst without abscess

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and April 2021
Review date: April 2024
JCIA: Yes, completed

Liposuction

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

Criteria

Liposuction is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: S621, S622

Diagnoses challenged in this policy
ICD10 code: L98.7 - Excessive and redundant skin and subcutaneous tissue

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 Codes for the clinical criteria.

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued

JCIA: Yes, completed

One-step nucleic acid amplification as an intra-operative diagnostic method for detecting metastasis in breast cancer

One-step nucleic acid amplification (OSNA) is a promising emerging technique as one of the sentinel node biopsy techniques and as such is still under evaluation. Its benefits are identification of lymph node metastasis during the initial breast surgery and therefore enabling decision and undertaking of further lymph node resection (or not) during that initial surgery, avoiding thus the need for a second surgery and reducing the length of hospital stay. Current evidence identifies that the main uncertainty with OSNA is the potential over diagnosis of breast cancer metastasis. For example, higher proportion of micro-metastasis identified using OSNA than histopathology.

Criteria

OSNA is commissioned for all patients being surgically treated for breast cancer to allow evaluation of the diagnostic technique for a period of one year until further evidence becomes available.

Codes

Procedures challenged in this policy
OPCS Code:

Sentinal Axillary Lymph Node Biopsy with Isotope (OSNA) = T87.3 + Y39.2 + O14.2

Diagnoses for which the above procedures are permitted
ICD10 Code: C500, C501, C502, C503, C504, C505, C506, C508, C509

D05.0 - Lobular carcinoma in situ
D05.1 - Intraductal carcinoma in situ
D05.7 - Other carcinoma in situ of breast
D05.9 - Carcinoma in situ of breast, unspecified

Date approved: April 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Removal of benign skin lesions (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Removal of benign skin lesions means treating lumps, bumps or tags on the skin that are not suspicious of cancer. Treatment carries a risk of infection, bleeding or permanent scarring and sometimes anaesthetic risks, so it is not usually offered by the NHS if it is just to improve appearance. Treatment (surgical excision or cryotherapy) may be offered if certain criteria are met. A patient with a skin or subcutaneous lesion that has features

suspicious of malignancy must be treated or referred according to NICE skin cancer guidelines. This policy does not refer to premalignant lesions and other lesions with potential to cause harm.

This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:

- anal skin tags
- benign moles (excluding large congenital naevi)
- corn/callous
- dermatofibroma
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- lipomas
- milia
- molluscum contagiosum (non-genital)
- neurofibromata
- non-genital viral warts in immunocompetent patients
- seborrhoeic keratoses (basal cell papillomata)
- skin tags (fibroepithelial polyps) including anal tags
- solar comedones
- spider naevi (telangiectasia) – although multiple lesions may be a sign of underlying disorders in adults and children best initially addressed through advice and guidance
- xanthelasmata

Criteria

The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be considered for removal:

- The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this causing regular bleeding (more than twice weekly for at least four weeks caused by everyday activities i.e. not due to picking)
- There is repeated infection requiring 2 or more antibiotic courses per year
- The lesion bleeds (more than twice weekly for at least four weeks) in the course of normal everyday activity
- The lesion causes pain requiring long-term daily medication
- The lesion is obstructing an orifice or impairing field vision
- The lesion significantly impacts on function e.g. restricts joint movement
- The lesion causes pressure symptoms which are unavoidable, cannot be managed conservatively and cause atrophy. Verruca on the feet do not normally meet this criteria as they can be pared back to avoid pressure symptoms
- If left untreated, more invasive intervention would be required for removal
- Facial viral warts causing significant psychological distress (e.g. school avoidance), in those aged under 18 years who are able to tolerate cryotherapy
- Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic

The following are outside the scope of this policy recommendation:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE skin cancer guidelines
- Any lesion where there is diagnostic uncertainty i.e. genetic diseases, premalignant lesions (actinic keratoses, Bowen disease) or lesions with premalignant potential should be referred or, where appropriate, treated in primary care
- Removal of lesions other than those listed above

Referral to appropriate speciality service (e.g. dermatology or plastic surgery):

- The decision as to whether a patient meets the criteria is primarily with the referring clinician. If such lesions are referred, then the referrer should state that this policy has been considered and why the patient meets the criteria. The referrer should not guarantee treatment will be provided but explain that clinicians will consider the potential risks and benefits with the patient. A clinician will not offer treatment if the risks outweigh benefits
- This policy applies to all providers, including general practitioners (GPs), GPs with enhanced role (GPwER), independent providers of NHS care, and community or intermediate NHS services

Codes

Procedures challenged in this policy

S063, S064, S065, S066, S067, S068, S069, S081, S082, S083, S088, S089, S091, S092, S093, S094, S095, S098, S099, S101, S102, S111, S112, B353, C101, C108, C109, C111, C112, C118, C119, C121, C122, C123, C124, C125, C126, C128, C129, D021, D022, D028, D029, E091, E092, E096, E098, E099, F011, F018, F019, F021, F022, F028, F029, N012, N013, N018, N019, N242, N271, N272, N273, N278, N279, P054, P058, P059, P061, P062, P063, P065, P068, P069, P111, P112, P113, P114, P118, P119, T291, T292, T293, T298, T299

Relevant diagnoses for this policy

Code (any position) is not like: C43, C44, C46, C49

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script

WHEN Primary_Spell_Procedure IN (
‘S063’,’S064’,’S065’,’S066’,’S067’,’S068’,’S069’,’S081’,’S082’,’S083’
,’S088’,’S089’,’S091’,’S092’,’S093’,’S094’,’S095’,’S098’,’S099’,’S101’
,’S102’,’S111’,’S112’,’B353’,’C101’,’C108’,’C109’,’C111’,’C112’,’C118’
,’C119’,’C121’,’C122’,’C123’,’C124’,’C125’,’C126’,’C128’,’C129’,’D021’

,’D022’,’D028’,’D029’,’E091’,’E092’,’E096’,’E098’,’E099’,’F011’,’F018’,’F019’,’F021’,’F022’,’F028’,’F029’
,’N012’,’N013’,’N018’,’N019’,’N242’,’N271’,’N272’,’N273’,’N278’,’N279’
,’P054’,’P058’,’P059’,’P061’,’P062’,’P063’,’P065’,’P068’,’P069’,’P111’
,’P112’,’P113’,’P114’,’P118’,’P119’,’T291’,’T292’,’T293’,’T298’,’T299’)
AND not (Any_Spell_Diagnosis like ‘%C4[34][0123456789]%’)
AND not (Any_Spell_Diagnosis like ‘%D0[34][0123456789]%’
OR Any_Spell_Diagnosis like ‘%L570%’)
AND (Any_Spell_Diagnosis LIKE ‘%D17[01239]%’
OR Any_Spell_Diagnosis LIKE ‘%D22[012345679]%’
OR Any_Spell_Diagnosis LIKE ‘%D23[012345679]%’
OR Any_Spell_Diagnosis LIKE ‘%D280%’
OR Any_Spell_Diagnosis LIKE ‘%D29[024]%’
OR Any_Spell_Diagnosis LIKE ‘%B081%’
OR Any_Spell_Diagnosis LIKE ‘%B07%’
OR Any_Spell_Diagnosis LIKE ‘%I781%’
OR Any_Spell_Diagnosis LIKE ‘%L72[01289]%’
OR Any_Spell_Diagnosis LIKE ‘%L82%’
)
-- Only Elective Activity
AND APCS.Admission_Method not like (‘2%’)
THEN ‘F_skin_lesions’
Exclusions

a WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like ‘%C[0-9][0-9]%’
AND Any_Spell_Diagnosis not like ‘%D0%’
AND Any_Spell_Diagnosis not like ‘%D3[789]%’
AND Any_Spell_Diagnosis not like ‘%D4[012345678]%’
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>’02’

Date approved: August 2017, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Removal of tattoos

A tattoo can be removed by laser, surgical excision, or dermabrasion.

Criteria

Tattoo removal is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS Code: S091, S092, S108, S109, S601, S602

Diagnoses challenged in this policy
ICD10 Code: L818

Diagnoses for which the above procedures are permitted
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Repair of lobe of external ear (split earlobes)

The external ear lobe can be damaged partially or completely as result of trauma or wearing earrings. Correction of split earlobes is not always successful, and the earlobe is a site where poor scar formation is a recognised risk.

Criteria

Repair of lobe of external ear is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: D062

Diagnoses challenged in this policy
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Resurfacing procedures: dermabrasion, chemical peels and laser treatment

Dermabrasion involves removing the top layer of the skin to make it look smoother and healthier. Scarring and permanent discolouration of skin are rare complications.

Criteria

Resurfacing procedures: dermabrasion, chemical peels and laser treatment are not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: S091, S092, S103, S113, S601, S602

Diagnoses challenged in this policy
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

Date approved: August 2016; November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Revision mammoplasty (including prosthesis removal or replacement) (National Evidence Based Intervention)

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

Patients should be informed at the time of initial surgery that implants are likely to need replacement, and further surgery may be required.

In the case of implant rupture, severe capsular contracture, recurrent infection, breast disease and BIA-ALCL the benefit of removing an implant outweighs the risk of keeping the implant in place.

It is accepted that the NHS has a duty of care to patients who require their implant to be removed for a listed clinical indication, but only if their private provider is unable to offer this care. As the NHS does not routinely commission breast implants for cosmetic reasons, removal but not replacement is considered appropriate in these cases.

Concerns have been expressed about the potential side effects of breast implants including the development of BIA-ALCL and BII or Autoimmune Syndrome Induced by Adjuvants (ASIA).

The BIA-ALCL is uncommon and in the UK is currently estimated to be 1 per 15,000 implants sold. The most recent guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) states that based on the current available evidence people with breast implants do not need to have them removed in the absence of symptoms of ALCL. The MHRA states this position is consistent with international regulators and they will continue to collect data on ALCL in patients with breast implants and review the guidance in light of any new evidence.

BII/ASIA is used by some to describe a constellation of symptoms felt to be associated with their breast implants. However, BII/ASIA is not a World Health Organization recognised disease. The MHRA states there is no single disease which could explain the reported symptoms and it is currently unknown whether there is a link between breast implants and the reported health problems.

Criteria

This guidance applies to those 18 years and over.

This proposal does not cover the following:

- Gender reassignment surgery
- Implants inserted following surgery for breast cancer or breast cancer prevention performed under the NHS. In these cases, please refer to the Association of Breast Surgery (ABS) Guidance for the Commissioning of Oncoplastic Breast Surgery
- Surgery to remove breast implants should only be considered for the following clinical indications:
    - After implant leakage or rupture

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

  OR
    - Implants are complicated by recurrent implant infection or seroma

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

Revision mammoplasty will also be considered in the following circumstances:

- Implants with capsule formation that interferes with mammography

OR

- Implant is a PIP implant

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

Patients whose initial procedure was privately funded should seek assurance from their private provider in the first instance.

If, however, the patient meets one of the above clinical indications, and the private provider is unable to offer the patient surgery, the patient can be offered an NHS referral for breast implant removal but not for replacement.

Where a patient is eligible for implant removal due to a problem associated with a single implant, bilateral implant removal should be offered.

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

The removal of breast implants due to symptoms termed as Breast Implant Illness (BII) or Autoimmune Syndrome Induced by Adjuvants (ASIA) on social media, or due to the risk of developing Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is not currently recommended.

Only patients whose initial procedure was funded by the NHS should be considered for both implant removal and replacement. In line with current guidance, patients eligible to have their implant replaced must be informed of the potential risk of BIA-ALCL.

As per guidance NG180 from the National Institute for Health and Care Excellence (NICE), discuss lifestyle modifications with people having surgery — for example stopping smoking and reducing alcohol consumption — in order to reduce the risk of post-operative complications. See NICE guidance NG180 on Perioperative care in adults for more information.

Codes

Procedures challenged in this policy
B302, B303, B304, B314

Relevant diagnoses for this policy
None.
T85.4 - Mechanical complication of breast prosthesis and implant
T85.8 - Other complications of internal prosthetic devices, implants and grafts, not elsewhere classified + Y83.1 - Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, Surgical operation with implant of artificial internal device

Diagnoses for which the above procedures are permitted
C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509, Z853

D05.0 - Lobular carcinoma in situ
D05.1 - Intraductal carcinoma in situ
D05.7 - Other carcinoma in situ of breast
D05.9 - Carcinoma in situ of breast, unspecified

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('B303', 'B307')
AND (Any_Spell_Diagnosis LIKE '%Z421%')
AND (NOT( Any_Spell_Diagnosis LIKE '%T85[487]%'
OR Any_Spell_Diagnosis LIKE '%N60[0123489]%'
OR Any_Spell_Diagnosis LIKE '%N61%'
OR Any_Spell_Diagnosis LIKE '%N63%'
OR Any_Spell_Diagnosis LIKE '%N64[01234589]%'
OR Any_Spell_Diagnosis LIKE '%C84[6789]%'
OR Any_Spell_Diagnosis LIKE '%Y812%'
)
OR Any_Spell_Diagnosis IS NULL
)
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3A_Breast_Prosthesis_Removal'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Outpatient

```
WHEN Any_Appointment_Procedure LIKE '%B30[37]%'
AND ( Any_Appointment_Diagnosis LIKE '%Z421%')
AND (NOT( Any_Appointment_Diagnosis LIKE '%T85[487]%'
OR Any_Appointment_Diagnosis LIKE '%N60[0123489]%'
OR Any_Appointment_Diagnosis LIKE '%N61%'
OR Any_Appointment_Diagnosis LIKE '%N63%'
OR Any_Appointment_Diagnosis LIKE '%N64[01234589]%'
OR Any_Appointment_Diagnosis LIKE '%C84[6789]%'
OR Any_Appointment_Diagnosis LIKE '%Y812%'
)
OR Any_Appointment_Diagnosis IS NULL
)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
```

THEN '3A_Breast_Prosthesis_Removal'

Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: November 2016, February 2019, November 2022 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Rhinoplasty

Rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People often ask for this procedure to improve self-image.

Criteria

Rhinoplasty is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS Code: E023, E024, E025, E026, E073

Diagnoses challenged in this policy
There are no appropriate ICD10 Codes for the clinical criteria

Diagnoses for which the above procedures are permitted
There are no appropriate ICD10 Codes for the clinical criteria

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Scars and keloids

Criteria

Treatment for scars and keloids is not routinely commissioned.

Codes

Procedures challenged in this policy

OPCS Code: S063, S064, S065, S081, S082, S091, S092, S101, S102, S108, S109, S111, S112, S118, S119, S604, Y064

S06.3 - Shave excision of lesion of skin of head or neck
S06.4 - Shave excision of lesion of skin NEC
S06.5 - Excision of lesion of skin of head or neck NEC
S08.1 - Curettage and cauterisation of lesion of skin of head or neck
S08.2 - Curettage and cauterisation of lesion of skin NEC
S09.1 - Laser destruction of lesion of skin of head or neck
S09.2 - Laser destruction of lesion of skin NEC
S10.1 - Cauterisation of lesion of skin of head or neck NEC
S10.2 - Cryotherapy to lesion of skin of head or neck
S10.8 - Other specified other destruction of lesion of skin of head or neck
S10.9 - Unspecified other destruction of lesion of skin of head or neck
S11.1 - Cauterisation of lesion of skin NEC
S11.2 - Cryotherapy to lesion of skin NEC
S11.8 - Other specified other destruction of lesion of skin of other site
S11.9 - Unspecified other destruction of lesion of skin of other site
S60.4 - Refashioning of scar NEC
Y06.4 - Excision of scar tissue NOC – this code would only ever be in a secondary position

Diagnoses challenged in this policy

ICD10 Code: L905, L910 in the primary position.

Diagnoses for which the above procedures are permitted

ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.
Date approved: August 2016, November 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Skin camouflage services

Patients with disfiguring facial scars, birthmarks and other skin conditions can seek to disguise these conditions with skin camouflage, with advice from skin camouflage services in acute trust hospitals.

Criteria

One advice session within acute trust skin camouflage clinic services is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

1. The patient is suffering from significant facial disfigurement
2. The deformity is capable of being camouflaged, disguised or minimised with camouflage products
3. The patient has accessed charity services provided in the community without any benefit (a report from the service setting out why they have been unable to benefit the patient will aid decision making)

Patients with funding approval will receive advice on techniques and products to use to manage their disfigurement.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
Birthmark = Q82.5
Scar or disfigurement due to scar = L90.5

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and February 2021
Review date: February 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Surgical treatment for hair loss

Introduction

Hair loss may occur naturally, or it may be related to disease or the use of certain medications. Symptoms of hair loss vary depending on the cause of the condition and range from a small bald patch to a complete loss of all body hair.

This policy replaces the previous male pattern baldness commissioning policy.

Criteria

Surgical treatment for hair loss is not routinely commissioned. This includes hair loss in all genders and is inclusive of conditions such as male pattern baldness, alopecia, hair thinning or hair loss and treatments such as grafting and transplants. This is because surgical treatments for hair loss is deemed to be a cosmetic procedure.

Codes

Procedures challenged in this policy

OPCS Code: S211, S212, S218, S219, S331, S332, S333, S338, S339
S21.1 - Hair bearing flap of skin to scalp for male pattern baldness
S21.2 - Hair bearing flap of skin to scalp NEC
S21.3 - Hair bearing flap of skin to nasolabial area
S21.4 - Hair bearing flap of skin to chin area
S21.8 - Other specified hair bearing flap of skin
S21.9 - Unspecified hair bearing flap of skin
S33.1 - Hair bearing punch graft to scalp for male pattern baldness
S33.2 - Hair bearing strip graft to scalp for male pattern baldness
S33.3 - Hair bearing graft to scalp for male pattern baldness NEC
S33.8 - Other specified hair bearing graft of skin to scalp
S33.9 - Unspecified hair bearing graft of skin to scalp
S34.1 - Hair bearing graft to nasolabial area
S34.2 - Hair bearing graft to chin area
S34.8 - Other specified hair bearing graft of skin to other site
S34.9 - Unspecified hair bearing graft of skin to other site
C10.2 - Hair bearing flap to eyebrow
C10.3 - Hair bearing graft to eyebrow

Diagnoses challenged in this policy

The ICD10 Codes for male pattern baldness are L648, L649
L63.0 - Alopecia (capitis) totalis
L63.1 - Alopecia universalis
L63.2 - Ophiasis
L63.8 - Other alopecia areata
L63.9 - Alopecia areata, unspecified
L64.0 - Drug-induced androgenic alopecia
L64.8 - Other androgenic alopecia
L64.9 - Androgenic alopecia, unspecified
L65.0 - Telogen effluvium
L65.1 - Anagen effluvium
L65.2 - Alopecia mucinosa
L65.8 - Other specified nonscarring hair loss
L65.9 - Nonscarring hair loss, unspecified
L66.0 - Pseudopelade
L66.1 - Lichen planopilaris
L66.2 - Folliculitis decalvans
L66.3 - Perifolliculitis capitis abscedens
L66.4 - Folliculitis ulerythematosa reticulata
L66.8 - Other cicatricial alopecia
L66.9 - Cicatricial alopecia, unspecified

Diagnoses for which the above procedures are permitted

Date approved: August 2016, November 2018 and March 2022
Review date: March 2025 or earlier if new guidance issued
JCIA: Yes. Completed

Thigh lift, buttock lift and arm lift, excision of redundant skin or fat

These surgical procedures are performed to remove loose skin or excess fat to reshape body contours.

Criteria

Thigh lift, buttock lift, and arm lift, excision of redundant skin or fat are not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: S031, S032, S033, (S038, S039 with Z495 or Z501)

Diagnoses challenged in this policy
L98.7 excessive and redundant skin and subcutaneous tissue.

Diagnoses for which the above procedures are permitted
There are no appropriate ICD10 codes for the clinical criteria.

Date approved: August 2016, November 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Vaginoplasty

Criteria

Non-reconstructive vaginoplasty or vaginal rejuvenation used to restore vaginal tone and appearance is not routinely commissioned.

Codes

Procedures challenged in this policy
P213, P214, P215

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Vascular birthmarks

Vascular birthmarks (congenital vascular lesions) are marks made up of excess or abnormal blood vessels in the skin. There are three common types: salmon patches (naevus simplex - no treatment required); port wine stains (naevus flammeus – treatable by pulse dye laser); and strawberry naevi (infantile haemangiomas – treated with oral propranolol. Please note that pyrogenic granulomas are not a vascular birthmark and can arise at any age (treated by topical timolol if small, or surgical curettage.

Criteria

Laser treatment for port wine stains is not routinely commissioned. Refer large port wine stains on cosmetically sensitive sites via advice and guidance for a dermatology opinion, as laser may be indicated, and onward referral can then be made to tertiary centres such as Bristol Children's Hospital or Great Ormond Street Hospital.

Codes

Procedures challenged in this policy

None

Relevant diagnoses for this policy

Q82.5 - Congenital non-neoplastic naevus

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved:
August 2016, November 2018 and October 2022
Review date: October 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Cardiology

Angioplasty for PCI (percutaneous coronary intervention) in stable angina (National Evidence Based Intervention) (Criteria based access and prior approval required) (UHP)

Stable angina is typically defined as exertional chest discomfort that is relieved by rest. However, there is a variation to the presentation of stable angina, and this is beyond the scope of this document. The European Society of Cardiology (ESC) and American Heart Association/ American College of Cardiology (AHA/ACC) guidelines recommend that in most patients with stable angina, percutaneous coronary intervention (PCI) should be considered for symptom relief. Ideally medical therapy, which should include therapies for the reduction of cardiovascular risk as well as anti-anginal therapies, should be optimised prior to PCI being considered.

Criteria

This guidance applies to those 18 years and over.

This guidance does not apply to:

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

PCI should only be performed in patients with stable angina if patients:

- Have ongoing anginal symptoms despite optimal anti-anginal medication*

OR

- Have ongoing angina symptoms with intolerance of anti-anginal medications*

OR

- Are participating in clinical research in stable coronary artery disease

In addition, if agreed at an appropriately constituted myocardial revascularisation cardiac multidisciplinary meeting (MDM)**, PCI may also be performed in patients with stable angina in the following cases:

- In patients with impaired left ventricular systolic function

OR

- In patients with left main stem disease

OR

- In patients with significant ischemic burden

OR

- Where PCI is otherwise considered appropriate by the MDM.**

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

*Optimal medical management should be offered and include:

Lifestyle interventions:

- Weight management
- Smoking cessation
- Adherence to a cardioprotective diet
- Regular physical activity

Risk reduction management:

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

Anti-anginal medication in line with current guidelines:

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

** Patients without ongoing angina should be discussed at an appropriate multidisciplinary meeting (MDM) before being offered PCI. This could include patients that are not within these criteria, for example, patients undergoing transcutaneous aortic valve implantation, asymptomatic patients with evidence of significant ischaemia, occupational indications, or patient preference.

An appropriately constituted myocardial revascularisation MDM would typically include:

- MDM coordinator
- Interventional cardiologist – at least one (the norm should be two or more)
- Non-interventional cardiologists – at least one (the norm should be two or more)
- Cardiac surgical consultant – at least one (the norm should be two or more)
- Other attendees including cardiac anaesthetists / intensivists may be required for some cases

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('K491', 'K492', 'K493', 'K494', 'K498',
'K499', 'K504', 'K751', 'K752', 'K753', 'K754', 'K758', 'K759')
AND ( Any_Spell_Diagnosis LIKE '%I20[89]%')
AND (NOT ( Any_Spell_Diagnosis LIKE '%I50[01]%'
OR Any_Spell_Diagnosis LIKE '%I518%')
OR Any_Spell_Diagnosis IS NULL )
-- Age between 18 and 120
```

AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3G_Angioplasty_PCI'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
--Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Outpatient

WHEN (Any_Appointment_Procedure LIKE '%K49[123489]%'
OR Any_Appointment_Procedure LIKE '%K504%'
OR Any_Appointment_Procedure LIKE '%K75[123489]%')
AND (NOT (Any_Appointment_Diagnosis LIKE '%I50[01]%'
OR Any_Appointment_Diagnosis LIKE '%I518%')
OR Any_Appointment_Diagnosis IS NULL)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3G_Angioplasty_PCI'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
  AND Any_Appointment_Diagnosis not like '%D0%'
  AND Any_Appointment_Diagnosis not like '%D3[789]%'
  AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
  OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Asymptomatic carotid artery stenosis screening (National Evidence Based Intervention)

Extracranial internal carotid stenosis, narrowing of the lumen of the internal carotid arteries, is most commonly attributed to atherosclerotic plaque formation and may present symptomatically as a Transient Ischaemic Attack (TIA) or ischaemic stroke. Carotid artery stenosis is thought to be the cause of approximately 8% of all ischaemic strokes. However, in some cases asymptomatic carotid artery stenosis may be identified as either an incidental finding on imaging or in individuals with known vascular disease, such as coronary atherosclerosis, peripheral arterial disease, abdominal aortic aneurysm or contralateral carotid stenosis. Asymptomatic carotid artery stenosis is defined as luminal narrowing in the absence of a history of TIA, ischaemic stroke, or other neurological signs or symptoms attributable to carotid artery disease.

Investigation of carotid artery stenosis may involve use of carotid duplex ultrasound, CT angiography and MR angiography. However, the increased risks of ionising radiation and adverse reactions to intravenous contrast mean CT and MR-based imaging would be more suitable for second line imaging to define the anatomy in more detail, rather than as a screening method. Carotid duplex ultrasound is a non-invasive method used to measure blood flow through the carotid arteries. It enables quantification of the degree of luminal narrowing with atherosclerotic disease, based on the North American Symptomatic Carotid Endarterectomy Trial (NASCET) measurements. A meta-analysis identified that duplex ultrasound in the detection of greater than 50% angiographic stenosis of the internal carotid arteries has a sensitivity and specificity of 98% and 88% respectively compared to angiography.

Criteria

This guidance applies to those 18 years and over.

- Screening for carotid artery stenosis should NOT be performed in asymptomatic individuals
- There is no indication for asymptomatic screening even in patients with known peripheral vascular disease
- Other than to risk stratify patients for coronary intervention, there is no indication for asymptomatic screening of the carotid arteries in patients undergoing other forms of cardiac surgery
- There is no routine indication for follow up for asymptomatic patients with carotid artery stenosis

Please note that this guidance is intended as a standard threshold for access. However, if you/ your patient falls outside of these criteria, the option to apply for an Individual Funding Request is still available to you.

Additionally, there is no evidence that patients diagnosed with peripheral vascular disease benefit from undergoing carotid artery stenosis screening for this indication only.

There is no clear evidence for being able to risk stratify an asymptomatic patient population for carotid artery stenosis screening.

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN ( Any_Spell_Procedure LIKE '%U111%'
OR
( ( Any_Spell_Procedure LIKE '%U117%'
OR Any_Spell_Procedure LIKE '%U21[126]%'
OR Any_Spell_Procedure LIKE '%U355%')
AND ( Any_Spell_Procedure LIKE '%Z361%'
OR Any_Spell_Procedure LIKE '%Z95[567]%') )
)
AND (NOT ( Any_Spell_Diagnosis LIKE '%I63[01289]%'
OR Any_Spell_Diagnosis LIKE '%G45[123489]%')
OR Any_Spell_Diagnosis IS NULL )
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3E_Carotid_Stenosis_Screening'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)

-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Outpatient

```
WHEN ( Any_Appointment_Procedure LIKE '%U111%'
OR
( ( Any_Appointment_Procedure LIKE '%U117%'
OR Any_Appointment_Procedure LIKE '%U21[126]%'
OR Any_Appointment_Procedure LIKE '%U355%')
AND ( Any_Appointment_Procedure LIKE '%Z361%'
OR Any_Appointment_Procedure LIKE '%Z95[567]%') )
)
AND (NOT ( Any_Appointment_Diagnosis LIKE '%I63[01289]%'
```

OR Any_Appointment_Diagnosis LIKE '%G45[123489]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date) between 18 AND 120
THEN '3E_Carotid_Stenosis_Screening'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Diagnostic coronary angiography for low risk stable chest pain (National Evidence Based Intervention)

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

This guidance applies to adults aged 19 years and over.

NICE guidelines recommend that where a diagnosis of chest pain cannot, by clinical assessment alone, exclude stable angina, 64-slice (or above) CT coronary angiography should be offered as first-line investigation. Cardiac catheterisation and coronary angiography are generally considered to be safe procedures. However, as with all medical procedures, there are some associated risks. The main risks of coronary angiography include:

- Haematoma or bruising in groin or arm
- Allergy to the contrast
- A very small risk including damage to the artery in the arm or leg where the catheter was inserted, heart attack, stroke, kidney damage and, very rarely, death

(risk of a serious complication occurring is estimated to be less than 1 in 1,000. People with serious underlying heart problems are most at risk.)

Criteria

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.

Codes

Procedures challenged in this policy

K63.1 Angiocardiography of combination of right and left side of heart
K63.2 Angiocardiography of right side of heart NEC
K63.3 Angiocardiography of left side of heart NEC
K63.4 Coronary arteriography using two catheters
K63.5 Coronary arteriography using single catheter

K63.6 Coronary arteriography NEC
K63.8 Other specified
K63.9 Unspecified

Relevant diagnoses for this policy

None listed

Diagnoses for which the above procedures are permitted

I20.1 – angina pectoris with documented spasm
I20.8 - Other forms of angina pectoris inc. stable angina
I20.9 – Angina pectoris, unspecified inc ischaemic chest pain
I23.0 Hemopericardium as current complication following acute myocardial infarction
I23.1 Atrial septal defect as current complication following acute myocardial infarction
I23.2 Ventricular septal defect as current complication following acute myocardial infarction
I23.3 Rupture of cardiac wall without hemopericardium as current complication following acute myocardial infarction
I23.4 Rupture of chordae tendineae as current complication following acute myocardial infarction
I23.5 Rupture of papillary muscle as current complication following acute myocardial infarction
I23.6 Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction
I23.8 Other current complications following acute myocardial infarction
I24.0 Acute coronary thrombosis not resulting in myocardial infarction
I24.1 Dressler's syndrome
I24.8 Other forms of acute ischemic heart disease
I25.0 - Atherosclerotic cardiovascular disease, so described
I25.1 Atherosclerotic heart disease of native coronary artery
I25.2 Old myocardial infarction
I25.3 Aneurysm of heart
I25.4 Coronary artery aneurysm and dissection
I25.5 Ischemic cardiomyopathy
I25.6 Silent myocardial ischemia
I25.8 Other forms of chronic ischemic heart disease
I25.9 Chronic ischemic heart disease, unspecified
Cancer diagnoses are a global exclusion

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) LIKE '%K63[12345689]%'
AND NOT ( Any_Spell_Diagnosis LIKE '%I20[018]%'
OR Any_Spell_Diagnosis LIKE '%I21[012349]%'
OR Any_Spell_Diagnosis LIKE '%I2[24][0189]%'
OR Any_Spell_Diagnosis LIKE '%I23[01234568]%'
```

```
OR Any_Spell_Diagnosis LIKE '%I25[012345689]%')
AND NOT ( Any_Spell_Procedure LIKE '%U10[1-9]%'
OR Any_Spell_Procedure LIKE '%U205%'
OR Any_Spell_Procedure LIKE '%U115%')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2A_Angio'
Exclusions

 WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: October 2022 and January 2025
Review date: No plans for further reviews unless evidence based intervention programme issue updates to policy
JCIA: Yes, completed

Exercise electrocardiogram (ECG) for screening for coronary heart disease (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

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

This guidance applies to adults aged 19 years and over.

In randomised control trials, screening with exercise ECG in asymptomatic patients found no improvement in health outcomes, even when focussing on higher risk populations such as those with diabetes. There is no research examining whether the addition of exercise ECG to traditional CHD risk factors results in accurate reclassification, however cohort studies looking at the role of resting ECG abnormalities found inconsistent impact on clinical decisions.

Reliability of exercise ECG testing varies based on many features including age, gender and known history of CHD, which significantly limits its utility as a screening tool. ECG sensitivity has been cited as 45-50% and specificity of 85-90%. Sensitivity and specificity data of exercise ECG testing is dependent upon the cohort of patients being studied: sensitivity is higher in patients with triple-vessel disease, and lower in patients with

single-vessel disease. Gender differences mean that exercise ECG is only moderately specific for the diagnosis of CHD in women.

The European Society of Cardiology (ESC) recommend the use of a risk-estimation system i.e. SCORE to calculate total risk estimation for asymptomatic patients >40 years of age without evidence of diabetes, chronic kidney disease, cardiovascular disease, or familial hypercholesterolemia. The assessment of a family history of premature CVD is recommended. A validated clinical score should be used in patients <50 years of age who have a family history of premature CVD in a first-degree relative.

In asymptomatic but high-risk adults (with diabetes, a strong family history of CVD, or when previous risk-assessment tests suggest a high risk of CVD), functional imaging or coronary CTA may be considered for cardiovascular risk assessment.

For people at low risk of cardiovascular disease, the potential harms of screening with exercise ECG is thought by some (including the US Preventative Service Task Force) to be equal to or exceed the potential benefits. For people at intermediate to high risk, current evidence is thought to be insufficient to assess the balance of benefits and harms of screening. Therefore, the US Preventative Services Task Force recommends against screening for CHD with resting or exercise ECG in adults at low risk for CHD events.

Chou et al cite that exercise ECG screening has not been shown to improve patient outcomes and is instead associated with potential harms due to false-positive results leading to potentially unnecessary tests and procedures.

Overall, in asymptomatic patients without a history of CHD, the potential harms of exercise ECG (which includes arrhythmias, acute MI, sudden cardiac death and harms of subsequent angiography or revascularisation procedures after abnormal test) are considered by many to exceed the screening benefit. However, literature examining the frequency of these harms is lacking.

Criteria

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

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

Codes

Procedures challenged in this policy

U19.4 Exercise electrocardiography

Relevant diagnoses for this policy

Not available

Diagnoses for which the above procedures are permitted

Cancer diagnoses are a global exclusion

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN LEFT(Primary_Spell_Procedure,4) LIKE '%U194%'
AND ( Any_Spell_Diagnosis LIKE '%I20[189]%'
OR Any_Spell_Diagnosis LIKE '%I24[08]%'
OR Any_Spell_Diagnosis LIKE '%I25[012345689]%')
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
BETWEEN 19 AND 120
then '2L_ExerciseECG'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Outpatient

```
WHEN Any_Appointment_Procedure LIKE '%U194%'
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2L_ExerciseECG'
```

Exclusions

```
WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
```

```
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: October 2022 and January 2025
Review date: No plans for further reviews unless evidence based intervention programme issue updates to policy
JCIA: Yes, completed

Preoperative electrocardiogram (ECG) (National Evidence Based Intervention)

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

This guidance applies to adults aged 19 years and over.

In the UK, most patients are seen in preoperative assessment clinics within 12 weeks of elective surgery, where a structured history and examination is performed by a nurse. Relevant preoperative investigations may also be taken according to locally developed protocols.

Routine preoperative investigations are expensive, labour intensive, and of questionable value unless shown to affect quality of care or clinical outcomes. Tests which have not been shown to change outcomes or influence perioperative management may cause anxiety for patients, delays in treatment due to results of uncertain relevance, and referral for further investigations or treatment. In addition, some investigations can be associated with increased patient morbidity. A more structured approach is therefore required.

In general, patients who are otherwise healthy or having relatively non-invasive surgery may require few, if any, pre-operative tests. NICE recommend that ECGs should not be routinely offered before low risk, non-cardiac elective surgery. Low risk surgery includes minor or intermediate procedures, such as excision of skin lesions, abscess drainage, knee arthroscopy or hernia repair.

However, some patient groups should have ECG pre-operatively. This can include patients who have a history of cardiovascular disease (such as heart attack, stroke, heart failure, peripheral arterial disease), palpitations or comorbidities that would predispose them to cardiovascular disease such as diabetes or renal disease. In addition, patients who are assessed as higher risk, and therefore scored as an ASA physical classification status of 3 or more (patient has severe systemic disease), with no ECG in the preceding 12 months, would benefit from further investigation.

Finally, an ECG would be prudent in patients over the age of 65 attending for major surgery.

Criteria

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.

Evidence based intervention national coding script

There is no coding for this intervention

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Completed, Yes

Preoperative chest x-ray (National Evidence Based Intervention)

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

This guidance applies to adults aged 19 years and over.

Please note this guidance is a recommendation and it should be used in the context of the overall care pathway and when all alternative interventions that may be available locally have been undertaken.

Criteria

Pre-operative chest radiographs should not be routinely performed in adult elective surgical patients. They may be appropriate for patients who have not had a CT chest and meet the following criteria:

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

Evidence based intervention national coding script

No coding is available for the procedure or indications.

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Ears, nose and throat (ENT)

Congenital ear deformity correction surgery including pinnaplasty

Congenital ear deformity surgery or pinnaplasty surgery is a cosmetic procedure normally performed on a child to correct the absence of a helix formation in one or both ears.

Criteria

Congenital ear deformity correction surgery is not routinely commissioned.

This policy does not apply to the hearing loss associated with microtia and congenital aural atresia.

Codes

Procedures challenged in this policy
D03.1, D03.2, D03.3, D03.4, D03.8, D03.9

Relevant diagnoses for this policy
Q17.5 Prominent ear including bat ear
Q17.8 Other specified congenital malformations of ear
Q17.9 Congenital malformation of ear, unspecified
0 to 18-year-olds only.

Diagnoses for which the above procedures are permitted
No relevant codes listed

Date approved: April 2018 and February 2021
Review date: February 2024
JCIA: Yes, completed

Continuous positive airway pressure for the treatment of obstructive sleep apnoea or hypopnoea syndrome

Continuous positive airway pressure (CPAP) for the treatment of obstructive sleep apnoea or hypopnoea syndrome (OSAHS) is not routinely funded and is subject to this restricted policy.

CPAP is a treatment for obstructive sleep apnoea. It uses air pressure generated by a machine, delivered through a tube into the mask that fits over the nose or mouth.

Criteria

CPAP is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

CPAP devices

Funding for treatment including the issuing of a single CPAP device will only be provided for patients meeting the criteria set out below.

The patient has been diagnosed with:

1. OSAHs (including mild, moderate or severe OSAHs) and either:
    - conservative management has been fully engaged in and complied with for period of at least 6 months by the patient and has not proven successful in reducing the impact of OSAHS
    - conservative management is inappropriate before commencing treatment (note: would not expect conservative management to be inappropriate in many cases and where conservative management is inappropriate patients will be expected to fully engage with conservative management once treatment has commenced

2. And the patient is experiencing significant functional impairment which is likely to be corrected or significantly improved by treatment. Significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing
3. And the patient has signed an agreement to appropriately insure and maintain the CPAP device and return it to the service upon cessation of treatment or reimburse the full replacement cost of the device to the NHS

Treatment cessation

Patients will have been considered to have failed to comply with treatment with a CPAP if over a 6-month period and the patient has failed to use the device on average for:

- 70% of days
- 4 hours per night when used

Patients who fail to comply with these treatment requirements, must cease treatment and return the device to the provider for reimbursement and reissue to another patient where appropriate or reimburse the NHS the full replacement cost of the device.

Patients who do not receive adequate benefit from the treatment (for example there is little or no improvement in their apnoea and hypopnoea index or Epworth sleepiness scale scores should also be assessed to establish whether it is appropriate for their treatment to continue.

Codes

Procedures challenged in this policy
E85.6 continuous positive airway pressure

Diagnoses challenged in this policy
ICD10 codes: G473

Date approved: April 2018, November 2018 significant functional impairment definition amended only and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Grommets including in the treatment of glue ear all ages (National Evidence Based Intervention in Children under 12 locally adapted)

The medical term for glue ear is otitis media with effusion (OME). Grommets can help drain fluid out of the middle ear.

Glue ear is a common childhood condition in which the middle ear becomes filled with fluid. It can sometimes present in adults.

The NHS Cornwall and Isles of Scilly Integrated Care Board policy identifies when grommets will be commissioned in both children and adults and in cases where there is or is not present OME.

Criteria

Children under 12 with OME criteria-based access and prior approval required (RCHT and UHP) National evidence based intervention

Referral of children with glue ear should be made to the paediatric audiology service which will undertake a diagnostic hearing test and then complete a further period of watchful waiting of 12 weeks before referral to ENT services for treatment.

Insertion of grommets in children with OME is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met.

- OME persists after a period of at least 6 weeks watchful waiting in primary are to the date of referral
- Hearing level in the better ear of 25 to 30dbHL or worse averaged at 0.5, 1, 2, and 4kHz
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25 to 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, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance
- Treatment for OME will be considered in children where grommets will facilitate investigation for congenital sensorineural hearing loss who also have glue ear. This is to support auditory brain response (ABR) hearing test under general anaesthetic in line with national hearing screening policies. It may also be considered to facilitate medical and surgical treatments (cochlear implants) for congenital deafness in children

It is good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

Codes

Procedures challenged in this policy

Dominant procedure code starts D151 and primary diagnosis code is 1 of:

- H652 Chronic serious otitis media
- H653 Chronic mucoid otitis media
- H661 Chronic tubotympanic suppurative otitis media
- H662 Chronic atticoantral suppurative otitis media
- H663 Other chronic suppurative otitis media
- H664 Suppurative otitis media, unspecified
- H669 Otitis media, unspecified, this includes acute and chronic

Dominant procedure code starts D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Relevant diagnoses for this policy

Dominant procedure code starts: D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Diagnoses for which the above procedures are permitted

Q90.0,1,2,9 Down syndrome
Q35.1,3,5,7,9 Cleft palate

Children over 12 with OME

The criteria for grommets in children over the age of 12 with OME is the same as under 12 years (above). However, prior approval is not required for this procedure.

Children of all ages without OME

Insertion of grommets in children is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met.

- The child has acute otitis media when there have been at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year.

Adults with OME

Insertion of grommets in adults is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- middle ear effusion causing measured conductive hearing loss of 30dbHL or worse averaged at 0.5, 1, 2 and 4kHz, persisting for at least 6 months and resistant to medical treatments

    - in addition, the patient must have significant functional impairment the possible alternative treatment option of a hearing aid should be discussed, at the discretion of the clinician
- severe retraction of the tympanic membrane if the clinician feels that this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma

Insertion of grommets is not routinely commissioned for pain in the ears (for example, on flying), for Eustachian tube dysfunction (in the absence of other qualifying symptoms or signs (for example, middle ear effusion) or for the treatment of Meniere's disease.

Codes

Procedures challenged in this policy

Dominant procedure code starts D151 and primary diagnosis code is 1 of:

- H652 Chronic serious otitis media
- H653 Chronic mucoid otitis media
- H661 Chronic tubotympanic suppurative otitis media
- H662 Chronic atticoantral suppurative otitis media
- H663 Other chronic suppurative otitis media
- H664 Suppurative otitis media, unspecified
- H669 Otitis media, unspecified, this includes acute and chronic

Dominant procedure code starts D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Relevant diagnoses for this policy

Dominant procedure code starts: D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Diagnoses for which the above procedures are permitted

Q90.0,1,2,9 Down syndrome
Q35.1,3,5,7,9 Cleft palate

Date approved: November 2016, February 2019, November 2019 and March 2025.
Review date: No plans for further reviews unless evidence based intervention programme issue updates to policy
JCIA: Yes, completed.

Laryngeal or voice box surgery

Laryngeal surgery has the primary aim of improving or restoring the quality of a person's voice. It does not include surgery where the primary aim is to treat other symptoms and disease of the larynx, for example, malignancy.

Criteria

Laryngeal surgery is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

The patient has significant dysphonia, defined as:

1. Their voice has unexpectedly changed (in terms of quality, pitch, loudness or vocal effort)
2. The voice change has significantly limited their ability to communicate with others
3. The patient is experiencing significant functional impairment* which is likely to be corrected or significantly improved by surgery. *Note: significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing
4. The patient has completed a course of voice therapy via an NHS provided speech and language therapist
5. The dysphonia is due to organic pathology for which surgical intervention will be effective

Note voice box surgery is not commissioned by NHS Cornwall and Isle of Scilly Integrated Care Board as part of the treatment for patients undertaking the gender dysphonia pathway.

Codes

Procedures challenged in this policy
E314, E315

Relevant diagnoses for this policy
R49.0

Procedures for which the above procedures are permitted
If in the same attendance:
E298, E299, E301, E302, E303, E308, E309, E313, E314, E315, E318, E319, E333, E334, E338, E339, E341, E343, E348, E349, E352, E353, E354, E355, E358, E359, E361, E368, E369, E388, E389

Diagnoses for which the above procedures are permitted
A155, A164, C320, C321, C322, C323, C328, C329, D020, D141, D380, J380, J381, J382, J383, J384, J385, J386, J387, Q310, Q311, Q312, Q313, Q315, Q318, Q319, S110, S170, T173, T270, T271, T274, T275

Date approved: April 2018, November 2018 – significant functional impairment definition amended only and February 2021
Review date: February 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Removal of adenoids (adenoidectomy) (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Adenoids are lymphatic tissue that reside in the postnasal space and arise from the roof of the nasopharynx. Adenoids are only usually present in children and tend to grow from birth, reaching the largest size when a child is between 3 and 5 years of age, before slowly shrinking away by adulthood. When the adenoids are enlarged or inflamed, they may contribute to glue ear (otitis media with effusion), which can affect hearing. They can also cause symptoms of nasal blockage, mouth breathing, obstructive sleep and other upper respiratory tract symptoms (e.g. persistent runny nose).

Criteria

Removal of adenoids in children with glue ear

NICE guidance recommends that adjuvant adenoidectomy in people under 18 years of age should not be performed for the treatment of glue ear in the absence of persistent and/or frequent upper respiratory tract symptoms.

When children have persistent glue ear that affects hearing, one option for treatment of the hearing loss is with grommet insertions (ventilation tubes) and guidance for this intervention is already set out in the NHS Cornwall and Isles of Scilly Integrated Care Board grommets policy. In some circumstances, when a child is undergoing surgery to insert grommets, the adenoids may also be partially resected at the same time. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.

This guidance applies to children aged under 12 years of age.

Adjuvant adenoidectomy for the treatment of glue ear can be considered if:

- The child is undergoing grommet surgery for treatment of hearing loss due to glue ear
- The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated glue ear
- The benefits and risks of adenoidectomy has been discussed with the child and their family or carers, and a shared decision has been made on whether to have the procedure. Including that there is a risk of haemorrhage, and velopharyngeal insufficiency

This guidance only refers to children undergoing adenoidectomy for the treatment of glue ear and should not be applied to other conditions where adenoidectomy should continue to be routinely funded:

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

- For persistent nasal obstruction in children and adults with adenoidal hypertrophy
- In preparation for speech surgery in conjunction with the cleft surgery team

Removal of adenoids in children or adults for other conditions

Adenoidectomy will be funded in either a child or an adult:

- as part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (for example as part of adenotonsillectomy)
- as part of the treatment of chronic rhinosinusitis in children
- for persistent nasal obstruction in children and adults with adenoidal hypertrophy
- for biopsy purposes in adults or children for the suspicion of cancer and where the adenoids are asymmetrical and/or suspicious lesions are present
- in preparation for speech surgery in conjunction with the cleft surgery team

Codes

Procedures challenged in this policy

E20.1 Total adenoidectomy
E20.4 Suction diathermy adenoidectomy
E20.8 Other specified operations on adenoid
E20.9 Unspecified operations on adenoid
With D15.1 Myringotomy with insertion of ventilation tube through tympanic membrane

Relevant diagnoses for this policy

H65.2 Chronic serous otitis media
H65.3 Chronic mucoid otitis media
H65.4 Other chronic nonsuppurative otitis media
H65.9 Unspecified nonsuppurative otitis media
H66.1 Chronic tubotympanic suppurative otitis media
H66.3 Other chronic suppurative otitis media
H66.4 Suppurative otitis media, unspecified
H66.9 Otitis media, unspecified
H68.1 Obstruction of Eustachian tube
H69.8 Other specified disorders of Eustachian tube
H69.9 Unspecified Eustachian tube disorder

Diagnoses for which the above procedures are permitted

G47.3 Sleep apnoea
J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinusitis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
Q35.1 Cleft hard palate
Q35.3 Cleft soft palate

Q35.5 Cleft hard palate with cleft soft palate
Q35.7 Cleft uvula
Q35.9 Cleft palate, unspecified
Q37.0 Cleft hard palate with bilateral cleft lip
Q37.1 Cleft hard palate with unilateral cleft lip
Q37.2 Cleft soft palate with bilateral cleft lip
Q37.3 Cleft soft palate with unilateral cleft lip
Q37.4 Cleft hard and soft palate with bilateral cleft lip
Q37.5 Cleft hard and soft palate with unilateral cleft lip
Q37.8 Unspecified cleft palate with bilateral cleft lip
Q37.9 Unspecified cleft palate with unilateral cleft lip
Cancer diagnoses are a global exclusion

Evidence based intervention national coding script

```
WHEN Any_Spell_Procedure like '%E20[1489]%'
AND Any_Spell_Procedure like '%D151%'
AND Primary_Spell_Diagnosis LIKE 'H65[2349]%'
AND NOT ( Any_Spell_Diagnosis LIKE '%G473%'
OR Any_Spell_Diagnosis LIKE '%J32[0123489]%'
OR Any_Spell_Diagnosis LIKE '%J352%'
OR Any_Spell_Diagnosis LIKE '%Q35[13579]%'
OR Any_Spell_Diagnosis LIKE '%Q37[01234589]%')
-- Age 0 to 11
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)<=1
1
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2D_adenoid_removal'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: April 2018, July 2021 and January 2025
Review date: No plans for further reviews unless evidence based intervention programme issue updates to policy
JCIA: Yes, completed

Removal of ear wax in secondary care

Ear wax may be wet or dry and is a normal physiological substance that protects the ear canal. It has several functions including aiding removal of keratin from the ear canal by naturally migrating out of the ear from movement of the jaw. It cleans, lubricates, and protects the lining of the ear canal, trapping dirt and repelling water.

In the vast majority of people, persistent use of ear wax softeners will be sufficient enough to resolve any issues they experience with ear wax. Full details on the use of ear wax softeners can be found in the NHS Cornwall and Isles of Scilly Integrated Care Board patient information leaflet.

Although wax can obscure the view of the tympanic membrane, it does not cause permanent hearing impairment.

This policy outlines the criteria for when referral to secondary care for ear wax removal can be made.

Criteria

Removal of ear wax in secondary care is only commissioned in certain circumstances – the GP will need to provide documented evidence that the patient meets the criteria outlined below:

Ear wax remains troublesome following use of the ear wax softener standardised regime and:

- there is a clearly documented active ear infection
- or active ear disease including eczema or dermatitis of the ear canal or external ear
- or a known tympanic perforation
- or there is a past history ear surgery for example stapedotomy, myringoplasty or mastoid surgery
- or there is a healed tympanic membrane perforation where an aural care or ENT specialist has documented the advice to avoid treatment outside of secondary care; for example, the tympanic membrane is very thin and at risk of perforation from irrigation

Codes

Procedures challenged in this policy

OPCS Code: D07.1,
D07.1 - Irrigation of external auditory canal for removal of wax
D07.2 - Removal of wax from external auditory canal NEC

Relevant diagnoses for this policy

ICD10 Code: None

Diagnoses for which the above procedures are permitted

ICD10 code:
H61.2 with 1 of the following:
H60.5 eczema or dermatitis of external ear.
Tympanic membrane perforation - H72.0, H72.1, H72.2, H72.8, H72.9

Active ear infection:
- middle ear = H66.9
- external ear = H60.3
- inner ear (labyrinthitis) = H83.0

H66.0 - Acute suppurative otitis media
H66.1 - Chronic tubotympanic suppurative otitis media
H66.2 - Chronic atticoantral suppurative otitis media
H66.3 - Other chronic suppurative otitis media
H66.4 - Suppurative otitis media, unspecified
H66.9 - Otitis media, unspecified
H65.0 - Acute serous otitis media
H65.1 - Other acute nonsuppurative otitis media
H65.2 - Chronic serous otitis media
H65.3 - Chronic mucoid otitis media
H65.4 - Other chronic nonsuppurative otitis media
H65.9 - Nonsuppurative otitis media, unspecified
H60.8 - Other otitis externa
H60.9 - Otitis externa, unspecified

The codes below will be linked to another ICD-10 code to explain the other disease it's linked to:
H62.0 - Otitis externa in bacterial diseases classified elsewhere
H62.1 - Otitis externa in viral diseases classified elsewhere
H62.2 - Otitis externa in mycoses
H62.3 - Otitis externa in other infectious and parasitic diseases classified elsewhere
H62.4 - Otitis externa in other diseases classified elsewhere
H67.0 - Otitis media in bacterial diseases classified elsewhere
H67.1 - Otitis media in viral diseases classified elsewhere
H67.8 - Otitis media in other diseases classified elsewhere

Date approved: September 2019, March 2021 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Replacement hearing aid policy (under review)

NHS Cornwall and Isles of Scilly Integrated Care Board commissions several providers to fit hearing aids to people who have an aidable hearing loss following hearing assessment. This policy applies to replacement hearing aids via both any qualified provider (AQP) and non-AQP pathways.

Hearing aid providers will inform each user of the replacement aid policy that is in place in the NHS Cornwall and Isles of Scilly Integrated Care Board area and include a copy of this policy within the persons individual management plans.

Criteria

Hearing aid replacement due to failure or defectiveness within manufacturer warranty (3 years)

The hearing aid dispenser or audiologist should check the date of supply of the hearing aid to the person is within 3 years. The warranty expiry date is also printed on the housing of the hearing aid. They should check that the aid is defective or failed because of manufacturer failure as opposed to poor handling by the user.

Where these criteria are met, replacement aid(s) are provided free of charge to the user. The defective hearing aid will be returned by the provider under the manufacturer's warranty and replaced free of charge to the provider for a new or reconditioned instrument with a new 3-year warranty. NHS Cornwall and Isles of Scilly Integrated Care Board will not pay for any hearing aids meeting this criteria.

Defective hearing aid(s) should be swapped at the providers location or at the user's home (if domiciliary) for a new like for like product as initially dispensed. They should be programmed to the last stored setting for the original instrument. Where possible this is done at the time the faulty instrument is returned, otherwise a fitting appointment should be made at the soonest convenience for the hearing aid user.

Hearing aid has failed or is defective outside of the manufacturer's warranty (after 3 years)

The hearing aid dispenser or audiologist should check the date of supply of the hearing aid to the person is not within the 3-year warranty period. The warranty expiry date is also printed on the housing of the hearing aid

They should check that the aid is defective or failed as consequence of the aid as opposed to poor handling by the user.

Where these criteria are met, the replacement aid(s) tariff outlined in the provider contracts can be invoiced to NHS Cornwall and Isles of Scilly Integrated Care Board. It must be made clear on the invoice the charge is being made because of failure or defectiveness outside of manufacturers guarantee.

Defective hearing aid(s) should be swapped at the provider's location or at the user's home (if domiciliary) for a new like for like product as initially dispensed. They should be programmed to the last stored setting for the original instrument. Where possible this is done at the time the faulty instrument is returned, otherwise a fitting appointment should be made at the soonest convenience for the hearing aid user.

Hearing aid damaged or lost through patient careless or use for other than intended purpose

If the hearing aid(s) are lost or damaged beyond repair and this is due to neglect or carelessness of the user or use for other than intended purpose, NHS Cornwall and Isles of Scilly Integrated Care Board will not pay for any replacement. In these circumstances the cost is chargeable by the provider to the hearing aid user. They should only be charged the NHS replacement tariff for the replacement hearing aid. Hearing aid users should be made explicitly aware of this policy at the initial fitting stage of the pathway.

Exclusions

- People under 18 years old
- User has a documented diagnosis of dementia or learning disability
- Aid is lost or damaged through road traffic collision with police incident number
- Aid is lost through theft with police incident number unless patient or carer is happy to claim back through insurance
- User is in receipt of guaranteed Pension Credit (proof is required)
- User is in receipt of Universal Credit (proof is required) which replaces the following benefits:
    - Child Tax Credit
    - Housing Benefit
    - Income Support
    - income-based Jobseekers' Allowance
    - income-related Employment and Support Allowance
    - Working Tax Credit
- Has a valid tax exception certificate on presentation of certificate
- Has a valid HC2 or HC3 certificate on presentation of certificate
- Has documented evidence of dual sensory loss (registered partially sighted or registered blind)

In the case of these exclusions, the provider will invoice NHS Cornwall and Isles of Scilly Integrated Care Board the replacement aid tariff outlined in their contract and in line with process for Hearing aid has failed or is defective outside of the manufacturer's warranty (after 3 years). The invoice should clearly illustrate that the policy exclusion criteria has been met. Evidence must be made available within the users records as this policy will be subject to audit processes.

Invoice classification:

- replacement or lost aid outside of manufacturer warranty
- replacement or lost aid policy exclusions evidenced

Codes

Procedures challenged in this policy

There are ICD-10 codes for failed or defective hearing aids.

NHS Cornwall and Isles of Scilly Integrated Care Board will use invoicing data and routine audit with our providers to ensure compliance against the criteria listed above.

Diagnoses challenged in this policy
No relevant diagnosis codes

Diagnoses for which the above procedures are permitted
No relevant diagnosis codes

Date approved: March 2021, July 2021, January 2022, and April 2026
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Septorhinoplasty

Septorhinoplasty is a combination of both a septoplasty and rhinoplasty. Whilst rhinoplasty is often performed for purely cosmetic reasons, septoplasty is conducted to alleviate nasal obstruction. In some instances, it may be necessary to improve the appearance of the nose to also alleviate the nasal obstruction and this procedure is called a septorhinoplasty.

Criteria

Rhinoplasty is not routinely commissioned.

Septorhinoplasty for cosmetic reasons is not routinely commissioned.

Exceptions for commissioning are:

- where the nasal obstruction cannot be managed by medical therapy
- the nasal obstruction cannot be reasonably addressed by septoplasty and/or reduction of inferior turbinates alone

Codes

Procedures challenged in this policy
E023, E073, E024

Diagnoses challenged in this policy
There are no relevant ICD10 codes for the clinical criteria

Diagnoses for which the above procedures are permitted
There are no relevant ICD10 codes for the clinical criteria

Date approved: July 2021
Review date: July 2024 or earlier if new guidance is issued

JCIA: Yes, completed

Shave or surgical rhinophyma

Criteria

Shave or surgical rhinophyma is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate procedure codes.

Relevant diagnoses for this policy
L711

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and February 2021
Review date: February 2024 or earlier if new guidance issued
JCIA: Yes, completed

Snoring in the absence of obstructive sleep apnoea (National Evidence Based Intervention)

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in 4 adults snore, if it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of obstructive sleep apnoea (OSA) and should not be applied to the surgical treatment for people who snore and have proven OSA who many benefit from surgical intervention as part of OSA treatment.

Surgical treatments including uvulopalatopharyngoplasty (UVPP) for isolated snoring are not routinely commissioned.

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

Alternative treatments

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

- weight loss
- stopping smoking
- reducing alcohol intake
- medical treatment of nasal congestion (rhinitis)
- mouth splints (to move jaw forward when sleeping)

Criteria

Surgery for isolated snoring is not routinely commissioned.

Further guidance on surgical intervention for snoring in people with OSA is below:

- continuous positive airway pressure (CPAP) is recommended as a treatment option for adults with moderate or severe symptomatic obstructive sleep apnoea or hypopnoea syndrome (OSAHS) in accordance with NICE technology appraisal 139
- ENT surgery (including tonsillectomy) will only be considered for snoring in OSAHS to improve compliance with CPAP; or with nasal pathology such as nasal polyps or deviated septum
- in children with obstructive sleep apnoea or hypopnoea syndrome (OSAHS), tonsillectomy may be recommended as a treatment option (please review guidance)

Codes

Procedures challenged in this policy
F324, F325, F326

Relevant diagnoses for this policy
Not like: G473 and patient age is between 18 and 120

Diagnoses for which the above procedures are permitted
G473

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN ('F324','F325','F326')
AND Primary_Spell_Diagnosis like '%R065%'
AND Primary_Spell_Diagnosis not like '%G473%'
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'A_snoring'
```

Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: August 2017, February 2019, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Surgical intervention for chronic rhinosinusitis (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT and UHP)

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

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

CRS as a term encompasses a wide range of phenotypes but can broadly be divided into two main types. Chronic rhinosinusitis with Nasal Polyposis (CRSwNP) and Chronic Rhinosinusitis without Nasal Polyposis (CRSsNP). First-line treatment is with appropriate medical therapy, which should include intranasal steroids and nasal saline irrigation. In the case of CRSwNP a trial of a short course of oral steroids should also be considered.

Where first-line medical treatment has failed patients should be referred for diagnostic confirmation and they then may be considered for endoscopic sinus surgery. This involves surgery using a telescope via the nasal cavity to open the sinuses and, if present, remove nasal polyps, both improving the effectiveness of ongoing medical therapy and relieving obstruction.

The surgery is usually undertaken under general anaesthetic as a day-case procedure in otherwise healthy individuals.

This guidance applies to adults and children.

Criteria

Patients are eligible to be referred for specialist secondary care assessment in any of the following circumstances:

- a clinical diagnosis of CRS has been made (as set out in RCS or ENT-UK commissioning guidance) in primary care and patient still has moderate or severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation
- in addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5 to 10 days of oral steroids (0.5mg per kg to a max of 60 mg)
- patient has nasal symptoms with an unclear diagnosis in primary care
- any patient with concerning clinical findings as outlined within the nasal and sinus red flags guidelines should be referred urgently via ENT nasal pathway

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

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

AND

- disease-specific symptom patient reported outcome measure (for example a sino-nasal outcome test (SNOT-22) or specialist consultation confirms moderate to severe symptoms after trial of appropriate medical therapy (this should include counselling on technique and compliance as outlined in RCS and ENT-UK commissioning guidance recommended secondary care pathway)

AND

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

AND

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

OR

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

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 (for example 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 or CRS)
- treatment with topical and/or oral steroids contra-indicated.
- as part of surgical access or dissection to treat non-sinus disease (for example pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)

Codes

Procedures challenged in this policy

Y76.1 Functional endoscopic sinus surgery
Y76.2 Functional endoscopic nasal surgery
E12.1 Ligation of maxillary artery using sublabial approach
E12.2 Drainage of maxillary antrum using sublabial approach
E12.3 Irrigation of maxillary antrum using sublabial approach
E12.4 Transantral neurectomy of vidian nerve using sublabial approach
E12.8 Other specified operations on maxillary antrum using sublabial approach
E12.9 Unspecified operations on maxillary antrum using sublabial approach
E13.1 Drainage of maxillary antrum NEC
E13.2 Excision of lesion of maxillary antrum
E13.3 Intranasal antrostomy
E13.4 Biopsy of lesion of maxillary antrum (we will leave in unless we hear otherwise)
E13.5 Closure of fistula between maxillary antrum and mouth
E13.6 Puncture of maxillary antrum
E13.7 Neurectomy of vidian nerve NEC
E13.8 Other specified other operations on maxillary antrum
E13.9 Unspecified other operations on maxillary antrum
E14.1 External frontoethmoidectomy
E14.2 Intranasal ethmoidectomy
E14.3 External ethmoidectomy
E14.4 Transantral ethmoidectomy
E14.5 Bone flap to frontal sinus
E14.6 Trephine of frontal sinus
E14.7 Median drainage of frontal sinus
E14.8 Other specified operations on frontal sinus
E14.9 Unspecified operations on frontal sinus
E15.1 Drainage of sphenoid sinus
E15.2 Puncture of sphenoid sinus
E15.3 Repair of sphenoidal sinus
E15.4 Excision of lesion of sphenoid sinus
E15.8 Other specified operations on sphenoid sinus

E15.9 Unspecified operations on sphenoid sinus
E16.1 Frontal sinus osteoplasty
E16.2 Drainage of frontal sinus NEC
E16.8 Other specified other operations on frontal sinus
E16.9 Unspecified other operations on frontal sinus
E17.1 Excision of nasal sinus NEC
E17.2 Excision of lesion of nasal sinus NEC
E17.3 Biopsy of lesion of nasal sinus NEC
E17.4 Lateral rhinotomy into nasal sinus NEC
E17.8 Other specified operations on unspecified nasal sinus
E17.9 Unspecified operations on unspecified nasal sinus
E08.1 Polypectomy of internal nose

Relevant diagnoses for this policy

J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinusitis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
102 Academy of Medical Royal Colleges EBI list 2 guidance
J33.0 Polyp of nasal cavity
J33.1 Polypoid sinus degeneration
J33.8 Other polyp of sinus
J33.9 Nasal polyp, unspecified

Diagnoses for which the above procedures are permitted

Cancer diagnoses are a global exclusion

Exclude any patients admitted as a non-elective admission

Evidence based intervention national coding script

```
WHEN (( Any_Spell_Procedure LIKE '%E081%'
OR Any_Spell_Procedure LIKE '%E1[257][123489]%'
OR Any_Spell_Procedure LIKE '%E1[34][1-9]%'
OR Any_Spell_Procedure LIKE '%E14[1-9]%'
OR Any_Spell_Procedure LIKE '%E16[1289]%'
OR Any_Spell_Procedure LIKE '%E641%')
AND Any_Spell_Procedure LIKE '%Y76[12]%'
)
AND ( Primary_Spell_Diagnosis LIKE '%J310%'
OR Primary_Spell_Diagnosis like'J32[0123489]%'
OR Primary_Spell_Diagnosis like'J33[0189]%'
)
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
```

THEN '2C_sinus_surgery'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: July 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Tonsillectomy for recurrent tonsillitis (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

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

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

Criteria

The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, supported by ENT UK commissioning guidance and NICE:

- Sore throats are due to acute tonsillitis

AND

- The risks of tonsillectomy vs active monitoring have been discussed with the adult or child and their family or carers, and a shared decision has been made on whether to have the procedure. This discussion should be documented

AND

- The episodes are disabling and prevent normal functioning

AND

- 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

The impact of recurrent tonsillitis on a patient's quality of life and ability to work or attend education should be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe or uncontrolled symptoms, or if complications (e.g. quinsy) have developed.

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances, tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:

- 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

Please note this guidance only relates to patients with recurrent tonsillitis. This guidance should not be applied to other conditions where tonsillectomy should continue to be funded, these include:

- Obstructive sleep apnoea / sleep disordered breathing in children
- Suspected cancer (e.g. asymmetry of tonsils)
- Recurrent quinsy (abscess next to tonsil)
- Emergency presentations (e.g. treatment of parapharyngeal abscess)
- Tonsillar enlargement causing acute upper airways obstruction

Tonsillectomy for tonsil stones, tonsilloliths or halitosis is not routinely commissioned.

Codes

Procedures challenged in this policy

F341, F342, F343, F344, F345, F346, F347, F348, F349, F361

Relevant diagnoses for this policy

There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted

C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48,

C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99, G47, J36

Evidence based intervention national coding script

WHEN Primary_Spell_Procedure IN
('F341','F342','F343','F344','F345','F346','F347','F348','F349','F361')
AND (Any_Spell_Diagnosis like '%J030%'
OR Any_Spell_Diagnosis like '%J038%'
OR Any_Spell_Diagnosis like '%J039%'
OR Any_Spell_Diagnosis like '%J350%')
AND not (Any_Spell_Diagnosis like '%C[0-8][0-9]%'
OR Any_Spell_Diagnosis like '%C9[0-7]%')
AND not (Any_Spell_Diagnosis like '%G473%'
OR Any_Spell_Diagnosis like '%J36%'
OR Any_Spell_Diagnosis like '%J390%')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'H_tonsil'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: November 2016, February 2019, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Eye problems

Cataract surgery (National Evidence Based Intervention)

Cataract referrals should not be accepted unless a formally documented shared decision-making process has been performed by their referring primary care optometrist with the patient (and their family members or carers, as appropriate) as part of a referral. This includes but is not limited to:

- How the cataract affects the person's vision and quality of life
- Whether one or both eyes are affected
- What cataract surgery involves, including possible risks and benefits
- How the person's quality of life may be affected if they choose not to have cataract surgery
- Whether the person wants to have cataract surgery

Cataract surgery represents 6% of all surgery performed in the UK (over 400,000 procedures a year) with a pre-pandemic predicted growth of 25% in the next 10 years. Patients who are referred need to be reasonable candidates for surgery and have a desire to undergo the operative procedure. Current referral processes often refer patients who, when they have had an informed discussion, do not wish to undergo surgery, which has produced huge variability in conversion rates (from direct cataract referral to undergoing surgery) nationwide, with rates ranging from 40-92%. The reason for poor conversion rates can be due to many factors including commissioning of services, incomplete training, and lack of engagement of primary care staff on shared decision making. The ideal conversion rate to cataract surgery is not agreed, but rates of more than 80% can be achieved by referral guidelines and efficient forms, as recommended by the Royal College of Ophthalmologists.

Shared decision-making tools have been proven to improve conversion rates and lead to better patient experience and clinical outcomes. Their use is endorsed by the Department of Health policy 'Equity and Excellence: liberating the NHS' highlighting the importance of the patient's opinion and choice with regards to their care. This guidance uses evidence to propose that all referral pathways for cataract surgery should include shared decision-making tools.

Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability that patients may experience because of cataracts. The criteria set out below attempt to explicitly take that into account.

This policy also recognises the increasing body of evidence that second eye surgery does indeed benefit patients.

Criteria

This policy applies to both first and second eyes with a best corrected visual acuity of 6/12 or worse in the affected eye being used as the threshold for cataract surgery.

A best corrected visual acuity of better than 6/12 in the affected eye, will not normally be funded.

Cataract surgery is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- a best corrected visual acuity of 6/12 or worse in the affected eye (please ensure best corrected visual acuity information included with referral)
- have difficulty in carrying out their employment duties due to a need for good acuity
- with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions
- who need to drive at night who experience significant glare due to cataracts which affects driving
- have difficulty with reading, or recognising faces, due to lens opacities
- with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field
- with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye
- with glaucoma who require cataract surgery to control intra ocular pressure
- with diabetes who require clear views of their retina to look for retinopathy
- with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (for example, treatment with anti-VEGFs)

Please note the reasons why the patient's vision and lifestyle are adversely affected by cataracts and the likely benefits the patient would gain from having surgery, or any other exceptional circumstances, must be clearly documented in the clinical records.

Codes

Procedures challenged in this policy

C711, C712, C713, C714, C715, C716, C717, C718, C719, C72, C720, C721, C722, C723, C724, C725, C726, C727, C728, C729, C741, C742, C743, C744, C745, C746, C747, C748, C749, C75, C750, C751, C752, C753, C754, C755, C756, C757, C758, C759, C73, C730, C731, C732, C733, C734, C735, C736, C737, C738, C739

Relevant diagnoses for this policy

H25, H250, H26, H260, H280, H281, H282, Q120

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('C751', 'C712','C754', 'C711','C713',
'C718', 'C719')
AND ( Any_Spell_Diagnosis LIKE '%H25[01289]%'
OR Any_Spell_Diagnosis LIKE '%H26[012389]%'
OR Any_Spell_Diagnosis LIKE '%H28[012]%'
OR Any_Spell_Diagnosis LIKE '%Q120%'
)
-- Only Elective Activity
```

AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date) between 18 AND 120
THEN '3C_Cataract_Surgery'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: August 2017, March 2018 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Chalazia (Meibomian cysts) removal (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

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

Criteria

Incision and curettage (or triamcinolone injection for suitable candidates) of chalazia should only be undertaken if at least one of the following criteria have been met:

- Has been present for more than 6 months and has been managed conservatively with warm compresses, lid cleaning and massage for 4 weeks
- Interferes significantly with vision
- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection that has required medical attention twice or more within a six-month time frame
- Is a source of infection causing an abscess which requires drainage

Indications for direct referral

- Diagnostic uncertainty: Suspected eyelid malignancy should be referred for specialist opinion (please refer to the provider directory of services for guidance as to which clinics these patients should be investigated).

Once it is established that a lesion is a simple meibomian cyst and that it is not malignant its removal will not normally be funded by the NHS though a clinician may request exceptional funding. Clinicians referring on this basis should make the patient explicitly aware that removal of the lesion may not occur.

Exceptions

- Children under the age of 10: Meibomian cysts may cause astigmatism, and visual development could potentially be at risk up until the age of 10. In these circumstances the removal of the cyst may be undertaken as an exception to the decision not the fund the procedure.

Note surgery to improve appearance alone is not commissioned.

Codes

Procedures challenged in this policy
Code starts C121, C122, C124, C191, C198

Relevant diagnoses for this policy
And primary diagnosis code is like H001

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN
('C121','C122','C123','C124','C125','C126','C128','C129','C191','C198','C199')
AND Primary_Spell_Diagnosis IN ('H000','H001')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'K_chalazia'
```

Exclusions

```
 WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
```

-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: April 2018, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Laser surgery for short sight (myopia)

Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. However, there are alternative methods of correction such as spectacles and contact lenses.

Criteria

Laser surgery for correction of short sight is not routinely commissioned.

Codes

Procedures challenged in this policy
C442, C444, C445, C461

Relevant diagnoses for this policy
The code for short sightedness (high myopia) is H521.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.
Date approved: November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Multifocal intraocular lenses in treatment of adults with cataracts

Criteria

Multifocal intraocular lenses in treatment of adults with cataracts is not routinely commissioned.

Current evidence indicates that compared with standard treatment using monocular lenses, the balance of costs, adverse effects and benefits does not support commissioning for adults with cataracts.

Requests to fund multi-focal intraocular lenses for children with rare cataract conditions will be considered on an individual patient basis.

Codes

Procedures challenged in this policy
C751, C754, C758

Relevant diagnoses for this policy
H250, H251, H252, H258, H259, H260, H261, H262, H263, H264, H268, H269, H280, H281, H282, Q120

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and September 2022
Review date: September 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Optical coherence tomography (OCT) use in diabetic retinopathy referral (National Evidence Based Intervention)

Diabetic macular oedema (DMO) is the leading cause of blindness in young adults in developed countries. The best way of preventing visual loss in patients with diabetes is early detection and treatment. Every diabetic person in the UK is required to attend (at minimum) an annual Diabetic Eye Screening (DES) where a 2D colour fundus (retina) image is taken. DES services are commonly held in the community or primary care with agreed criteria for referral to HES. Referrals to HES are made if there is a grade of R2 (pre-proliferative diabetic retinopathy) or R3 (proliferative retinopathy) and/or M1 (diabetic macular oedema/DMO) on the 2D colour fundus image. However, in DMO, leaked fluid builds up at the macula (the central part of the retina) causing swelling/elevation which is difficult to detect on a 2D image. OCT is a non-invasive imaging tool, using light waves to take high resolution cross-sectional 3D images of the retina. It allows accurate detection of DMO and quantification of the degree of oedema through the measure of the central retinal thickness (CRT).

Thresholds for treatment are based on OCT measures of CRT. NICE recommends active treatment of DMO with licensed intravitreal injections in eyes with CRT of 400 µm or more. Individuals with non-central DMO or CRT <400µm may also be suitable for macular laser treatment. As retinal thickness is essential to make a clinical decision on treatment but cannot be accurately judged with 2D colour fundus image, an OCT is required to decide on treatment.

Current protocols in DES are significantly variable by geography with regards to OCT use. NHS Scotland introduced the inclusion of OCT surveillance in DES in January 2021. However, these changes have not been adopted in England at present.

Therefore, the use of OCT in diabetic maculopathy referral refinement pathways would reduce unnecessary referrals to HES.

Criteria

This guidance applies to those 18 years and over.

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

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

- Diabetic eye screening (DES)

OR

- Local referral refinement

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

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

Evidence based intervention national coding script

Admitted Patient Care

WHEN LEFT(Primary_Spell_Procedure,4) IN ('C873', 'C911')

```
AND (Any_Spell_Diagnosis LIKE '%H36[08]%' AND
( Any_Spell_Diagnosis LIKE '%E103%'
OR Any_Spell_Diagnosis LIKE '%E113%'
OR Any_Spell_Diagnosis LIKE '%E123%'
OR Any_Spell_Diagnosis LIKE '%E133%'
OR Any_Spell_Diagnosis LIKE '%E143%'
OR Any_Spell_Diagnosis LIKE '%O24[012349]%'))
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3B_OCT_in_Diabetic_Retinopathy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
Outpatient

WHEN (Any_Appointment_Procedure LIKE '%C873%'
OR Any_Appointment_Procedure LIKE '%C911%')
AND (Any_Appointment_Diagnosis LIKE '%H36[08]%'
AND
( Any_Appointment_Diagnosis LIKE '%E103%'
OR Any_Appointment_Diagnosis LIKE '%E113%'
OR Any_Appointment_Diagnosis LIKE '%E123%'
OR Any_Appointment_Diagnosis LIKE '%E133%'
OR Any_Appointment_Diagnosis LIKE '%E143%'
OR Any_Appointment_Diagnosis LIKE '%O24[012349]%'
)
)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3B_OCT_in_Diabetic_Retinopathy'

Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
```

```
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, Completed

Raised intraocular pressure

The policy has been developed in line with NICE guideline NG81, glaucoma: diagnosis and management, November 2017.

Criteria

Important note:

- If a patient's IOP is measured by a community optometrist at 35 mmHg or over with symptoms of primary angle closure the patient should be referred as an emergency to the hospital eye services (HES)
- If a patient's IOP is measured by a community optometrist at 35 mmHg or over with no symptoms then an urgent referral to the HES should be carried out

All patients with one or more of the following detected during GOS or private sight test should be referred to the HES:

- Suspect visual field
- Suspicious optic nerve head
- Suspicious anterior chamber angle found during GOS or private sight test

Referral of patients with raised ocular pressure following a repeat IOP reading via slit lamp GAT and full threshold/suprathreshold perimetry to specialist hospital services should be made only when:

- Intraocular pressure during a repeat IOP measurement is 24-32mmHg

Codes

Procedures challenged in this policy

No appropriate codes, this is a diagnostic.

Relevant diagnoses for this policy

There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and September 2022
Review date: September 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Surgical correction of strabismus or amblyopia in adults

Strabismus (including Estopropria, Exotropia, Hypertropia or Hypotropia) “Strabismus, or squint means a misalignment of the two eyes. It may arise for a variety of reasons and may be present from birth or arise at any time in life. If strabismus arises after the visual system matures (around the age of 8), strabismus usually results in diplopia (double vision). If it arises at an earlier age, the brain adapts by suppressing the image from the squinting eye, so that diplopia is no longer a problem, but this adaptation comes at the price of loss of stereopsis (detailed depth perception) and sometimes at the price of reduced visual acuity in one eye (amblyopia or lazy eye).

Strabismus and amblyopia are common, and the treatment of these conditions is covered in the specialty training of ophthalmologists. Many general ophthalmologists continue to manage these conditions including surgery for strabismus. Strabismus does not always require surgery. Correction of a hyperopic refractive error with spectacles or contact lenses may sometimes allow the eyes to straighten completely or to a cosmetically satisfactory degree. Weak convergence may respond to convergence exercises. Some people may be quite untroubled by a squint which others would regard as intolerable. Surgery for strabismus varies from procedures which are technically straightforward (e.g., recession or resection of the horizontal rectus muscles for simple convergent or divergent squint) to much more complex adjustments, perhaps involving several muscles, or muscles that have had previous surgery. Most surgery takes place under general anaesthesia” (Royal College of Ophthalmologists, 2016).

Surgery for cosmetic concern

In addition, the Royal College states: “Surgery for strabismus is most commonly undertaken to improve the appearance of the eyes or to eliminate diplopia but is sometimes also undertaken to improve a restricted range of eye movement or to eliminate an abnormal head posture which has been adopted to avoid diplopia. A squint that is obvious to others can be psychologically distressing and is rightly regarded as a disfiguring condition for which treatment should be offered if the patient wishes it. It should not therefore be classified as a low priority treatment for funding” (Royal College of Ophthalmologists, 2016).

Whilst noting this view and recognising the impact of cosmetic concerns, the NHS Cornwall and Isles of Scilly Integrated Care Board does not routinely commission surgeries or treatments for other cosmetic concerns.

Criteria

Surgical correction of strabismus or amblyopia in adults is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

The patient is suffering from strabismus which is:

1. Causing intractable significant diplopia, as evidenced in either the GP's referral letter or Consultant's clinic letter

AND

2. All appropriate conservative methods have been exhausted and have failed to resolve the diplopia (note – patients suffering from intractable diplopia are considered to be suffering from significant functional impairment), as evidenced in either the GP's referral letter or Consultant's clinic letter

Patients who are concerned with their cosmetic appearance due to strabismus or connected conditions should be managed conservatively and advised that surgery to correct a cosmetic defect is not routinely commissioned.

Codes

Procedures challenged in this policy

C31.1 - Recession of medial rectus muscle resection of lateral rectus muscle of eye
C31.2 - Bilateral recession of medial recti muscles of eyes
C31.3 - Bilateral resection of medial recti muscles of eyes
C31.4 - Bilateral recession of lateral recti muscles of eyes
C31.5 - Bilateral resection of lateral recti muscles of eyes
C31.6 - Recession of lateral rectus muscle resection of medial rectus muscle of eye
C31.8 - Other specified combined operations on muscles of eye
C31.9 - Unspecified combined operations on muscles of eye
C32.1 - Recession of medial rectus muscle of eye NEC
C32.2 - Recession of lateral rectus muscle of eye NEC
C32.3 - Recession of superior rectus muscle of eye
C32.4 - Recession of inferior rectus muscle of eye
C32.5 - Recession of superior oblique muscle of eye
C32.6 - Recession of inferior oblique muscle of eye
C32.7 - Recession of combinations of muscles of eye
C32.8 - Other specified recession of muscle of eye
C32.9 - Unspecified recession of muscle of eye
C33.1 - Resection of medial rectus muscle of eye NEC
C33.2 - Resection of lateral rectus muscle of eye NEC
C33.3 - Resection of superior rectus muscle of eye
C33.4 - Resection of inferior rectus muscle of eye
C33.5 - Resection of superior oblique muscle of eye
C33.6 - Resection of inferior oblique muscle of eye
C33.7 - Resection of combinations of muscles of eye

C33.8 - Other specified resection of muscle of eye
C33.9 - Unspecified resection of muscle of eye
C37.4 - Repair of muscle of eye NEC
As applied to adults only

Relevant diagnoses for this policy

H500, H501, H502, H503, H504, H505, H506, H508, H509, H490, H491, H492, H493, H494, H498, H499, H530, H536 H539 codes in primary position

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and September 2022
Review date: September 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Vitreous floaters

Floaters are small shapes that some people see floating in their field of vision. They can be different shapes and sizes and may look like:

- tiny black dots
- small, shadowy dots
- larger cloud-like spots
- long, narrow strands

Patients may have many small floaters in their field of vision or just one or two larger ones. Most floaters are small and quickly move out of the field of vision. Floaters are often most noticeable when looking at a light-coloured background, such as a white or clear sky.

Floaters are small pieces of debris that float in the eye's vitreous humour. Vitreous humour is a clear, jelly-like substance that fills the space in the middle of the eyeball.

The debris casts shadows on to the retina (the light-sensitive tissue lining the back of the eye). If you have floaters, it is these you will see.

Floaters can occur as eyes change with age. In most cases, they do not cause significant problems and do not require treatment.

In rare cases, floaters may be a sign of a retinal tear or retinal detachment (where the retina starts to pull away from the blood vessels that supply it with oxygen and nutrients).

Individuals should seek medical attention immediately if they notice an increase or sudden change in the floaters, particularly if they notice white flashes and some loss of vision.

Criteria

Treatments for vitreous floaters are not routinely commissioned.
This includes:

- Vitrectomy
- Laser vitreolysis
- Eye drops and medications

Codes

Procedures challenged in this policy

OPCS Codes:
C79.1 - Vitrectomy using anterior approach
C79.2 - Vitrectomy using pars plana approach
C79.3 - Injection of vitreous substitute into vitreous body NEC
C79.4 - Injection into vitreous body NEC
C79.5 - Internal tamponade of retina using gas
C79.6 - Internal tamponade of retina using liquid
C79.7 - Removal of internal tamponade agent from vitreous body
C79.8 - Other specified operations on vitreous body
C79.9 - Unspecified operations on vitreous body

Relevant diagnoses for this policy

ICD10 Code: H43.3, Q14.0 codes in primary position.

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved: April 2018, February 2019 and September 2022
Review date: September 2025 or earlier if new guidance is issued
JCIA: Yes, completed

General surgery

Alfa pumps for the removal of ascites due to liver disease

When patients suffer from liver disease, the liver and kidneys stop working properly and fluid stops being exchanged within the cells in the way it should. This leads to ascites, an excess of fluid, which gathers in the abdomen. There is no way for this fluid to be removed from the body naturally and up to 15 litres of it can gather around patients' abdominal organs. Ascites can make patients look pregnant, as well as being painful, often causing hernias, and can take away the appetite, making patients weak and leading to malnutrition. These patients may have to make weekly trips to the hospital to have the fluid drained from their abdomen.

The alfa pump, a CE-marked device, which is implanted beneath the skin of the abdomen, works by pumping fluid from the abdomen into the bladder, where it is removed from the body naturally through urination. The fully implantable, battery powered, pump system eliminates the build-up of ascites and the onset of associated symptoms. In alcoholic cirrhotic patients once the symptoms of liver disease are reduced or eliminated, the liver has a better chance of recovery, as long as patients abstain from drinking alcohol (McCune, 2015).

Criteria

Alfa pumps for the removal of ascites is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- patient must have the ability to operate the device
- patient must have cirrhosis of the liver defined by histological and/or clinical, and/or radiological criteria
- patient must present with refractory ascites* and require periodic large volume paracentesis (large volume defined as more than 5 litres in accordance with the clinical guidance of European Association for the Study of the Liver (EASL), which recommends withdrawal of 5 litres should precipitate administration of albumin)

* Definition of refractory ascites [Moore and Aithal, Gut 2006 Oct; 55 Suppl 6: vi1-12] Ascites that cannot be mobilised or early recurrence of which (that is, after therapeutic paracentesis) cannot be satisfactorily prevented by medical therapy.

This includes 2 different subgroups:

1. Diuretic resistant ascites: ascites that are refractory to dietary sodium restriction and intensive diuretic treatment (spironolactone 400mg per day) and frusemide 160 mg per day for at least 4 weeks, and a salt restricted diet of less than 90 mmol per day (5.2g of salt) per day)
2. Diuretic intractable ascites: ascites that is refractory to therapy due to the development of diuretic induced complications that preclude the use of an effective diuretic dosage

Alfa pumps will not be commissioned on any of the following indications:

- patient has had a gastrointestinal haemorrhage over the last 7 days
- renal failure defined as serum creatinine higher than or equal to 2mg per decilitre
- severe coagulopathy defined as prothrombin time greater than 40% more than upper limit of normal (as determined locally)
- platelet count of less than 40,000 per microliter unless platelet therapy is given at the time of surgery
- clinical evidence of recurring bacterial peritonitis, defined as 2 or more episodes over the last 6 months or a single episode within the last 2 weeks

- clinical evidence of recurring urinary infections, defined as 2 or more episodes over the last 6 months or a single episode within the last 2 weeks
- clinical evidence of loculated ascites
- advanced hepatocarcinoma defined as one which exceeds Milan criteria
- obstructive uropathy, residual urinary volume exceeding 100ml, or any bladder anomaly which might contraindicate implantation of the device
- other concomitant disease or condition likely to significantly decrease life expectancy or present anaesthetic risk (for example moderate to severe congestive heart failure)
- immuno-modulatory treatment (including zothiaprine, methotrexate, anti-tumour necrosis factor (TNF) therapies) used within last 4 months
- known as suspected hepatic or extra hepatic malignancy, unless adequately treated or in complete remission for more than 3 years
- body mass index (BMI) more than 40 presenting a risk for surgery and tunnelled lines
- patients with contraindications for general anaesthesia

Codes

Procedures challenged in this policy

T462 Drainage of ascites

Diagnoses challenged in this policy

ICD10 Code: C22, C221, C240, I500, K922, K658, K659, K650, N130, N138, N139
C22.0 Malignant neoplasm: Liver cell carcinoma
C22.1 Malignant neoplasm: Intrahepatic bile duct carcinoma
C22.9 Malignant neoplasm: Liver, unspecified
C24.0 Malignant neoplasm: Extrahepatic bile duct
I50.0 Congestive heart failure
K92.2 Gastrointestinal haemorrhage, unspecified
K65.0 Acute peritonitis
K65.8 Other peritonitis
K65.9 Peritonitis, unspecified
N13.8 Other obstructive and reflux uropathy
N13.9 Obstructive and reflux uropathy, unspecified
N19.X Unspecified kidney failure
E66.8 Other obesity

Diagnoses for which the above procedures are permitted

R18.X Ascites
K74.6 Other and unspecified cirrhosis of liver + R18.X ascites
K70.3 Alcoholic cirrhosis of liver + R18.X ascites

Date approved: April 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

Appendectomy without confirmation of appendicitis (National Evidence Based Intervention)

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

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

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

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

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

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

This guidance applies to adults and children.

Criteria

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

Where patients present with a high clinical suspicion of appendicitis, then imaging may not be necessary, but imaging can help identify which patients can be managed conservatively. If there is clinical doubt, then imaging can reduce the negative appendicectomy rate. Most patients should have an ultrasound as the first-line investigation. If the diagnosis remains equivocal, a contrast-enhanced CT (CECT,

preferably low dose) can be performed to give a definitive diagnosis prior to the patient returning to the surgical unit for a decision on management.

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

Evidence based intervention national coding script

WHEN LEFT(Primary_Spell_Procedure,4) in ('H011','H012','H013','H018','H019')
AND NOT (Any_Spell_Diagnosis LIKE '%K35[238]%'
OR Any_Spell_Diagnosis LIKE '%K3[67]%')
THEN '2R_CTappENDicitis'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
--Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: January 2025.
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Appropriate colonoscopy in the management of hereditary colorectal cancer (National Evidence Based Intervention)

Criteria

Follow the British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer.

Family history of CRC

For individuals with moderate familial CRC risk:

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

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

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

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

For symptomatic patients, investigate earlier.

Juvenile Polyposis Syndrome (JPS)

For asymptomatic individuals with JPS:
- Offer colorectal surveillance from 15 years
- Then offer a surveillance colonoscopy every 1-3 years, personalised according to colorectal phenotype

For symptomatic patients, investigate earlier.

For some patients with multiple risk factors for CRC, for example those with Lynch Syndrome and inflammatory bowel disease/multiple polyps, more frequent colonoscopy

may be indicated. This needs to be guided by clinicians but with a clear scientific rationale linked to risk management.

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN        LEFT(Primary_Spell_Procedure,4) in
('H221','H228','H229','H682','H684','H688','H689')
AND Any_Spell_Procedure NOT LIKE '%H68[13]%'
AND NOT ( Any_Spell_Diagnosis LIKE '%D126%'
OR Any_Spell_Diagnosis LIKE '%Q858%'
OR Any_Spell_Diagnosis LIKE '%Z0[89][012789]%'
OR Any_Spell_Diagnosis LIKE '%Z121%')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2NO_UnnecColonoscopy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
Outpatient

WHEN ( Any_Appointment_Procedure like '%H22[189]%'
OR Any_Appointment_Procedure like '%H68[2489]%')
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%D126%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Q858%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z08[012789]%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z09[012789]%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z121%'
AND Any_Appointment_Procedure NOT like '%H68[13]%'
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2NO_UnnecColonoscopy'
```

Exclusions

```
WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR   Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Cholecystectomy (National Evidence Based Intervention)

Cholecystectomy is a surgical procedure that removes the gallbladder. The gallbladder in an organ located just below the liver on the right side of the body. It is usually performed laparoscopically (keyhole), but can be performed open, which involves a large cut under the right rib cage. A cholecystectomy can be performed for numerous indications, two of which are gallstones or gallstone pancreatitis. An interval cholecystectomy is one that is performed some weeks after the initial acute presentation, while an index cholecystectomy is one that is performed at the time of acute admission.

Note: Patients with suspected gallbladder carcinoma or severe complications should be referred immediately, without delay. Patients with asymptomatic common bile duct (CBD) stones or dilated CBD without stones should be referred to gastroenterology or surgery.

This guidance applies to adults aged 19 years and over.

Criteria

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.

Cholecystectomy is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- symptomatic gallbladder stones
- confirmed episode of gallstone induced pancreatitis
- confirmed episode of cholecystitis
- episode of obstructive jaundice caused by biliary calculi.
- where there is clear evidence of patients being at risk of gallbladder carcinoma (for example porcelain gallbladder, gallbladder polyp >1cm)
- where there is clear evidence of patients being at risk of gallbladder complications
- gallbladder polyps that are symptomatic, associated with risk factors for malignancy or demonstrate rapid growth
- biliary dyskinesia

References

1. Clinical Guideline. 2014 Gallstone disease: diagnosis and management. [CG188].
2. Malik HT, Marti J, Darzi A, Mossialos E. Savings from reducing low-value general surgical interventions. Br J Surg. 2018 Jan;105(1):13-25. doi:10.1002/bjs.10719.
3. Schuster k, Holena D, salim A, savage S, crandall M, american association for the surgery of trauma emergency surgery guideline summaries: 2018, acute appendicitis, acute cholecystitis, acute diverticulitis, acute pancreatitis, and small bowel obstruction. Trauma surg acute care open. 2019; 4: e000281.
4. da Costa DW, Bouwense SA, Schepers NJ, Besselink MG, van Santvoort HC, van Brunschot S et al.; Dutch Pancreatitis Study Group. Same-admission versus interval cholecystectomy for mild gallstone pancreatitis (PONCHO): a multicentre randomised controlled trial. Lancet 2015; 386:1261 – 1268.
5. Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (2015) Pathway for management of acute gallstone disease
6. Gutt CN, Encke J, Köninger J, Harnoss JC, Weigand K, Kipfmüller K et al. Acute cholecystitis: early versus delayed cholecystectomy, a multicenter randomized trial (ACDC study, NCT00447304). Ann Surg 2013; 258: 385–393.
7. Ozardes A, Tokac M, dumlu EG, bozkurt B, ciftci B, yetisir F, kilic M. Early versus delayed laparoscopic cholecystectomy for acute cholecystitis: a prospective, randomise study. INt surg 2014;99: 56-61.

8. Tokyo Guidelines 2018: surgical management of acute cholecystitis: safe steps in laparoscopic cholecystectomy for acute cholecystitis. November 2017.

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) in
('J181','J182','J183','J184','J185','J188','J189')
AND Primary_Spell_Diagnosis LIKE '%K851%'
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2Q_interval_cholecystectomy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02
```

Date approved: August 2017, September 2019, January 2022 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Chronic fatigue syndrome or myalgic encephalomyelitis referral for treatment

Chronic fatigue syndrome (CFS) or myalgic encephalomyelitis (ME) comprises a range of symptoms that includes fatigue, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. A person's symptoms may fluctuate in intensity and severity, and there is also great variability in the symptoms different people experience. CFS or ME is characterised by debilitating fatigue that is unlike everyday fatigue and does not improve with sleep or rest and can be triggered by minimal activity. This raises especially complex issues in adults and children with CFS or ME (NICE CG53).

Criteria

Funding for treatment will only be commissioned where patients meet the criteria below (if under 16 must be under the care of a paediatrician), the referral letter and patient's medical record need to clearly evidence how these criteria are met:

Adult patients should have:

Fatigue lasting for more than 4 months, with all of the following features:

- new or had a specific onset fatigue (that is, it is not lifelong)
- persistent and/or recurrent
- unexplained by other conditions
- has resulted in a substantial reduction in activity level characterised by post-exertional malaise and/or fatigue (typically delayed, for example by 24 hours, with slow recovery over several days or longer)

And 1 or more of the following symptoms:

- difficulty with sleeping, such as insomnia, hypersomnia, unrefreshing sleep, a disturbed sleep-wake cycle
- muscle and/or joint pain that is multi-site and without evidence of inflammation
- headaches
- painful lymph nodes without pathological enlargement
- sore throat
- cognitive dysfunction, such as difficulty thinking, inability to concentrate, impairment of short-term memory, and difficulties with word-finding, planning or organising thoughts and information processing
- physical or mental exertion makes symptoms worse
- general malaise or flu-like symptoms
- dizziness and/or nausea
- palpitations in the absence of identified cardiac pathology
- sensitivities to light, noise, motion, foods, chemicals

And meet all of the following criteria:

1. No major psychiatric illness with psychotic or manic features
2. No history of failed CFS or ME services (or specific new reasons why referral should be reconsidered)
3. Not receiving concurrent rehabilitation from another provider
4. No ongoing medical investigation for other conditions

Exclusions: Inpatient CFS or ME therapy is not routinely commissioned.
Referral to alternative providers or services for CFS or ME which are not commissioned by the NHS in line with this policy is not routinely commissioned.

Codes

Procedures challenged in this policy

OPCS Code: There are no appropriate OPCS Codes.

Diagnoses challenged in this policy

ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.

Date approved: April 2018, April 2020 and January 2022.
Review date: January 2025 or earlier if new guidance is issued.
JCIA: Yes, completed

Correction of chest wall deformity for cosmetic purposes

Criteria

Correction of chest wall deformity for cosmetic purposes is not routinely commissioned. Note, non-cosmetic thoracic surgery is commissioned by NHS England and NHS Improvement.

Codes

Procedures challenged in this policy
T021, T018, T019, T028, T029, T053, T058

Relevant diagnoses for this policy
- M95.4 Acquired deformity of chest and rib.
- Q67.8 Other congenital deformities of chest.

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: November 2016 and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

Divarication of recti

The rectus abdominus muscles pass from the ribs and breastbone to the pubic bones. They are the most superficial of the abdominal muscles. Below them are the oblique muscles and transversus abdominus. A ligamentous band called the linea alba holds the recti together. This separation is called diastasis or divarication of the recti.

Counselling should be discussed and offered to all patients before correction of a divarication of recti if there is a view that the patient is requesting this intervention solely based on being unhappy with their appearance.

This intervention is not offered for cosmetic concerns.

Criteria

Surgery to correct a divarication of recti is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

1. Patient has a clinical need for reconstructive surgery following trauma-pregnancy is not considered a traumatic event and muscle separation following normal pregnancy is common
2. Patient has a congenital divarication of recti
3. Divarication of recti is disabling and causes significant functional impairment*

* Significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Note: this policy is not for hernia repair as this has own policy and associated criteria.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
- M620 Diastasis of muscle.
- No code for divarication.
- Q79.5 Congenital diastasis recti (please note this code is not exclusive to this condition and may be used to capture another diagnosis).

Diagnoses for which the above procedures are permitted
There are no appropriate codes.
Date approved: April 2018, November 2018 – significant functional impairment definition amended only and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis (National Evidence Based Intervention)

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

This guidance applies to adults aged 19 years and over.

Criteria

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.

Evidence based intervention national coding script

```
-- APCS Procedure
WHERE 1=1
-- Main Procedure
AND APCS.[Der_Procedure_All] LIKE '%J43[12389]%'

--Diagnosis
AND (APCS.[Der_Diagnosis_All] LIKE '%K851%')
-- With no APCE Procedure within 30 days
AND (
CASE WHEN APCEP.[Primary_Procedure_Code] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Primary_Procedure_Date])<=3 THEN 1 ELSE 0 END
+
CASE WHEN APCEP.[Procedure_Code_2] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_2])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_3] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_3])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_4] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_4])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_5] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_5])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_6] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_6])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_7] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_7])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_8] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_8])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_9] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_9])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_10] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_10])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_11] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_11])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_12] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_12])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_13] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_13])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_14] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_14])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_15] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_15])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_16] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_16])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_17] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_17])<=3 THEN 1 ELSE 0 END +
```

```
CASE WHEN APCEP.[Procedure_Code_18] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_18])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_19] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_19])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_20] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_20])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_21] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_21])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_22] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_22])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_23] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_23])<=3 THEN 1 ELSE 0 END +
CASE WHEN APCEP.[Procedure_Code_24] LIKE '%J43[12389]%' AND
datediff(dd,apcs.Admission_Date,[Procedure_Date_24])<=3 THEN 1 ELSE 0 END
)>0
```

Exclusions

```
 WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy.
JCIA: Yes, completed

Haemorrhoid surgery (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Haemorrhoids are swellings that develop inside and outside the anus. The majority of haemorrhoids are not a sign of severe pathology and can be managed conservatively. Conservative management of haemorrhoids (especially lower grade haemorrhoids) include lifestyle changes e.g. avoiding straining, eating more fibre or drinking more water.

For patients who cannot be managed conservatively, depending on the size and severity of the haemorrhoids they may be suitable for outpatient therapy in the form of rubber band ligation or injection.

Criteria

Conservative management techniques include.

- dietary and lifestyle advice (increase fluid and insoluble fibre intake, discourage straining)
- bulk forming laxative (or osmotic laxative or stool softener)
- non-opioid analgesia and/or topical haemorrhoid preparations for symptomatic relief

If these treatments are unsuccessful many patients will respond to outpatient treatment (non-surgical measures).

Surgical treatment

Surgical treatment should only be considered for:

- Persistent grade 1 (rare) or 2 haemorrhoids that have not improved with non-operative measures
- Severe (grade 3 or grade 4), which combine internal/external haemorrhoids with persistent pain or bleeding
- Irreducible and large external haemorrhoids

There are a variety of surgical options that are available to patients with severe haemorrhoid. These include:

- Stapled haemorrhoidoplasty
- Haemorrhoid artery ligation operation
- Radiofrequency ablation of haemorrhoids
- Excisional haemorrhoidectomy
- For patients who meet the criteria for surgery, a shared decision-making process should be used to support the choice of intervention taking into account patient's choice, severity of haemorrhoids and medical comorbidities

This guidance is reflective of current known and approved interventions, however in the future, new surgical treatment options may be developed. Once the potential new techniques are shown to be safe and effective by NICE, they should be included in the consenting process.

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

Note, the removal of anal skin tags is not routinely commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board.

Non-surgical treatment

Non-surgical measures (rubber band ligation, injection sclerotherapy or infra-red coagulation) is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- recurrent haemorrhoids
- persistent bleeding
- failure of documented conservative management techniques after at least 3 months

Codes

Procedures challenged in this policy
H511, H512, H513, H518, H519

Diagnoses for which the above procedures are permitted
C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

Evidence based intervention national coding script

```
WHEN (Primary_Spell_Procedure IN ( 'H511','H512','H513','H518','H519'
,'H521','H522','H523','H524','H528'
,'H529','H531','H532','H533','H538'
,'H539')
OR ( Primary_Spell_Procedure = 'L703'
AND Any_Spell_Procedure LIKE '%Y524%'
AND Any_Spell_Procedure LIKE '%Y532%'
AND Any_Spell_Procedure LIKE '%Z378%')
)
AND ( Any_Spell_Diagnosis like '%K64[01234589]%'
OR Any_Spell_Diagnosis like '%O224%'
OR Any_Spell_Diagnosis like '%O872%')
AND not ( Any_Spell_Diagnosis like '%C[0-8][0-9]%'
OR Any_Spell_Diagnosis like '%C9[0-7]%')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'I_haemmor'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
```

AND apcs.Administrative_Category<>'02'

Date approved: August 2017, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy.
JCIA: Yes, completed

Hernia management and repair in adults (National evidence based intervention)

This policy covers the management of inguinal, umbilical, incisional and femoral hernias, and lists the criteria for referral.

This guidance applies to adults aged 19 years and over.

Criteria

The referral letter and patient's medical record need to clearly evidence how these criteria are met:

Initial management of patients with hernia

Patients with BMI more than 35, the decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered.

Patients who smoke should be warned of clinical advice that hernia recurrence rates are 3 times higher in smokers than non-smokers. All patients who smoke should be encouraged to stop and offered information on local cessation support services.

Inguinal (National Evidence Based Intervention)

Criteria based access: Minimally symptomatic inguinal hernia in men can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients, who are to be counselled about the natural cause of a hernia and the surgical risks in repairing it under informed consent.

In women all suspected groin hernias should be urgent referrals.

Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- symptomatic, for example symptoms are such that they cause significant functional impairment*

- the hernia is difficult or impossible to reduce (for example history of incarceration or real difficulty reducing the hernia confirmed by ultrasound)
- inguino-scrotal hernia
- the hernia increases in size month on month

Umbilical

Criteria based access: Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

- pain or discomfort that causes significant functional impairment*
- increase in size month on month
- to avoid incarceration or strangulation of bowel in at risk patients, for example in cases where the hernia is difficult or impossible to reduce

Incisional

Criteria based access**:** Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

- pain or discomfort that causes significant functional impairment*
- conservative management has been tried first, for example weight reduction where appropriate

Femoral

All suspected femoral hernias are routinely commissioned for a referral to secondary care due to the increased risk of incarceration or strangulation.

Impalpable hernia and groin pain

Impalpable hernia and groin pain not routinely commissioned.

Hernia surgery is not commissioned in patients with groin pain and no visible external swelling. Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair.

Management of persistent groin pain that has not resolved after a period of watchful waiting should be based on individual clinical assessment. Where groin pain is severe and persistent with diagnostic uncertainty, options include referral for musculoskeletal assessment or imaging. Ultrasound should not be routinely requested in the early management of groin pain.

Laparoscopic hernia repair

Laparoscopic hernia repair is commissioned for:

- primary unilateral groin hernia repair
- bilateral groin hernia repair
- recurrent hernia
- incisional hernia

Hernia surgery is not commissioned for impalpable hernias found incidentally during laparoscopic repair of a hernia on the other side.

*Note significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures permitted in this policy

For laparoscopic repairs add Y75.2 in secondary position directly after one of the below codes.

T20.1 Primary repair of inguinal hernia using insert of natural material
T20.2 Primary repair of inguinal hernia using insert of prosthetic material
T20.3 Primary repair of inguinal hernia using sutures
T20.4 Primary repair of inguinal hernia and reduction of sliding hernia
T20.8 Other specified primary repair of inguinal hernia
T20.9 Unspecified primary repair of inguinal hernia

T25.1 Primary repair of incisional hernia using insert of natural material
T25.2 Primary repair of incisional hernia using insert of prosthetic material
T25.3 Primary repair of incisional hernia using sutures
T25.8 Other specified primary repair of incisional hernia
T25.9 Unspecified primary repair of incisional hernia

T21.1 Repair of recurrent inguinal hernia using insert of natural material
T21.2 Repair of recurrent inguinal hernia using insert of prosthetic material
T21.3 Repair of recurrent inguinal hernia using sutures
T21.4 Removal of prosthetic material from previous repair of inguinal hernia
T21.8 Other specified repair of recurrent inguinal hernia
T21.9 Unspecified repair of recurrent inguinal hernia

T23.1 Repair of recurrent femoral hernia using insert of natural material
T23.2 Repair of recurrent femoral hernia using insert of prosthetic material
T23.3 Repair of recurrent femoral hernia using sutures
T23.4 Removal of prosthetic material from previous repair of femoral hernia
T23.8 Other specified repair of recurrent femoral hernia

T23.9 Unspecified repair of recurrent femoral hernia

T26.1 Repair of recurrent incisional hernia using insert of natural material
T26.2 Repair of recurrent incisional hernia using insert of prosthetic material
T26.3 Repair of recurrent incisional hernia using sutures
T26.4 Removal of prosthetic material from previous repair of incisional hernia
T26.8 Other specified repair of recurrent incisional hernia
T26.9 Unspecified repair of recurrent incisional hernia

T97.1 Repair of recurrent umbilical hernia using insert of natural material
T97.2 Repair of recurrent umbilical hernia using insert of prosthetic material
T97.3 Repair of recurrent umbilical hernia using sutures
T97.8 Other specified repair of recurrent umbilical hernia
T97.9 Unspecified repair of recurrent umbilical hernia

Relevant diagnoses for this policy

K40.2 Bilateral inguinal hernia, without obstruction or gangrene
K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
K42.9 Umbilical hernia without obstruction or gangrene
K43.2 Incisional hernia without obstruction or gangrene
K41.2 Bilateral femoral hernia, without obstruction or gangrene
K41.9 Unilateral or unspecified femoral hernia, without obstruction or gangrene

Diagnoses for which the above procedures are permitted

Cancer diagnoses are a global exclusion

Evidence based intervention national coding script (inguinal hernia)

```
WHEN left(Primary_Spell_Procedure,4) IN ('T201','T202','T203','T204','T208','T209')
AND Primary_Spell_Diagnosis like 'K40[29]%'
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2B_hernia_repair'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
```

AND apcs.Administrative_Category<>'02'

Date approved: August 2017, March 2018 and November 2018 – significant functional impairment definition amended only, July 2021 and January 2025 for inguinal hernia
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

Hyperhidrosis treatment

Hyperhidrosis can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, and the face of otherwise healthy people.

Criteria

Botulinum Toxin for the treatment of hyperhidrosis is not routinely commissioned.

Codes

Procedures challenged in this policy

S53.2 Injection of therapeutic substance into skin
Z49.2 Skin of axilla

Relevant diagnoses for this policy

The ICD10 code for hyperhidrosis is R61.0, R61.1, R61.9.

Date approved: November 2016 and October 2022.
Review date: October 2025 or earlier if new guidance is issued.
JCIA: Yes, completed

Laparoscopic ventral rectopexy and stapled transanal rectal resection (STARR)

Criteria

Laparoscopic ventral rectopexy and STARR in the management of internal rectal prolapse and obstructed defecation syndrome is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- treatment for full thickness prolapse can often present as an emergency and does not require prior approval
- each patient to be considered by a multidisciplinary pelvic floor team, consisting of a gynaecological surgeon, a colorectal surgeon and pelvic floor physiologists and will not be quorate unless a representative from each of these groups is present

The multi-disciplinary team (MDT) confirms that:

- they recommend this treatment for this patient over all alternatives
- the potential benefit outweighs potential harms
- the MDT is satisfied that the necessary capacity and expertise available to handle this intervention is in place in the proposed delivery setting

Conservative management has been tried and has failed. This includes a selection of the following appropriate for the individual:

- dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback
- the patient has unresolved faecal incontinence or obstructed defecation syndrome
- symptoms cause significant functional impairment*

*Note: significant functional impairment is defined as

- a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing
- the risks, benefits, and side effects of the procedure have been discussed with the patient, and the patient wishes to be considered for this treatment

If the MDT agrees ventral mesh rectopexy or STARR is the most appropriate treatment for the patient's condition, a request for prior approval should be made to the relevant commissioner.

Codes

Procedures challenged in this policy
Primary procedure code of H41.5 or primary procedure code H35.5 and Y75.2 in a secondary position.

Relevant diagnoses for this policy
K623

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018; November 2018 – significant functional impairment definition amended only and March 2021.
Review date: March 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

SpyGlass direct visualisation cholangioscopy in complex hepatopancreaobiliary disease

Criteria

SpyGlass direct visualisation cholangioscopy in complex hepatopancreaobiliary is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- indeterminate pancreato-biliary lesions, including:
    - suspected cholangiocarcinoma
    - suspected pancreatic carcinoma
- patients with primary sclerosing cholangitis
- inconclusive diagnostic results from initial standard endoscopic tissue acquisition techniques, such as endoscopic retrograde cholangiopancreatography (ERCP), biliary ductal brush or cytology and endoscopic ultrasound-guided fine needle aspiration (EUS-FNA)
- have been reviewed and referred via the MDT for hepato-pancreato- biliary (HPB) disease
- benign emergency referrals, including migrated pancreatic duct stents that otherwise require opened surgery (note this group of patients is expected to be approximately less than 10% of the cohort of the patients within this policy)

Exclusions

Treatment of bile duct stones is excluded from this policy.

Codes

Procedures challenged in this policy

U168, U169

Relevant diagnoses for this policy

Treatment bile duct stones: C220, C221, C222, C223, C224, C227, C229, C240, D015, D135, K803, K804, K805

Diagnoses for which the above procedures are permitted, if in the same attendance.

Exclusion treatment bile duct stones: J18, J180, J181, J182, J183, J184, J185, J186, J187, J188, J189, J27, J271, J272, J274, J275, J276, J277, J278, J279, J28, J280, J281, J282, J283, J284, J285, J286, J287, J288, J289, J30, J300, J301, J302, J303, J304, J305, J306, J307, J308, J309, J31, J310, J311, J312, J313, J314, J315, J316, J317, J318, J319, J32, J320, J321, J322, J323, J324, J325, J326, J327, J328, J329, J33, J330, J331, J332, J333, J334, J335, J336, J337, J338, J339, J34, J340, J341, J342, J343, J344, J345, J346, J347, J348, J349, J35, J350, J351, J352, J353, J354, J355, J356, J357, J358, J359, J37, J370, J371, J372, J373, J374, J375, J376, J377, J378, J379, J38, J380, J381, J382, J383, J384, J385, J386, J387, J388, J389, J40, J400, J401, J402, J403, J404, J405, J406, J407, J408, J409, J41, J410, J411, J412, J413, J414, J415, J416, J417, J418, J419, J43, J430, J431, J432, J433, J434, J435, J436, J437, J438, J439, J44, J440, J441, J442, J443, J444, J445, J446, J447, J448, J449, J46, J460, J461, J462, J463, J464, J465, J466, J467, J468, J469, J47, J470, J471, J472, J473, J474, J475, J476, J477, J478, J479, J48, J480, J481, J482, J483,

J484, J485, J486, J487, J488, J489, J49, J490, J491, J492, J493, J494, J495, J496, J497, J498, J499, J50, J500, J501, J502, J503, J504, J505, J506, J507, J508, J509, J51, J510, J511, J512, J513, J514, J515, J516, J517, J518, J519, J52, J520, J521, J522, J523, J524, J525, J526, J527, J528, J529, J53, J530, J531, J532, J533, J534, J535, J536, J537, J538, J539, J76, J760, J761, J762, J763, J764, J765, J766, J767, J768, J769, Z30, Z300, Z301, Z302, Z303, Z304, Z305, Z306, Z307, Z308, Z309

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed

Radiofrequency ablation for Barrett's oesophagus

Barrett's oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus (gullet), usually because of the abnormal backflow of stomach acid into the oesophagus. These cells can develop an abnormality called dysplasia which may progress to become cancer. Most patients with Barrett's oesophagus do not develop cancer of the oesophagus, but because the risk is increased people with this condition usually have checks on a regular schedule. If a high-grade type of dysplasia is found, the standard treatment advised is surgery to remove the oesophagus (oesophagectomy) to reduce the risk of the development and spread of cancer. This is a major operation with associated significant risks.

The use of heat energy applied from a tube passed into the oesophagus has been shown to destroy the changed cells in a high proportion of patients. This technique of radiofrequency ablation carries less risk of serious complications than having the oesophagus removed. The long-term effectiveness of the technique is not known, and patients must have regular checks of the oesophagus after successful treatment.

Criteria

Radiofrequency ablation is commissioned as an option to patients with high grade dysplasia as an alternative to oesophagectomy in suitable patients or for patients in whom oesophagectomy is not an option. This should be provided in accordance with NICE CG106 and IPG344.

Codes

Procedures challenged in this policy

G14.5 - Fibreoptic endoscopic destruction of lesion of oesophagus NEC +
Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
G17.8 - Other specified endoscopic extirpation of lesion of oesophagus using rigid oesophagoscope +
Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
G04.3 - Open destruction of lesion of oesophagus NEC +
Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
G43.5 - Fibreoptic endoscopic destruction of lesion of upper gastrointestinal tract NEC +

Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC +
Z27.1 - Oesophagus

Relevant diagnoses for this policy
C150, C151, C152, C153, C154, C155, C158, C159, D130, K227, K228, K229

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and October 2021
Review date: October 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Referral for bariatric surgery (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT and UHP)

There are a variety of surgical options available for promoting weight loss. These bariatric procedures include: Roux-en-Y gastric bypass; one anastomosis (mini) gastric bypass; vertical sleeve gastrectomy; adjustable gastric banding; placement of an intragastric balloon/endoscopically or otherwise; or Endoscopic Bariatric procedures such as an Endoscopic Sleeve Gastrectomy. The specific type of procedure should be decided as part of a shared decision making conversation between the patient and the surgeon, supported by the weight management MDT, during which risks and possible outcomes are discussed.

Bariatric procedures aim to promote weight loss and improve other metabolic complications of obesity. This proposed guidance establishes criteria for referral of a patient to a bariatric surgical centre for consideration of performing a bariatric surgical procedure.

Criteria
This guidance applies to those aged 18 years and over.

For patients with a BMI of 50 kg/m^2 or more, surgery should be considered as a first-line treatment intervention.

Patients with a BMI less than 50 kg/m^2 should be referred for consideration of bariatric surgery if they meet the following criteria:

- The patient has a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 39.9 kg/m with significant obesity-related complications likely to improve with weight loss (for example, type 2 diabetes, cardiovascular disease, obstructive sleep apnoea, non-alcoholic fatty liver disease with or without steatohepatitis or hypertension (including idiopathic intracranial hypertension)

AND,
agree to the necessary long-term follow up after surgery (for example, lifelong annual reviews)

Consider referral for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background using a lower BMI threshold (reduced by 2.5 kg/m^2), to account for the fact that these groups are prone to central adiposity and their cardiometabolic risk occurs at lower BMI.

Expedited assessment
Offer an expedited assessment for bariatric surgery to people:

- with a BMI of 35 kg/m^2 or more who have recent-onset (diagnosed within the past 10 years) type 2 diabetes **and**
- as long as they are also receiving, or will receive, assessment in a specialist overweight and obesity management service.

Consider an expedited assessment for bariatric surgery for people:

- with a BMI of 30 to 34.9 kg/m^2 who have recent-onset (diagnosed within the past 10 years) type 2 diabetes **and**
- who are also receiving, or will receive, assessment in a specialist overweight and obesity management service.

Consider an expedited assessment for bariatric surgery for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African–Caribbean background using a lower BMI threshold (reduced by 2.5 kg/m^2) than in recommendation 1.9.4, to account for the fact that these groups are prone to central adiposity and their cardiometabolic risk occurs at lower BMI.

Assessment for bariatric surgery must follow the NICE guideline NG246 Medicines and surgery | Overweight and obesity management | Guidance | NICE

Postoperative and longer-term follow-up care
Offer people who have had bariatric surgery a follow-up care package for a minimum of 2 years within the bariatric service. Include:

- monitoring nutritional intake, (including protein and vitamins) and mineral deficiencies
- monitoring for comorbidities
- medications review
- individualised dietary and nutritional assessment, advice and support
- advice and support on physical activity
- psychological support tailored to the person
- information about professionally led or peer-support groups. **[2014]**

After discharge from follow up by the bariatric surgery service, ensure people are offered at least annual monitoring of nutritional status and appropriate supplementation after bariatric surgery, as part of a shared-care model with primary care.

Codes

Relevant diagnoses for this policy

E66.0 - Obesity due to excess calories
E66.1 - Drug-induced obesity

E66.2 - Extreme obesity with alveolar hypoventilation
E66.8 - Other obesity
E66.9 - Obesity, unspecified

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Coding Script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('G281', 'G282', 'G283', 'G284', 'G285', 'G301',
'G302', 'G303', 'G304', 'G321', 'G328', 'G329', 'G331', 'G338', 'G339')
AND ( Any_Spell_Diagnosis LIKE '%E66[01289]%')
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date) between
18 AND 120
THEN '3F_Bariatric_Surgery'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: August 2017, March 2018, January 2025 and October 2025.
Review date: There are no plans for any further reviews unless national guidance changes
JCIA: Yes, completed.

Repeat colonoscopy (National Evidence Based Intervention)

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

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

small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used.

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

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

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

Criteria

Risk Surveillance Criteria for Colonoscopy

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

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

OR

- 5 or more premalignant polyps

Surveillance colonoscopy after polypectomy

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

- Offer one-off surveillance colonoscopy at 3 years

For individuals with no high-risk findings:

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

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

Surveillance colonoscopy after potentially curative CRC resection

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

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

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

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

- Site-checks at 2-6 months and 18 months from the original resection
- Once no recurrence is confirmed, patients should undergo postpolypectomy surveillance after 3 years
- Further surveillance colonoscopy to be determined in accordance with the post-polypectomy high-risk criteria

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

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

Ongoing colonoscopic surveillance:

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

Evidence based intervention national coding script

Admitted patient care

```
WHEN        LEFT(Primary_Spell_Procedure,4) in
('H221','H228','H229','H682','H684','H688','H689')
AND Any_Spell_Procedure NOT LIKE '%H68[13]%'
AND NOT ( Any_Spell_Diagnosis LIKE '%D126%'
OR Any_Spell_Diagnosis LIKE '%Q858%'
OR Any_Spell_Diagnosis LIKE '%Z0[89][012789]%'
OR Any_Spell_Diagnosis LIKE '%Z121%')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
```

THEN '2NO_UnnecColonoscopy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
Outpatient

WHEN (Any_Appointment_Procedure like '%H22[189]%'
OR Any_Appointment_Procedure like '%H68[2489]%')
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%D126%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Q858%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z08[012789]%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z09[012789]%'
AND ISNULL(Any_Appointment_Diagnosis,'') not LIKE '%Z121%'
AND Any_Appointment_Procedure NOT like '%H68[13]%'
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2NO_UnnecColonoscopy'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Revisional metabolic and bariatric surgery

Metabolic and bariatric surgery is a specialised treatment for severe and complex obesity, to be offered after a comprehensive weight management pathway that comprises MDT assessment, advice, education and counselling and includes specialised non-invasive interventions delivered by multidisciplinary obesity specialists, which may also include drug treatment.

The latter pathway is delivered within tier 3 services with non-specialist elements delivered by tier 1 and tier 2 services. In patients who have failed to lose weight using this pathway and are eligible according to NICE criteria, metabolic and bariatric surgery has been shown to be a cost-effective therapy that achieves significant and rapid excess weight loss and resolution of co-morbidities. However, to ensure the latter outcomes, patients need adequate pre-surgical input to ensure that they are well informed, prepared and ready to comply with surgical changes and accept the impact that it will have on their eating habits. Also essential will be compliance with post-operative follow up to monitor dietary and physical activity adherence, nutritional replacement and early detection and treatment of post-surgical medical and surgical complications.

Criteria

Group 1, 2 and 4a patients will be routinely commissioned. Groups 3 and 4b patients will not be routinely commissioned.

Group 1

Patients presenting with a clinical history, symptoms and/or signs that suggest acute medical and/or surgical complications that are related to their primary obesity operation.

Patients must be triaged and treated immediately if classified as emergency. Patients triaged by an MDT and may be assessed as ‘clinically urgent’ if they are judged to have a subsequent risk of developing emergency complications if they remain untreated. This category will include patients with adverse anatomical complications of the primary surgery.

This corrective surgery, or in rare cases reversal surgery, would routine and considered as good clinical practice. Providers should triage referral letters from GPs, hospital consultants on this basis.

Examples would include:

1. If there is a band complication, for example, slippage then the band can be repositioned or replaced. Conversion can be considered if the criteria as stipulated in the NHS Cornwall and Isles of Scilly Integrated Care Board policy on complex and specialised obesity surgery are met, the patient is on regular follow up and MDT review agrees
2. If there is a band erosion then band removal can be followed up by a bypass after 6 months if the criteria as stipulated in the NHS Cornwall and Isles of Scilly Integrated

Care Board policy on complex and specialised surgery are met, the patient is on regular follow up and MDT review agrees
3. If there is severe band intolerance with gastro-oesophageal reflux, oesophageal dysmotility, or persistent vomiting then the same as 1 and 2 above.

However, if NHS Cornwall and Isles of Scilly Integrated Care Board criteria are not met and/or there has been poor response to primary bariatric surgery (insufficient weight loss or weight regain in the absence of surgical complication), then NHS Cornwall and Isles of Scilly Integrated Care Board will only fund for band removal.

Medical emergencies might include profound macro and micronutrient deficiencies anaemia; malnutrition and metabolic abnormalities such as disabling intractable hypoglycaemia; and intractable diarrhoea.

Group 2

Patients in whom a 2-stage procedure was clinically recommended by an MDT (often in super-obese patients) in which case further surgery is a planned, timely event.

The receiving trust's triage and MDT approval process for the second operation will require evidence of patient compliance with the prescribed post-surgical (first stage operation) dietary and lifestyle regimen and progress with pre-set clinical targets.

Group 3

The patient has failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight. This category will include patients who following a gastric bypass develop a dilated gastric pouch or gastro-jejunal anastomotic dilatation. This category will not include patients who have previously had vertical banded gastroplasty.

The above group will not be routinely funded. If the treating clinician feels strongly that there are clinically exceptional reasons that are relevant to a particular case such as technical failure or other special circumstances in patients who have complied with planned follow up, then an application for funding can be made to the individual funding request (IFR) panel.

Group 4

1. Some patients may have had their primary obesity surgery outside of NHS contracts at private providers (in Europe, or within the UK) but subsequently present at NHS facilities as clinical emergencies. The NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment on a similar basis as group 1 patients
2. Many of these patients may not have met the full NHS Cornwall and Isles of Scilly Integrated Care Board criteria and guidance for their primary obesity surgery and may

not have been adequately followed up. These patients should be referred to the tier 2 or 2 weight management services

Any request for further (up to 2 years only) band filling and/or routine outpatient follow-up care (not associated with an acute, non-elective episode for these patients) will require the agreement of a commissioner at NHS Cornwall and Isles of Scilly Integrated Care Board and will need to demonstrate that the patient has met NHS Cornwall and Isles of Scilly Integrated Care Board eligibility criteria for obesity surgery. The patient's GP and private provider will therefore be required to collaborate to provide evidence on:

1. Weight management service attendance including tier 3
2. NHS Cornwall and Isles of Scilly Integrated Care Board criteria and guidance fulfilment
3. Primary obesity operation
4. Follow-up attendance
5. Response to primary operation defined by progress with reduction of excess weight at 1- and 2-years including impact on co-morbidities

Audit criteria

The following audit criteria will be required for all revision surgery:

1. Referral source and reason for application
2. Previous obesity procedure, when carried out and by which provider (NHS, private, NHS contracted provider)
3. Indication for operation and fulfilment of NHS Cornwall and Isles of Scilly Integrated Care Board criteria
4. Classification of admission (urgent, emergency, planned second stage, elective).
5. Revision procedure undertaken and provider
6. Discharge destination

Applications for funding to the IFR panel may be required for groups 3 and 4b, if it is felt that individualised or exceptional circumstances apply.

Codes

Procedures challenged in this policy

G251, G313, G322, G332, G717, G272, G273, G274, G275, G278, G279, G281, G282, G283, G284, G285, G288, G289, G301, G302, G303, G304, G305, G308, G309, G310, G311, G312, G313, G314, G315, G316, G318, G319, G320, G321, G322, G323, G324, G325, G328, G329, G330, G331, G332, G333, G334, G335, G336, G338, G339, G386, G387, G388, G389, G481, G482, G716

Relevant diagnoses for this policy

A09X, D501, D508, D509, D510, D511, D512, D513, D518, D519, D520, D521, D528, D529, D530, D550, E500, E501, E502, E503, E504, E505, E506, E507, E508, E509, E511, E512, E518, E519, E52X, E530, E531, E538, E539, E54X, E550, E559, E560,

E561, E568, E569, E58X, E59X, E60X, E610, E611, E612, E613, E614, E615, E616, E617, E618, E619, E630, E631, E638, E639, E54X, E550, E559, E560, E561, E568, E569, E58X, E59X, E60X, E610, E611, E612, E613, E614, E615, E616, E617, E618, E619, E630, E631, E638, E639, E640, E641, E642, E643, E648, E649, E15X, E160, E161, E162, K210, K219, K310, K314, K580, K589, K591, K911, R11X

Diagnoses for which the above procedures are permitted

There are no appropriate codes.

Date approved: April 2018
Review date: April 2020 or earlier if new guidance is issued
JCIA: Yes, completed

Tongue tie division

Tongue-tie (ankyloglossia) is a problem affecting some babies with a tight piece of membrane between the underside of their tongue and the floor of their mouth (lingual frenulum). It can sometimes affect the baby's feeding, making it hard for them to attach properly to their mother's breast.

Criteria

Treatment in primary care

Treatment in primary care will only be provided by NHS Cornwall and Isles of Scilly Integrated Care Board for infants who are considered suitable by the midwifery service, meeting the criteria set out below.

- infant is aged 12 weeks* or younger (*age corrected)
- infant has a tongue tie which is persistently preventing successful feeding, which could result in the infant’s faltering growth and that is not helped by additional infant feeding support
- infant has not undergone a previous tongue tie division
- there are no signs of infection

Treatment in secondary care

Opinion only from secondary care will be provided by NHS Cornwall and Isles of Scilly Integrated Care Board for infants aged 12* weeks or younger (*age corrected) who have congenital abnormalities (such as cleft lip or palate, trisomy 21, trisomy 18).

Infants who have one or more of the following are not suitable for treatment in the primary care service setting. Referral to secondary care for opinion and subsequent treatment must meet the criteria set out below:

- the tongue is thick and vascular
- there are aberrant structures beneath the tongue

- there is a family history of coagulation disorder
- the infant has congenital abnormalities, such as cleft lip or palate, trisomy 21, trisomy 18, and an opinion from ENT, orthodontics, oral and maxillofacial surgery has been sought confirming there is a need for tongue tie division

Infants older than 12 weeks old up to and including adults

Treatment for all patients older than 12 weeks (*age corrected), is not routinely commissioned.

Lip tie

The surgical correction of lip tie, where the lip is connected too tightly to the upper gum, is not routinely commissioned.

*Age corrected, or adjusted age, is your premature baby's chronological age minus the number of weeks or months he was born early. For example, a 1-year-old who was born 3 months early would have a corrected age of 9 months. (Raising Children, 2016)

Codes

Procedures challenged in this policy
F228, F262, F263

Relevant diagnoses for this policy
Q381

Diagnoses for which the above procedures are permitted
Q383, Q900, Q901, Q910, Q911, Q912, Q36, Q361, Q369, Q37, Q370, Q371, Q373, Q374, Q375, Q378, Q379

Date approved: February 2019
Review date: February 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Varicose veins (National Evidence Based Intervention locally adapted) Criteria based access and prior approval required (RCHT)

Varicose veins are dilated superficial veins in the leg. They are caused by incompetent valves, commonly in the long and short saphenous veins and their branches, although varicosities may be secondary to deep venous disease. They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin.

Asymptomatic or mild varicose veins present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes. Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated mild

pain or discomfort and slight ankle swelling. Severe varicose veins may present with phlebitis, ulceration, haemorrhage, significant oedema or haemosiderin staining.

Most varicose veins respond to conservative management, for example, exercise, weight loss and elevation of the leg 2 to 3 times daily. Varicose eczema, if severe or inflamed, can be treated effectively with topical steroids.

Interventional procedures such as surgical stripping or ligation, radio-frequency ablation, endoscopic procedures and sclerotherapy for example foaming, can improve symptoms in the short term but are less effective in the longer term, and are associated with a significant recurrence rate. Interventional procedures for mild and moderate varicose veins will not normally be commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board.

Criteria

Varicose vein treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- lower-limb skin marked eczema which has not responded to conservative measures
- superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence
- recurrent or ascending superficial phlebitis (DVT risk may be as high as 10% to 20% at presentation)
- a lower limb venous ulcer not healed within 2 weeks, with or without obvious varicose veins
- a healed venous leg ulcer
- severe swelling or pitting oedema
- symptomatic varicose veins in the presence of arterial insufficiency (absent pedal pulses)
- lipodermatosclerosis
- incipient ulceration with erythema and skin induration
- bleeding varicose veins

Patients not suitable for referral to vascular surgical clinics for NHS treatment:

- do not fulfil the above criteria
- whose concerns are cosmetic only
- pain or ache only, itch, mild swelling, minor changes of skin eczema and haemosiderosis

Codes

Procedures challenged in this policy
L832, L838, L839, L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L863, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888, L889

Relevant diagnoses for this policy
I80, I83

Diagnoses for which the above procedures are permitted
There is no code to identify those which have bled or are at risk of bleeding again. Codes for the other clinical criteria are any one of I830 or I832; I872; I800 or I801 or I802 or I803 or I809 or I831. There is no appropriate code to identify impact on quality of life.

Date approved: November 2016; November 2018 addition to the eligibility criteria included only; March 2019 review date extension approved only; July 2019 further review date extension approved only, January 2020 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed.

Venous angioplasty for multiple sclerosis

The effectiveness of venous angioplasty for stenotic and occlusive lesions in the extracranial venous systems of patients with MS has not yet been demonstrated in clinical trials. The American Academy of Neurology currently recommends that patients only use this treatment as part of a well-designed clinical trial.

Criteria

Venous angioplasty for the treatment of multiple sclerosis is not routinely commissioned.

Codes

Procedures challenged in this policy
L946, L947, L948, L949, L991

Relevant diagnoses for this policy
G35, G350, G35X, G35XD

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Miscellaneous

Brachycephaly in children/Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children (National Evidence Based Intervention)

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

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

This guidance applies to children aged 2 years and under.

Non-synostotic/positional plagiocephaly is a mechanical distortion that corrects itself as the child grows. Studies have shown that helmet therapy is no more effective than leaving the head to remould naturally as the baby grows. Choosing Wisely UK and Choosing Wisely Canada have both advised against helmet therapy as an intervention for positional plagiocephaly and brachycephaly. In the guideline NG127 Suspected neurological conditions: recognition and referral published in May 2019 NICE does not refer to helmet therapy and recommends: For babies aged under 1 year whose head is flattened on one side (plagiocephaly):

- Be aware that positional plagiocephaly (plagiocephaly caused by pressure outside the skull before or after birth) is the most common cause of asymmetric head shape
- Advise parents or carers of babies with positional plagiocephaly that it is usually caused by the baby sleeping in one position and can be improved by changing the baby's position when they are lying, encouraging the baby to sit up when awake, and giving the baby time on their tummy

The NICE committee discussed how measuring the distance between the tragus of the ear and the outer canthus of the eye is a useful adjunct to clinical inspection of the head shape of a child under 1 year and would help a clinician reassure parents that this was a benign condition. However, the committee acknowledged that this was not an absolute discriminator and that if there was uncertainty, referral for specialist assessment was appropriate.

In terms of positional plagiocephaly, the NICE committee recommend that once the flat area at the back of the head is relieved of pressure with changing position, and the child is spending more time sitting, natural growth of the head will reduce the flattening. The committee does not recommend referral for investigations or management for a condition that has an excellent prognosis over time. The committee recommends referral for assessment of developmental disorders if there is concern that delay in meeting early

motor milestones – rolling, sitting – is contributing to degree or maintenance of plagiocephaly. The referral would be for diagnostic assessment as well as assessing the need for therapy and provision of equipment such as adapted seating.

Consider referral to physiotherapy if there is concern of neck muscle pathology.

Criteria

As clinically evidenced by the four major designated supraregional craniofacial services in the UK (prior to the availability of Helmet therapy), 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.

There is clear evidence and expert consensus that a helmet does not affect the natural course of skull growth and should not be used. Helmets may be associated with significant risks such as pain, pressure sores and may adversely affect the bond between baby and parents. They are also expensive. 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.

Evidence based intervention national coding script

For interventions with fewer than 10 episodes during 2018/19, the activity and coding has not been included.

WHEN apcs.Der_Procedure_All like '%V04[89]%’
AND (apcs.Der_Diagnosis_All LIKE '%Q673%’)
AND
isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)<=2
AND APCS.Admission_Method not like ('2%’)
THEN ‘Z_Helmet_therapy'
Code Definitions

No appropriate classification procedure codes available for this treatment.

Exclusions

apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
apcs.der_diagnosis_all not like '%D0%' and
apcs.der_diagnosis_all not like '%D3[789]%' and
apcs.der_diagnosis_all not like '%D4[012345678]%'
This code captures code in the ranges C00-C99, D00-D09 and D37-D48.
Age range: the codes use the following age ranges 0-18 for children and 19-120 for adults.
— Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Blood Transfusion (National Evidence Based Intervention)

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

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

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

Criteria

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.

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('X331','X332','X338','X339')
AND ( Any_Spell_Diagnosis LIKE '%D5[02][0189]%'
OR Any_Spell_Diagnosis LIKE '%D51[012389]%')
AND NOT ( Any_Spell_Diagnosis LIKE '%D5[38][01289]%'
OR Any_Spell_Diagnosis LIKE '%D55[012389]%'
OR Any_Spell_Diagnosis LIKE '%D56[0123489]%'
OR Any_Spell_Diagnosis LIKE '%D57[01238]%'
OR Any_Spell_Diagnosis LIKE '%D59[012345689]%'
OR Any_Spell_Diagnosis LIKE '%D60[0189]%'
OR Any_Spell_Diagnosis LIKE '%D61[012389]%'
OR Any_Spell_Diagnosis LIKE '%D62%'
OR Any_Spell_Diagnosis LIKE '%D63[08]%'
OR Any_Spell_Diagnosis LIKE '%D64[0123489]%')
THEN '2EE_blood_transfusion'
Exclusions

WHERE 1=1
```

-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
--Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Complementary medicines or therapies

Criteria

Complementary therapies such as acupuncture, chiropractic therapy, homeopathy, hypnotherapy or osteopathy are not routinely commissioned.

Codes

Procedures challenged in this policy

X612, X613, X614, X618, X619, A706

Relevant diagnoses for this policy

None.

Diagnoses for which the above procedures are permitted

There are no appropriate codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2019
Review date: November 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Continuous glucose monitors

These are devices that allow for people with type 1 diabetes to see their (or their children's) glucose values continuously, enabling immediate therapeutic adjustments based on real time glucose results. The device has a sensor which is fitted sub-cutaneously and measures interstitial glucose, the sensors are time limited (usually 5 to 7 days) and thus need to be replaced regularly. The real-time monitor shows trends in glucose levels on an LCD display and indicates the rate of glucose change using arrows (the device can be a user's smartphone). They have predictive alarms for high or low glucose level and warn of impending hypoglycaemia or hyperglycaemia by sounding alarm.

Criteria

Continuous glucose monitors (CGM) are commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how the criteria is met.

Principles

1. The use of a CGM device must be supported by a multidisciplinary specialist diabetic team
2. CGM devices should not be routinely offered to all type 1 diabetic patients
3. All patients should have followed the clinical pathway of usual interventions such as dietetic care, structured education and, where necessary, specialist psychological support to manage their diabetes
4. Patients must be willing to commit to use their CGM device at least 70% of the time
5. Devices will be issued for a 24-month period only after which the device should be considered for withdrawal
6. Devices will be considered by the specialist team if the criteria 1 to 5 are met and the person meets the criteria as appropriate to their age as below

12 years old and over:

- 2 or more severe hypoglycaemic episodes within 12 months: where severe equals seizure or unconscious and unable to take oral treatment, with evidence that 999 will have been called), or for patients under the paediatric diabetes service, that the out of hours advice line will have been contacted at the time of the event with expectation that glucagon will have been administered
- in adults, an expectation that if these severe hypos occurred during the day that they will have informed the DVLA who will then make medical enquiries

Under 12 years old:

- under 5 years of age (age 4 years and below) *
- for 5-to-11-year age group either:
    - 1 severe hypoglycaemic episode where severe equals seizure or unconscious and unable to take oral treatment, with evidence that 999 has been called, or that the out of hours advice line has been contacted at the time of the event and an expectation that glucagon will have been administered
    - unawareness of hypoglycaemia resulting in fear of hypoglycaemia evidenced by checking blood glucose level between midnight and 5am on at least 4 nights per week for at least 2 months

These proposed criteria for funding of real-time continuous glucose monitoring (CGM) are based on the most high-risk scenarios in the following guidance:

- NICE Quality Standard 125, Diabetes in children and young people
- NICE Guideline NG18, Diabetes (type 1 and type 2) in children and young people
- NICE Guideline NG17, Type 1 diabetes in adults: diagnosis and management

- NICE Diagnostics Guidance 21, Integrated sensor-augmented pump therapy systems for managing blood glucose levels in type 1 diabetes (the MiniMed Paradigm Veo system and the Vibe and G4 platinum CGM system)
- NICE Medtech innovation briefing 51, MiniMed 640G system with SmartGuard for managing blood glucose levels in people with type 1 diabetes
- Association of Children's Diabetes Clinicians guideline for CGM and flash glucose scanners in April 2017

*ACDC says for all children who are of preschool age and below, but the use of an age cut-off is fairer. ACDC says about this group: Younger children are unable to recognise and respond to hypoglycaemia. They are at increased risk of neurocognitive sequelae because of hypoglycaemia and the risk of hypoglycaemic seizures is greatest in younger children. CGM studies in the pre-school children confirmed that most hypoglycaemia events were asymptomatic and only 32% were being detected despite plasma glucose levels being checked 10 times per day.

Children under the age of 6 years with hypoglycaemia unawareness have 6 times the risk of a severe hypoglycaemic episode when compared to those without hypoglycaemia unawareness.

Note Freestyle Libre not licensed for use under the age of 4 years.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
E100, E101, E102, E103, E104, E105, E106, E107, E108, E109

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: February 2019
Review date: February 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Enhanced external counterpulsation for patients with severe ischaemic heart disease

Ischaemic heart disease (coronary artery disease or CAD) is a condition in which fatty deposits build up in the linings of the walls of the coronary arteries. This causes a narrow artery and reduced blood flow to the heart muscle. Myocardial ischaemia results in central chest pain, causing stable angina, unstable angina and myocardial infarction.

Enhanced external counterpulsation (EECP) is a non-invasive method which has been used, mainly in the US, to treat patients with refractory angina pectoris, ineligible for further drug or surgical intervention. Pneumatic cuffs are applied to the lower limbs and controlled to inflate sequentially in time with the heartbeat during the time when the chambers of the heart fill, a process designed to increase coronary blood flow and improve heart output.

Criteria

EECP for patients with severe ischaemic heart disease is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
I210, I211, I212, I213, I214, I219 - acute MI's
I220, I221, I228, I229 - subsequent MI's
I200, I201, I208, I209 - angina
I240, I241, I248, I249 - acute ischaemic heart disease
I250, I251, I252, I253, I254, I255, I256, I258, I259 - chronic ischaemic heart disease

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and October 2021
Review date: October 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Extracorporeal shockwave therapy

Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. It may be applied in one or several sessions and local anaesthesia may be used because high-energy ESWT can be painful.

NICE guidance exists in relation to ESWT as treatment for several conditions:

- refractory tennis elbow (NICE, IPG 313)
- refractory achilles tendinopathy (NICE, IPG 571)
- refractory plantar fasciitis (NICE, IPG 311)
- refractory greater trochanteric pain syndrome (NICE, IPG 376)
- peyronie's disease (NICE, IPG 29)
- calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21)

NICE guidance for all but “Calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21)” states that for each condition: “The evidence on extracorporeal shockwave therapy (ESWT) raises no major safety concerns; however, current evidence on its efficacy is inconsistent.”

Although NICE guidance for calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21) states that “current evidence on the safety and efficacy of extracorporeal shockwave lithotripsy for calcific tendonitis of the shoulder appears adequate to support the use of the procedure, provided that normal arrangements are in place for consent, audit and clinical governance,” the use of this treatment is not routinely commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board.

Criteria

Extracorporeal shockwave therapy is not routinely commissioned for the following conditions:

- refractory tennis elbow
- refractory Achilles tendinopathy
- refractory Plantar fasciitis
- refractory greater trochanteric pain syndrome
- peyronie’s disease
- calcific tendonitis (tendinopathy) of the shoulder

Codes

Procedures challenged in this policy
OPCS Code: T74.5 - Extracorporeal shockwave lithotripsy of calculus of tendon

Diagnoses challenged in this policy
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.
M77.1 - Lateral epicondylitis (tennis elbow)
M67.8 - Other specified disorders of synovium and tendon
M72.2 - Plantar fascial fibromatosis
M70.6 - Trochanteric bursitis
N48.6 - Induratio penis plastica
M75.3 - Calcific tendinitis of shoulder

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

Date approved: April 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Flash glucose monitors

The NHS long term plan announced that the NHS will ensure that, access should be expanded to flash glucose monitors, where clinically appropriate, to those living with type 1 diabetes given the evidence that the technology improves diabetes control and reduces hospital admissions.

The flash glucose monitoring system is a device for the self-monitoring of glucose levels. Unlike traditional finger-prick devices (that measure the glucose level in the blood), this device measures the glucose level in the interstitial fluid, via a sensor that sits just under the skin. It updates readings every minute and stores data every 15 minutes giving a near-continuous record of measurements which can be accessed on demand. These devices do not provide real-time continuous glucose monitoring. There are models of flash glucose monitor which have a hypoglycaemia alarm, and these should be offered where licensed to do so.

FreeStyle Libre is a flash glucose monitor licensed for adults and children above the age of 4.

Criteria

Routinely commissioned:

1. Patients on insulin who are living with a learning disability, as recorded on their GP learning disability register
2. A 12-month use of FreeStyle Libre is routinely commissioned in pregnant women with type 1 diabetes, inclusive of post-delivery period

Commissioned with criteria:

Flash glucose monitors are commissioned for a 6-month trial initially where patients meet one of the criteria below and agree to the patient contract.

The referral letter and patient's medical record need to clearly evidence how this criteria is met:

1. People with type 1 diabetes OR with any form of diabetes on haemodialysis and on insulin treatment who, in either of the above, are clinically indicated as requiring intensive monitoring more than 8 times daily, as demonstrated on a meter download or review over the past 3 months
2. People with type 1 diabetes unable to routinely self-monitor blood glucose due to disability, who require carers to support glucose monitoring and insulin management
3. People who meet the nice criteria for a pump who have:
   - a haemoglobin A1c (HbA1c) in excess of 8.5% on multiple daily injection insulin therapy despite a high level of care
   - People whose attempts to achieve target HbA1c levels with multiple daily insulin injections results in the patient experiencing disabling hypoglycaemia

For the purpose of this guidance, disabling hypoglycaemia is defined as the repeated and unpredictable occurrence of hypoglycaemia that results in persistent anxiety about recurrence and is associated with a significant adverse effect on quality of life.

Other requirements, also known as the patient contract:

The person with diabetes must agree to

1. Take part in education on flash glucose monitoring, if appropriate (online or in person)
2. scan glucose levels no less than 8 times per day and use the sensor more than 70% of the time
3. attend regular reviews with the local clinical team
4. attend a NICE approved type 1 diabetes structured education programme, if appropriate and if person has not previously received structured education

Longer term use of flash glucose monitors, (after 6 month trial)

Continuing prescription for long-term use of flash glucose monitoring after the initial 6 months would be dependent on evidence of meeting the patient contract and that:

- on-going use of the flash glucose monitoring is demonstrably improving an individual's diabetes self-management- for example improvement of HbA1c or time in range; improvement in symptoms such as diabetic ketoacidosis (DKA) or hypoglycaemia; or improvement in psycho-social wellbeing

the person is actively engaging in regular outpatient reviews with the clinical team, should an adult patient miss two consecutive specialist follow up appointments without notice then the continuing prescription should be discontinued and a letter sent to the persons GP accordingly

- Better care for health conditions, Diabetes
- Diabetes UK consensus guideline for flash glucose
- Diabetes UK flash glucose monitoring; resource for professionals
- FreeStyle Libre for glucose monitoring

Please note Freestyle Libre is not licensed for use under the age of 4 years.

Codes

Procedures challenged in this policy

There are no appropriate codes.

Relevant diagnoses for this policy

E10.0, E10.1, E10.2, E10.3, E10.4, E10.5, E10.6, E10.7, E10.8, E10.9

Diagnoses for which the above procedures are permitted

There are no appropriate codes.

Date approved: July 2019 and March 2022
Review date: July 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Hyperbaric oxygen therapy

Despite the increasing use of hyperbaric oxygen therapy (HBOT) in a range of conditions there is very little evidence from clinical trials regarding its clinical effectiveness or cost effectiveness. In line with findings from the review of HBOT by NHS Quality Improvement Scotland, NHS Cornwall and Isles of Scilly Integrated Care Board will fund its use for conditions where there is a theoretical basis for its effectiveness, sufficient empirical evidence and clinical consensus.

Criteria

Hyperbaric oxygen therapy is not routinely commissioned.

Codes

Procedures challenged in this policy

X521

Relevant diagnoses for this policy

None.

Diagnoses for which the above procedures are permitted
T703, T58, T58X, T580, T790, T79, T79X, K627, O880 This list is not exhaustive.

Date approved: September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Multiple chemical sensitivity and clinical ecology and environmental medicine

Clinical ecology relies on the concept that multiple symptoms are caused by hypersensitivity to minute amounts of common foods and chemicals. MCS is also known as environmental illness, total allergy syndrome and idiopathic environmental intolerance (IEI).

Treatment usually emphasizes avoidance of suspect substances with lifestyle changes for example, diet modification and to avoid synthetic items. Clinical ecologists often advise many patients to take vitamin, mineral, and other supplements. They can also offer the specific treatment of enzyme potentiated desensitisation (EPD), which allegedly boosts the immune response against minute doses of allergens. To date, no clinical studies have been conducted which compare EPD to standard allergy immunotherapy (multiple chemical sensitivity).

Criteria

Investigation of multiple chemical sensitivity (MCS) and/or treatment with clinical ecology or environmental medicine is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and March 2021
Review date: March 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Open magnetic resonance imaging (MRI) scanning

Referral for open MRI scanning of greater than 0.7T - 70cm bore and 250kg as an alternative to conventional MRI in secondary care.

Criteria

Prior approval must be gained before referral. A prior approval form should be completed. This should be undertaken by the referring GP or consultant.

- patients who suffer from claustrophobia where an oral prescription anxiolytics or sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). Where there is clinical rationale for sedation being contra-indicated or inappropriate, for example an allergy or psychological disorders, then this must be stated for the referral to be approved by the commissioner
- patients who are obese or cannot fit comfortably in conventional MRI scanners

Standing, upright, weight-bearing or positional MRI will not be commissioned.

Codes

Procedures challenged in this policy
There are no appropriate OPCS codes for open MRI machine.

Diagnoses challenged in this policy
There are no appropriate OPCS codes for open MRI machine.

Diagnoses for which the above procedures are permitted
ICD10 code: E660, E661, E662, E668, E669, F402

Date approved: April 2018 and July 2021
Review date: February 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Paediatric speech and language therapy in secondary care

The speech and language therapy service specialises in helping children who have difficulties in communicating and swallowing.

This policy relates to children aged 18 years and under only.

Criteria

Paediatric speech and language therapy in secondary care is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how the criteria is met:

- the patient has feeding and swallowing difficulties (dysphagia)

Where a child or young person is in receipt of speech and language therapy ongoing into hospital, please contact the main speech and language therapy service for further information and support on 01208 834488.

Children experiencing voice difficulties, including a total loss of voice or a change to the voice including quality, pitch, resonance and volume will be seen by the paediatric community speech and language therapy team. Referral forms can be found on the early help hub

Referral to the ENT department is required for all paediatric voice cases. Patients cannot refer themselves directly.

Please note the service excludes children and young people who are inpatients and who are not or have not been known to the paediatric community speech and language therapy service prior to their admission. Where they are already known to the service the relevant clinician will follow them into hospital.

Adults (18 plus) with a clinical need can access speech and language therapy routinely.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
F80.0 - Specific speech articulation disorder
F80.1 - Expressive language disorder
F80.2 - Receptive language disorder
F80.3 - Acquired aphasia with epilepsy [Landau-Kleffner]
F80.8 - Other developmental disorders of speech and language
F80.9 - Developmental disorder of speech and language, unspecified
R47.0 - Dysphasia and aphasia
R47.1 - Dysarthria and anarthria
R47.8 - Other and unspecified speech disturbances
R49.0 – Dysphonia (hoarseness)
R49.1 – Aphonia (loss of voice)
R49.2 - Hypernasality and hyponasality
R49.8 - Other and unspecified voice disturbances (inc. change in voice)
R63.3 - Feeding difficulties and mismanagement
R13.X – Dysphagia

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: February 2019 and February 2022
Review date: February 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Polysomnography for children

Criteria

Inpatient polysomnography (sleep studies) as a clinical intervention is appropriate for children in only a limited number of cases, and is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:
The use of polysomnography for children has been established in a number of pathways to investigate the following conditions:

- sleep disordered breathing or obstructive sleep apnoea syndrome (including children with underlying neuromuscular or cranio-facial disorders)
- congenital central hypoventilation syndrome
- apparent life-threatening events in infancy
- sleep related neurological disorders (REM parasomnias, sleep related epilepsy, narcolepsy or idiopathic hypersomnia)
- children with excessive daytime sleepiness, or circadian rhythm disturbance
- regular review of children with Down's syndrome who are at high risk of obstructive sleep apnoea or sleep disordered breathing (up to 30% of children or young people with Down's syndrome have such problems

In the majority of cases a sleep study should take place in the home. Inpatient polysomnography will only be commissioned where:

- the home sleep study produces a negative result for sleep apnoea and further investigation is required
- it is not clinically safe to undertake a sleep study in the home, for example ventilated children
- there are complications with a home sleep study, or problems with compliance

Polysomnography will not be commissioned for the investigation of hypersomnia related to chronic fatigue syndrome or periodic limb movement disorder.

Codes

Procedures challenged in this policy
OPCS Code: U331

Diagnoses for which the above procedures are permitted
ICD10 Code: F510, F511, F512, F513, F514, F515, F518, F519, G470, G471, G472, G473, G474, G478, G479, Q900, Q901, Q902, Q909

F51.0 - Nonorganic insomnia
F51.1 - Nonorganic hypersomnia
F51.2 - Nonorganic disorder of the sleep-wake schedule

F51.3 - Sleepwalking [somnambulism]
F51.4 - Sleep terrors [night terrors]
F51.5 - Nightmares
F51.8 - Other nonorganic sleep disorders
F51.9 - Nonorganic sleep disorder, unspecified
G47.0 - Disorders of initiating and maintaining sleep [insomnias]
G47.1 - Disorders of excessive somnolence [hypersomnias]
G47.2 - Disorders of the sleep-wake schedule
G47.3 - Sleep apnoea
G47.4 - Narcolepsy and cataplexy
G47.8 - Other sleep disorders
G47.9 - Sleep disorder, unspecified
Q90.0 - Trisomy 21, meiotic nondisjunction
Q90.1 - Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2 - Trisomy 21, translocation
Q90.9 - Down syndrome, unspecified

Date approved: April 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Population screening outside of national screening committee guidelines

This policy is to confirm the UK national screening programme for conditions where screening is recommended, and that the NHS Cornwall and Isles of Scilly Integrated Care Board continue to support patients in line with the national screening policy. The NHS Cornwall and Isles of Scilly Integrated Care Board will not commission any screening which is not recommended by the national screening committee.

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition. The screening provider then offers information, further tests and treatment. This is to reduce associated problems or complications. Identification through this process can show that the patient may have the condition screened for. The patient may need further confirmatory diagnostic tests.

At each stage of the screening process, patients can make their own choices about further:

- tests
- treatment
- advice
- support

Criteria

Population screening outside of national guidelines is not routinely commissioned and is subject to this restricted policy.

Screening will only be commissioned by the NHS for patients meeting the criteria:

1. UK national screening committee advises on policy for screening for a wide range of population health problems and the NHS Cornwall and Isles of Scilly Integrated Care Board commissions screening programmes in line with these recommendations
2. Commissioner does not commission population screening for conditions where the UK national screening committee has said that it is not recommended

Read the full list of the UK national screening committee policies and recommendations.

Codes

Procedures challenged in this policy

There are no appropriate codes.

Relevant diagnoses for this policy

Z13.6 Abdominal aortic aneurysm
Z12.1 Bowel cancer
Z12.3 Breast cancer
Z12.4 Cervical cancer
Z13.5 Congenital cataract
Z13.7 Congenital heart disease
Z13.8 Congenital hypothyroidism
Z13.7 Crytorchidism
Z13.8 Cystic fibrosis (newborn)
Z13.7 Developmental dislocation of the hip (if congenital)
Z13.5 Diabetic retinopathy
Z13.7 Down's syndrome
Z13.7 Fetal anomalies
Z13.7 GA1
Z13.3 Growth for developmental disorder or disease or Z13.4 for developmental disorder in early childhood
Z13.7 HCU
Z13.5 Hearing (child)
Z13.5 Hearing (newborn)
Z11.5 Hepatitis B
Z11.4 Human immunodeficiency virus
Z13.7 IVA
Z13.7 MCADD
Z13.7 MSUD
Z13.7 Neural tube defect
Z13.7 PKU
Z13.0 Sickle cell and thalassaemia
Z13.0 Sickle cell disease (newborn)
Z11.3 Syphilis
Z13.7 T18 and T13

Z13.5 Vision defects

Please note any of the codes above will only be assigned in a primary position where no diagnosis, abnormal finding or symptom, injury or complication has been documented. If any of these are documented a code will be assigned for these instead and the Z code would not be assigned.

Diagnoses for which the above procedures are permitted

There are no appropriate codes.

Date approved: April 2018 and April 2021
Review date: April 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Weight loss drugs commissioning policy

Introduction

Over the last few years, the demand for medical therapies for the management of obesity has increased, as the pharmacological solutions have evolved. Currently, three medications are licenced in the UK and mandated by the National Institute for Health and Care Excellence (NICE) under technology appraisal guidance (TA) for weight loss:

- Liraglutide (Saxenda®) NICE TA 664
- Semaglutide (Wegovy® NICE TA 875
- Tirzepatide (Mounjaro®) NICE TA 1026

Liraglutide, semaglutide and tirzepatide are also used in the treatment of type 2 diabetes, which is out of scope of this policy.

At this time liraglutide and semaglutide for weight loss can only be prescribed within consultant led weight management services, or services that qualify as such by providing multidisciplinary management of overweight or obesity.

On the 23 June 2025 tirzepatide (Mounjaro®) received NHS England approval for use in primary care for the management of obesity, in line with eligibility set out in national guidance.

Tirzepatide may be prescribed within primary care or as part of specialist tier 3 and tier 4 weight management services, in accordance with NICE recommendations and NHS England implementation guidance see link https://www.nice.org.uk/guidance/ta1026/chapter/4-Implementation and local commissioning arrangements.

Summary

This commissioning policy sets out the criteria for weight loss medication where a NICE TA applies and where this can be prescribed by:

- primary care/community services (such as community pharmacy) in line with the NHS England implementation guidance for NICE TA1026 for a three-year period starting from 23 June 2025.
- specialist weight management services for patients with complex or urgent clinical needs.

The principles within this local commissioning policy are to ensure a consistent, transparent offer for patients by confirming

a. routine access to tirzepatide for weight loss aligns to the NHS England implementation guidance criteria as set out in 1. below

AND

b. access to semaglutide, and any other medication that is prescribed solely for weight loss will also align with the NHS England funding variation for tirzepatide as set out in 1. below

AND

c. exception criteria for people with urgent clinical needs to access to weight loss medication through the specialist weight management service as set out in 2. below

Criteria for primary care prescribing for weight management

At the time of writing the policy only tirzepatide (Mounjaro) and orlistat are licensed for delivery in primary care for weight management. There is no technology appraisal guidance on Orlistat and thus commissioning of this treatment is not mandatory.

Tirzepatide is recommended as an option for managing overweight and obesity, alongside a reduced-calorie diet and increased physical activity in adults in addition to participating in lifestyle support.

NHS England's interim commissioning guidance for NICE's technology appraisal guidance on tirzepatide sets out a phased approach to patient eligibility over a three-year period following publication of the guidance on 23 June 2025.

Cohort 1. 12 months
23 June 2025 to 22 June 2026

- adults with a BMI of 40 kg/m² * or more and
- at least four of the five health conditions listed in the table below

Cohort 2. 9 months
23 June 2026 to 31 March 2027

- adults meeting cohort 1 criteria, plus
- access extended to adults with a BMI of 35 kg/m² * or more and
- at least four of the five health conditions listed in the table below

Cohort 3. 15 months
1 April 2027 to 22 June 2028

- adults meeting criteria for cohort 1 and 2 plus

- access extended to adults with a BMI of 40 kg/m² * or more and
- at least three of the five health conditions listed

Qualifying Comorbidities	Definition for Initial Assessment
Atherosclerotic cardiovascular disease (ASCVD)	Established atherosclerotic CVD (ischaemic heart disease, cerebrovascular disease, peripheral vascular disease, heart failure)
Hypertension	Established diagnosis of hypertension and requiring blood pressure lowering therapy
Dyslipidaemia	Treated with lipid-lowering therapy, or with low-density lipoprotein (LDL) ≥ 4.1 mmol/L, or high-density lipoprotein (HDL) <1.0 mmol/L for men or HDL<1.3 mmol/L for women, or fasting (where possible) triglycerides ≥1.7 mmol/L
Obstructive Sleep Apnoea (OSA)	Established diagnosis of OSA (sleep clinic confirmation via sleep study) and treatment indicated i.e. meets criteria for continuous positive airway pressure (CPAP) or equivalent
Type 2 diabetes mellitus	Established type 2 diabetes mellitus **

* due to an increased risk of health conditions at lower BMI thresholds in these populations the BMI applied to assess eligibility for weight loss drugs must be adjusted by 2.5kg/m2 in people from south Asian, Chinese, other Asian, Middle Eastern, Black African or African Caribbean ethnic backgrounds to ensure equitable clinical provision and access to appropriate treatment.

**People with type 2 diabetes can be prescribed tirzepatide (Mounjaro®) for obesity or for glycaemic management in type 2 diabetes if they meet the criteria set out in the recommendations in either:

- NICE's technology appraisal guidance on tirzepatide (Mounjaro®) for managing overweight and obesity (NICE TA1026); or
- Tirzepatide (Mounjaro®) for treating type 2 diabetes (NICE TA924).

In all cohorts the patient must engage with the national NHS Behavioural Support for Obesity Prescribing (BSOP) Programme (also known as national wraparound service). Referral to this programme is mandated when tirzepatide is prescribed in primary care for weight management.
AND

(local policy) Treatment should be discontinued if:
a. less than 5% of initial weight has been lost despite 6 months of treatment at maximum tolerated dose
b. The patient does not engage with the national NHS BSOP programme

Exceptional criteria for urgent conditions (local policy)

Liraglutide (Saxenda®), semaglutide (Wegovy®), and tirzepatide (Mounjaro®) for weight management are available for use in the management of obesity in defined patient groups with the greatest clinical need, following assessment and initiation by the Specialist Weight Management Service (SWMS).

In the SWMS setting these weight loss medications are commissioned only if:

1. people are living with an urgent condition (see criteria in table 2 below) in which weight loss would improve outcomes or aid access to therapies and are referred by a secondary care specialist (General Practice referrals will not be accepted)

AND

2. people meet the NICE criteria for use for weight management in adults, including:
    a. Use alongside a programme of support that includes reduced-calorie diet and increased physical activity
    b. At least 1 weight-related co-morbidity

AND

3. the weight loss medication is prescribed until
    a. the patient has reached the target weight loss required for the surgical/other treatment required (with the possible exception of IIH) or
    b. target weight has been reached (for young adults age 16+ transitioning from the complications of excess weight clinics) or
    c. the treatment has been prescribed for 24 months (with the possible exception of IIH), whichever is sooner.

Urgent conditions***
are defined as a Body Mass Index (BMI) of greater than or equal to 35 kg/m2*, and at least one of the following priority conditions for specialist weight loss service

Table 2

Exceptional/urgent conditions	**Definition for Initial Assessment**
Active malignancy and need for urgent weight loss for planned therapy	e.g. radiotherapy or surgery
Urgent weight loss required for organ transplant	
Idiopathic intracranial hypertension (IIH)	requiring frequent lumbar punctures and/or with visual compromise
Patients undergoing planned time-sensitive surgery (including bariatric surgery) for life-limiting conditions,	where high BMI is the primary barrier to surgery and weight loss would be beneficial
Weight loss required for assisted conception in women under the care of fertility service	in cases where weight loss would be beneficial

Severe obstructive sleep apnoea, or obesity hypoventilation syndrome and/or severe asthma	where the condition is life limiting despite ongoing secondary care management with optimised treatment
Proven genetic cause of obesity	and not eligible for setmelanotide (NHSE commissioned)
Young adults (age 16+), who are transitioning from the Complications of Excess Weight (CEW) specialist clinics	who have been prescribed weight loss drugs as part of this treatment and need to continue the course

***Based on 'Guidance for the phased introduction of new medical therapies for weight management: A joint position statement by the Society for Endocrinology and Obesity Management Collaborative UK December 2023'

Codes

Procedures challenged in this policy

- Patients who do not meet eligibility criteria as above
- Patients already initiated on a GLP-1 agonist for other indications are not covered by this commissioning policy.
- Patients who do not meet the above criteria will not be eligible for weight loss medications. However, patients can still be referred to SWMS if they meet the criteria included in Clinical Commissioning Policy Specialist Weight Management Services and Bariatric Surgery for Adults as other weight management options may be available.

Diagnoses for which the above procedures are permitted

E66.0 - Obesity due to excess calories
E66.1 - Drug-induced obesity
E66.2 - Extreme obesity with alveolar hypoventilation
E66.8 - Other obesity
E66.9 - Obesity, unspecified

I10.X - Essential (primary) hypertension

E78.0 - Pure hypercholesterolaemia
E78.1 - Pure hyperglyceridaemia
E78.2 - Mixed hyperlipidaemia
E78.3 - Hyperchylomicronaemia
E78.4 - Other hyperlipidaemia
E78.5 - Hyperlipidaemia, unspecified
E78.6 - Lipoprotein deficiency
E78.8 - Other disorders of lipoprotein metabolism
E78.9 - Disorder of lipoprotein metabolism, unspecified

G47.3 - Sleep apnoea

E11.0 - Type 2 diabetes mellitus, With coma
E11.1 - Type 2 diabetes mellitus, With ketoacidosis
E11.2 - Type 2 diabetes mellitus, With renal complications
E11.3 - Type 2 diabetes mellitus, With ophthalmic complications
E11.4 - Type 2 diabetes mellitus, With neurological complications
E11.5 - Type 2 diabetes mellitus, With peripheral circulatory complications
E11.6 - Type 2 diabetes mellitus, With other specified complications
E11.7 - Type 2 diabetes mellitus, With multiple complications
E11.8 - Type 2 diabetes mellitus, With unspecified complications
E11.9 - Type 2 diabetes mellitus, Without complications
I25.0 - Atherosclerotic cardiovascular disease, so described
I25.1 - Atherosclerotic heart disease
I25.8 - Other forms of chronic ischaemic heart disease
I25.9 - Chronic ischaemic heart disease, unspecified

I73.9 - Peripheral vascular disease, unspecified

I50.0 - Congestive heart failure
I50.1 - Left ventricular failure
I50.9 - Heart failure, unspecified

Notes

- As part of treatment initiation discussions patients should be made aware of the NHS CIOS commissioning policy for abdominoplasty and apronectomy which are surgical procedures to remove excess fat and skin from the mid and lower abdomen and the implications of this for them.
- SWMS is a specialist multi-disciplinary team that work to empower, inform, and support patients, in a non-judgmental environment, to achieve sustainable weight loss, through a clinically lead multi-disciplinary service.

Date approved: 26 November 2025
Review date: 26 November 2028
JCIA: Yes, Completed

Musculoskeletal health

Arthroscopic surgery for meniscal tears (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

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

(BASK) recently published guidelines for the use of arthroscopic surgery to treat degenerate meniscal tears.

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.

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.

This guidance applies to adults and children.

Criteria

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.

For patients who do not fulfil criteria for first line arthroscopic meniscal surgery:

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.

Evidence based intervention national coding script

```
WHEN ( LEFT(Primary_Spell_Procedure,4) IN ('W821','W822','W823','W828','W829')
OR (LEFT(Primary_Spell_Procedure,4) = 'W714'
AND ( Any_Spell_Procedure LIKE '%Y767%'
AND Any_Spell_Procedure LIKE '%Z846%'))
OR (LEFT(Primary_Spell_Procedure,4) = 'W715'
AND ( Any_Spell_Procedure LIKE '%Y767%'
AND Any_Spell_Procedure LIKE '%Z846%'))
)
AND (Any_Spell_Diagnosis LIKE '%M232%'
OR ( Any_Spell_Diagnosis LIKE '%M233%'
AND Any_Spell_Diagnosis LIKE '%M238%')
)
AND Any_Spell_Diagnosis NOT LIKE '%S832%'
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2E_athroscopic_surgery_meniscal
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Bunion surgery (hallux valgus)

A bunion (hallux valgus) is a bony swelling at the base of the big toe. Not all people with bunions have symptoms.

Criteria

Surgical removal of bunions is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- conservative measures methods have been tried and documented to have failed
- moderate to severe deformity (omit overriding toes) is causing significant (documented) functional impairment* or prevents patients from finding comfortable footwear
- severe pain is causing significant functional impairment*
- recurrent infection
- recurrent ulcers
- the patient is willing to consider surgery

*Note significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
W792
W79.1 - Soft tissue correction of hallux valgus inc soft tissue correction of hallux valgus and excision of bunion

Relevant diagnoses for this policy
M201

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: November 2016, November 2018 – significant functional impairment definition amended only, February 2019 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Carpal tunnel syndrome release (National Evidence Based Intervention)

Carpal tunnel syndrome is very common, and mild cases may never require any treatment. Cases which interfere with activities or sleep may resolve or settle to a manageable level with non-operative treatments such as a steroid injection (good

evidence of short-term benefit (8-12 weeks) but many progress to surgery within 1 year). Wrist splints worn at night (weak evidence of benefit) may also be used but are less effective than steroid injections and reported as less cost-effective than surgery.

In refractory (keeps coming back) or severe case surgery (good evidence of excellent clinical effectiveness and long-term benefit) should be considered. The surgery has a high success rate (75 to 90%) in patients with intermittent symptoms who have had a good short-term benefit from a previous steroid injection. Surgery will also prevent patients with constant wooliness of their fingers from becoming worse and can restore normal sensation to patients with total loss of sensation over a period of months.

The hand is weak and sore for 3-6 weeks after carpal tunnel surgery, but recovery of normal hand function is expected, significant complications are rare (≈4%) and the lifetime risk of the carpal tunnel syndrome recurring and requiring revision surgery has been estimated at between 4 and 15%.

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) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)

  and
    - night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

Surgical treatment of carpal tunnel should be considered if one of the following criteria are met:

- The symptoms have been more than six months duration and significantly interfere with daily activities and sleep symptoms or have not settled to a manageable level having tried one local corticosteroid injection and nocturnal splinting for a minimum of 8 weeks

OR

- There is either:
    - a permanent (ever-present) reduction in sensation in the median nerve distribution

OR

    - muscle wasting or weakness of thenar abduction (moving the thumb away from the hand)

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Codes

Procedures challenged in this policy
A651, A659
Relevant diagnoses for this policy
G560

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script

WHEN Primary_Spell_Procedure = 'A651'
AND Primary_Spell_Diagnosis like '%G560%'
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'M_carpal'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: August 2017, March 2018, November 2018 – significant functional impairment definition amended only, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Direct access DXA scanning to help target treatment in adults at potential risk of osteoporotic (fragility) fracture

Direct access DXA scanning to help target treatment in adults at potential risk of osteoporotic (fragility) fracture.

Criteria

Note: If there is no intention to change the patient's treatment based on DXA result, then DXA scanning is not required and will not be routinely commissioned.

Direct access DXA scans is commissioned where patients suspected to be at relatively high risk of fragility fracture meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

1. The patient's absolute risk of having a fracture in the next 10 years has been estimated using FRAX or QFracture and assessed as intermediate or high.

Note: For patients above the age limits recognised by the tools, consider patients to be high risk; below the age ranges (less than 40 years) covered by these tools see the last bullet below, or consider specialist advice.

2. Patient had a DXA scan over 5 years ago and a repeat DXA scan would be helpful in reassessing the need for ongoing treatment
3. Patient had a DXA scan over 3 years ago and a repeat DXA scan would be helpful in reassessing the need to start (or restart) treatment
4. Patient has been formally diagnosed with coeliac disease within the previous 12 months and has not previously undergone DXA scanning or where a previous DXA scan was indicative of osteoporosis following which the patient has been on a gluten free diet for a minimum of 3 years
5. Patient is commencing or has received drug treatment for cancer which might have adversely affected bone mineral density (for example aromatase inhibitors or anti-androgen therapy)
6. The patient is aged under 40 with a major risk factor for fracture, defined as:
    - a history of multiple fragility fracture
    - history of hip or vertebral fracture
    - current or recent use of high-dose oral or high-dose systemic glucocorticoids (more than 7.5mg prednisolone or equivalent per day for 3 months or longer)

Note: Patients assessed as low risk should be reassured that a DXA scan is not necessary and advised on general measures to maintain bone health.

In patients whose previous assessment did not lead to treatment and who now require reassessment to judge whether treatment thresholds are now met, fracture risk may be reassessed including DXA scan provided the access criteria in this policy are still met and an interval of at least 3 years has passed since their last DXA scan.

Codes

Procedures challenged in this policy
OPCS code: U13.1

Diagnoses challenged in this policy
There are no appropriate ICD10 codes challenged under this policy.

Diagnoses for which the above procedures are permitted
M80. M81.

M82 is an asterisk code which means it must be paired with another code (dagger code). They provide dual classification showing the underlying disease (dagger code) and the manifestation (asterisk code). M82 can be in a primary position if it is the main condition treated. If not, it will be in the secondary position sequenced after the dagger code

Date approved: April 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Dupuytren's contracture release in adults (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

Dupuytren's is a progressive and lifelong genetic contracture of the fibrous elements related to the palmar fascia. The condition is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. While the condition is not painful, the condition may lead to function limitation due to inability to open up the fingers completely. All treatments aim to straighten the finger to improve hand function. Despite treatment, deformities may likely recur following intervention and multiple procedures may be required, progressively increasing the risk of additional complication.

Splinting and radiotherapy have not been shown be effective treatments of established Dupuytren's contractures.

Several treatments are available: needle fasciotomy, fasciectomy and dermofasciectomy. None of these interventions are curative. Some have slower recovery periods, higher complication rates or higher re-operation rates (for recurrence) than others.

The disease process affects the hand to varying degrees and patients may present at different stages in the disease process. It is hence important that the timing and choice of intervention is tailored to the individual patient and based on shared decision making between the patient and a practitioner with clinical expertise in the various treatment options. It is recommended that as part of the consultation process of patients undergoing intervention, a validated decision aid tool should be used during the consenting process to ensure that the patients' desired outcomes have been considered. An example of decision aid tool is on the NHS website.

Currently there is a lack of consensus and high-quality evidence on the best and most cost-effective long-term treatment option, however, this may change in the future.

Criteria

- This intervention should not be undertaken for purely cosmetic purposes – which is in accordance with NHS policy more widely

- Treatment is not indicated in cases where there is no contracture, or the contracture is not progressing and does not impair function

- An intervention (Needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for
    - MCPJ deformity *and* causing a significant functional impairment* OR
    - PIPJ deformity/contracture greater than 20o OR
    - multiple joints with significant functional impairment * OR
    - Recurrence after surgery with functional impairment* (consider referral on first presentation)

  AND the patient is willing to have an operation

A validated decision support tool could be used when consenting patients for possible intervention taking into account factors such as severity of deformity, patient choice and patient health status. An example of decision aid tool is on the NHS website.

As aligns with the NICE guidance, there is inadequate evidence to recommend the use of radiation therapy in the management of Dupuytren's disease. It should only be used with special arrangement for clinical governance, audit or research.

Codes

Procedures challenged in this policy
T521, T522, T525, T526, T541, T543, X654, X658, X659

Relevant diagnoses for this policy
M720 and patient age is between 19 and 120

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN
('T521','T522','T525','T526','T541','T543','X654','X658','X659')
AND Primary_Spell_Diagnosis='M720'
-- Age Between 19 and 120
AND
(ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120)
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'N_dupuytr'
```

Exclusions

```
WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
```

AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: August 2017, November 2018, November 2019 and January 2025.
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Excision of acromio-clavicular joint or arthroscopic surgical decompression for sub-acromial shoulder pain (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

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

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

Criteria

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

Excision of acromio-clavicular joint or arthroscopic surgical decompression for sub-acromial shoulder pain is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- failure of conservative treatment (including physiotherapy and exercise)
- if a temporary improvement has been demonstrated using injection surgery
- if there has been successful surgical treatment of the contralateral side following appropriate conservative management

Codes

Procedures challenged in this policy
W844+shoulder or O291 with Y767 as a secondary procedure

Relevant diagnoses for this policy
M754, M2551

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Evidence based intervention national coding script
WHEN ((Primary_Spell_Procedure ='O291'
AND Any_Spell_Procedure like '%Y767%')
OR (Primary_Spell_Procedure ='W844'
AND Any_Spell_Procedure like '%Z812%')
OR (Primary_Spell_Procedure ='W572'
AND Any_Spell_Procedure like '%Z812%'))
AND Any_Spell_Diagnosis like '%M754%'
AND Any_Spell_Diagnosis not like '%M751%'
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'L_should_decom'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: April 2018, November 2019 and January 2025
Review date: There are no plans for further reviews
JCIA: Yes, completed

Exogen ultrasound bone healing system

The long bones are those longer than they are wide.

The long bones considered by NICE during the review of clinical evidence include the:

- femora
- tibiae and fibulae of the legs
- the humerus, radius and ulnae of the arms

This policy refers only to these bones and not the other long bones, including metacarpals and metatarsals of the hands and feet, the phalanges of the fingers and toes, and the clavicles or collar bones. The latter were not considered under the NICE evidence review.

Criteria

Exogen ultrasound bone healing system is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

1. To treat long bone fractures with non-union, defined as a non-healing fracture at 6 months with no progression or signs of fracture healing
2. Surgery may be required to correct the non-union of the long bone fracture. This includes primary and revision surgery where primary surgery has failed
3. The patient would be eligible, fit and appropriate for surgery to treat the non-union
4. Patients must be able and willing to fully comply with the treatment regime of administering the device for 20 minutes per days for a minimum of 120 days either through self-management or with the help of carers
5. The patients and clinicians must confirm that they will comply with the terms of the warranty provided by the suppliers. This includes registering the device within 14 days of commencing treatment, complying with the treatment regime of using the device for 20 minutes a day for a minimum 120 days and returning the device to the suppliers at the end of treatment, whether the treatment is successful or not

Exclusions

Funding approval will not normally be commissioned where the patients meets the following criteria as the clinical evidence reviewed by NICE does not support the provision of exogen:

1. The patient has delayed healing
2. The patient has non-union of a fracture in a short bone, flat bone, irregular bone, scaphoid bone or sesamoid bone or other long bones not subject to a clinical evidence review by NICE
3. The patient has not reached skeletal maturity, for example the growth plates of children or adolescents that have not fully matured or closed, a normal finding in the x-rays of young people
4. The patient has an unstable surgical fixation, not well aligned or where inter-fragment gap is more than 10mm
5. The patient has an infection in the fracture
6. The patient is pregnant, has a pacemaker or vertebral or skull fracture
7. Surgery is contra-indicated for the patient for any other reason

Codes

Procedures challenged in this policy

OPCS code: There is not a specific OPCS code for exogen US bone healing as a procedure, there is only a code for ultrasound scan of bone or joint U13.2 but the latter is not an accurate way of identifying exogen healing. Desktop exercise required to audit against this policy.

Diagnoses challenged in this policy

ICD10 Code: S422, S423, S424, S520, S521, S522, S523, S524, S525, S526, S527, S528, S529, S720, S721, S722, S723, S724, S729, , S821, S822, S823, S824

S42.2 Fracture of upper end of humerus
S42.3 Fracture of shaft of humerus
S42.4 Fracture of lower end of humerus
S52.0 Fracture of upper end of ulna
S52.1 Fracture of upper end of radius
S52.2 Fracture of shaft of ulna
S52.3 Fracture of shaft of radius
S52.4 Fracture of shafts of both ulna and radius
S52.5 Fracture of lower end of radius
S52.6 Fracture of lower end of both ulna and radius
S52.7 Multiple fractures of forearm
S52.8 Fracture of other parts of forearm
S52.9 Fracture of forearm, part unspecified
S72.0 Fracture of neck of femur
S72.1 Pertrochanteric fracture
S72.2 Subtrochanteric fracture
S72.3 Fracture of shaft of femur
S72.4 Fracture of lower end of femur
S72.9 Fracture of femur, part unspecified
S82.1 Fracture of upper end of tibia
S82.2 Fracture of shaft of tibia
S82.3 Fracture of lower end of tibia
S82.4 Fracture of fibula alone

Diagnoses for which the above procedures are permitted

M84.02 Malunion of fracture, upper arm
M84.03 Malunion of fracture, forearm
M84.05 Malunion of fracture, pelvic region and thigh
M84.06 Malunion of fracture, lower leg
M84.12 Nonunion of fracture [pseudarthrosis], upper arm
M84.13 Nonunion of fracture [pseudarthrosis], forearm
M84.15 Nonunion of fracture [pseudarthrosis], pelvic region and thigh
M84.16 Nonunion of fracture [pseudarthrosis], lower leg
M84.22 Delayed union of fracture, upper arm
M84.23 Delayed union of fracture, forearm
M84.25 Delayed union of fracture, pelvic region and thigh
M84.26 Delayed union of fracture, lower leg

Date approved: April 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Fusion surgery for mechanical axial low back pain (National Evidence Based Intervention)

Spinal fusion is when two individual spinal vertebrae become joined together by bone formed as a result of surgery. This may involve the use of bone graft and/or surgical implants. The surgery aims to stop movement at segment(s) of the spine to stabilise the joint and remove pain. Spinal fusion is not recommended for patients with isolated back pain where there is no identified cause.

This guidance applies to adults aged 19 years and over.

Criteria

Spinal fusion surgery is not indicated for the treatment of isolated back pain i.e. pain which is localised to the back and not present in lower limbs, unless the following criteria are met:

- Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
- Scoliosis surgery
- Sacroiliac joint dysfunction
- Spinal fusion is appropriate during spinal decompression surgery for nerve compression, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.

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

Evidence based intervention national coding script

```
WHEN (LEFT(Primary_Spell_Procedure,4) LIKE '%V38[23456]%'
OR LEFT(Primary_Spell_Procedure,4) LIKE '%V39[34567]%'
OR LEFT(Primary_Spell_Procedure,4) LIKE '%V404%')
AND Primary_Spell_Diagnosis LIKE '%M54[34589]%'
AND NOT ( Any_Spell_Diagnosis LIKE '%M40[012]%'
OR Any_Spell_Diagnosis LIKE '%M41[01234589]%'
OR Any_Spell_Diagnosis LIKE '%M42[019]%'
OR Any_Spell_Diagnosis LIKE '%M43[01589]%'
OR Any_Spell_Diagnosis LIKE '%M45%'
```

```
OR Any_Spell_Diagnosis LIKE '%C41[24]%'
OR Any_Spell_Diagnosis LIKE '%M462%'
OR Any_Spell_Diagnosis LIKE '%M533%'
OR Any_Spell_Diagnosis LIKE '%M80[01234589]8%'
)
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2Y_back_pain_fusion'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Ganglion excision (National Evidence Based Intervention locally adapted)

Ganglia are benign fluid filled, firm and rubbery in texture lumps. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%).

Reassurance should be the first therapeutic intervention. Aspiration alone can be successful, but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates of up to 40% have been reported.

Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

Criteria

Removal of ganglia is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- persistent pain (for example. pain without spontaneous resolution within 1 to 2 years)
- significant functional Impairment*
- evidence of nerve compression

*Note significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
T591, T592, T598, T599, T601, T602, T608, T609

Relevant diagnoses for this policy
M674

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN ('T591','T592','T601','T602')
AND ( Primary_Spell_Diagnosis like '%M674%'
OR Primary_Spell_Diagnosis like '%M255%')
AND Any_Spell_Diagnosis not like '%M258%'
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'O_ganglion'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: November 2016, November 2018 – significant functional impairment definition amended only, February 2019, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy

JCIA: Yes, completed.

Hip impingement syndrome

Hip impingement syndrome is caused by unwanted contact between abnormally shaped parts of the head of the thigh bone and the hip socket. This results in limited hip movement and pain.

Criteria

Open or arthroscopic femoro-acetabular surgery for hip impingement in the absence of osteoarthritis is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- labral tear or impingement has been confirmed on MRI
- where hip arthroscopy is supported in the washout of an infected native hip joint in patient's refractory to medical management, patients with underlying disease or patients who are immunosuppressed
- where hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode (arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies)
- the clinician has ensured that the patient understands what is involved, is aware of the serious known complications outlined in NICE patient information and agrees to the treatment knowing that there is only evidence for relief of the symptoms in the short and medium term
- all available conservative methods have failed including activity modification, pharmacological intervention and specialist physiotherapy
- patient has severe symptoms causing pain or significant functional impairment* lasting more than 6 months
- aged between 18 and 50 years likely to gain most benefit

*Note: significant functional impairment is defined as a restriction or interference with an individual's capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
W581, Z843, or W844 with Z843

Relevant diagnoses for this policy
M248, Q658

Diagnoses for which the above procedures are permitted
M16, M160, M161, M162, M163, M164, M165, M166, M167, M168, M169

Date approved: August 2017, November 2018 – significant functional impairment definition amended only and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Injections for non-specific low back pain without sciatica (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

Many types of spinal injections do not have a strong evidence base. This guidance is focused on the use of diagnostic spinal injections (local anaesthetic only), radiofrequency denervation and NOT therapeutic injections for people with isolated lower back pain without sciatica.

Isolated back pain is common, often multifactorial and amenable to multimodal non-operative treatment (e.g. lifestyle modifications, weight loss, analgesia, exercise). Imaging (e.g. plain film radiographs, MRI) in the absence of focal neurology (e.g. sciatica) or 'red flags' may identify incidental, if not trivial, findings of age-related changes which can unnecessarily create a health anxiety for some patients, where simple reassurance would otherwise usually suffice.

NICE guidelines recommend that spinal injections should not be offered for the treatment of isolated lower back pain. Diagnostic spinal injections, specifically medial branch blocks do have a role as part of the diagnostic pathway for patients who may be suitable for facet joint denervation therapy.

Radiofrequency denervation is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves. This focused electrical energy heats and denatures the nerve. NICE supports denervation therapy for patients who meet the treatment criteria stated above.

Criteria

This guidance recommends:

1. Medial branch blocks (a spinal injection)

CAN be used diagnostically for patients with isolated lower back pain who have not responded to rehabilitation.

Should NOT be used therapeutically for patients with isolated lower back pain.

2. Radiofrequency denervation should be offered for patients with isolated lower back pain who meet all of the following criteria:

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

AND

- they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent)

AND

- after a positive response (defined as an improvement of 50% in the first 6 hours, ideally should be through diary exercises) to a diagnostic medial branch block with 1 ml or less of local anaesthetic at each level (No steroids)

3. Diagnostic sacroiliac joint injections (local anaesthetic only) should be used in patients whose pain is believed to arise from this joint.

4. For people with isolated low back pain the following injections should not be offered:

- Intra-articular facet joint injections
- Intradiscal therapy
- Platelet rich plasma
- Stem cell therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for isolated back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

5. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.

For further information please see NICE Guidance [NG 59] Low back pain and sciatica in over 16s: assessment and management.

The scope of the guidance does NOT cover the following:

Epidurals/nerve root blocks (local anaesthetic and steroid) which should be considered in patients who have acute and severe lumbar radiculopathy.

Codes

Procedures challenged in this policy

A521, A522, A528, A529, A577, A735, V544, X322, X323, X324, X325, X334 X335, X336, A573

Relevant diagnoses for this policy

- M541, M511 + G55.1 (radiculopathy and lumbar and other intervertebral disc disorders with radiculopathy).

- M545 (chronic low back pain)

Diagnoses for which the above procedures are permitted

- A521, A522, A577 + Z07.1 – Cervical spine, Z07.2 – Thoracic spine, Z07.3 – Lumbar spine, Z07.8 – Other specified with a diagnosis code M541, M511 +G55.1
- V544 +V55. +Z675 with a diagnosis code M545
- V485 + V55. with a diagnosis code M545

Evidence based intervention national coding script

```
WHEN (Primary_Spell_Procedure IN (
'A521','A522','A528','A529','A577','A735','V544','X322','X323','X324','X325','X334','X335','
X336'
,'A573')
OR (Primary_Spell_Procedure = 'W903' AND Any_Spell_Procedure like '%Z841%') )
AND Primary_Spell_Diagnosis IN ('M545')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'D_low_back_pain_inj'
Exclusions

 WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
--Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: 26 January 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed.

Knee arthroscopy diagnostic and therapeutic

Criteria

Diagnostic arthroscopy unless 1 or more of the following criteria are met diagnostic arthroscopy of the knee is not routinely commissioned:

- knee pain with diagnostic uncertainty following an MRI scan
- suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis

Therapeutic arthroscopy: Unless all the following criteria are met therapeutic arthroscopy of the knee is not routinely commissioned:

- clinical examination by a consultant specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament, rupture or loose body)
- where conservative treatment has failed or where it is clear that conservative treatment will not be effective

Codes

Procedures challenged in this policy

W821, W822, W823, W828, W829, W851, W852, W853, W858, W859, W861+KNEE, W831+KNEE, W832+KNEE, W833+KNEE, W834+KNEE, W835+KNEE, W836+KNEE, W837+KNEE, W838+KNEE, W839+KNEE, W841+KNEE, W842+KNEE, W843+KNEE, W844+KNEE

Relevant diagnoses for this policy

Not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99
Primary diagnosis ICD 10 code is like: M15, M17
Patient age is between 18 and 120.

Diagnoses for which the above procedures are permitted

C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99
Primary diagnosis ICD 10 code is like: M15, M17
Patient age is between 18 and 120.

Date approved: November 2016, February 2019 and November 2019
Review date: November 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Knee arthroscopy for patients with osteoarthritis (National Evidence Based Intervention)

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

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

Criteria

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

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

Codes

Procedures challenged in this policy

W821, W822, W823, W828, W829, W851, W852, W853, W858, W859, W861+KNEE, W831+KNEE, W832+KNEE, W833+KNEE, W834+KNEE, W835+KNEE, W836+KNEE, W837+KNEE, W838+KNEE, W839+KNEE, W841+KNEE, W842+KNEE, W843+KNEE, W844+KNEE

Relevant diagnoses for this policy

Not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99
and primary diagnosis ICD 10 code is like: M15, M17

Diagnoses for which the above procedures are permitted

C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99
and primary diagnosis ICD 10 code is like: M15, M17

Evidence based intervention national coding script

```
WHEN (Primary_Spell_Procedure IN ('W851','W852')
OR (Primary_Spell_Procedure = 'W802' AND
(Any_Spell_Procedure like '%Y767%'
AND Any_Spell_Procedure like '%Z846%' )))
AND ( Primary_Spell_Diagnosis like 'M17[0123459]%'
OR Primary_Spell_Diagnosis like 'M15[0123489]%')
AND Any_Spell_Procedure not like '%M238%'
-- Age Between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'C_knee_arth'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: November 2016, February 2019, November 2019 and January 2025
Review date: There are no plans for any further review
JCIA: Yes, completed

Knee MRI for suspected meniscal tears (National Evidence Based Intervention)

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

This guidance applies to adults aged 19 years and over.

Criteria

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

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

Evidence based intervention national coding script

Coding and count merged for T Knee MRI when symptoms are suggestive of osteoarthritis and U Knee MRI for suspected meniscal tears, producing a single metric.

Outpatient

```
WHEN LEFT(opa.Der_Procedure_All,4) in ('U133','U211')
AND (opa.Der_Procedure_All like '%Z846%'
OR opa.Der_Procedure_All like '%O132%')
AND (not ( opa.der_diagnosis_all like '%M00[01289]%'
OR opa.der_diagnosis_all like '%M01[01234568]%'
OR opa.der_diagnosis_all like '%M0[25][012389]%'
OR opa.der_diagnosis_all like '%M03[0126]%'
OR opa.der_diagnosis_all like '%M0[68][0123489]%'
OR opa.der_diagnosis_all like '%M07[0-6]%'
OR opa.der_diagnosis_all like '%M09[0128]%'
OR opa.der_diagnosis_all like '%M10[012349]%'
OR opa.der_diagnosis_all like '%M11[01289]%'
OR opa.der_diagnosis_all like '%M12[0123458]%'
OR opa.der_diagnosis_all like '%M13[0189]%'
OR opa.der_diagnosis_all like '%M14[01234568]%'
OR opa.der_diagnosis_all like '%M15[12348]%'
OR opa.der_diagnosis_all like '%M16[012345679]%'
OR opa.der_diagnosis_all like '%M17[2345]%'
OR opa.der_diagnosis_all like '%M238%'
OR opa.der_diagnosis_all like '%C40[289]%'
OR opa.der_diagnosis_all like '%C7[69]5%'
OR opa.der_diagnosis_all like '%D162%')
OR opa.der_diagnosis_all IS NULL)
AND ISNULL(opa.Age_at_Start_of_Episode_SUS,opa.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN 'C_knee_arth'
```

Code Definitions

Procedure codes (OPCS)

U133 Magnetic resonance imaging of bone
U211 Magnetic resonance imaging NEC

Z846 Knee joint (secondary to U code)
O132 Knee NEC (secondary to U code)

Diagnosis codes (ICD)

Inclusion

M150 Primary generalized (osteo)arthrosis
M159 Polyarthrosis, unspecified
M170 Primary gonarthrosis, bilateral
M171 Other primary gonarthrosis
M179 Gonarthrosis, unspecified
M232 Derangement of meniscus due to old tear or injury
S832 Tear of meniscus, current

Exclusion

M000 Staphylococcal arthritis and polyarthritis
M001 Pneumococcal arthritis and polyarthritis
M002 Other streptococcal arthritis and polyarthritis
M008 Arthritis and polyarthritis due to other specified bacterial agents
M009 Pyogenic arthritis, unspecified
M010 Meningococcal arthritis
M011 Tuberculous arthritis
M012 Arthritis in Lyme disease
M013 Arthritis in other bacterial diseases classified elsewhere
M014 Rubella arthritis
M015 Arthritis in other viral diseases classified elsewhere
M016 Arthritis in mycoses
M018 Arthritis in other infectious and parasitic diseases classified elsewhere
M020 Arthropathy following intestinal bypass
M021 Postdysenteric arthropathy
M022 Postimmunization arthropathy
M023 Reiter disease
M028 Other reactive arthropathies
M029 Reactive arthropathy, unspecified
M030 Postmeningococcal arthritis
M031 Postinfective arthropathy in syphilis
M032 Other postinfectious arthropathies in diseases classified elsewhere
M036 Reactive arthropathy in other diseases classified elsewher
M050 Felty syndrome
M051 Rheumatoid lung disease
M052 Rheumatoid vasculitis
M053 Rheumatoid arthritis with involvement of other organs and systems
M058 Other seropositive rheumatoid arthritis
M059 Seropositive rheumatoid arthritis, unspecified
M060 Seronegative rheumatoid arthritis
M061 Adult-onset Still disease

M062 Rheumatoid bursitis
M063 Rheumatoid nodule
M064 Inflammatory polyarthropathy
M068 Other specified rheumatoid arthritis
M069 Rheumatoid arthritis, unspecified
M070 Distal interphalangeal psoriatic arthropathy
M071 Arthritis mutilans
M072 Psoriatic spondylitis
M073 Other psoriatic arthropathies
M074 Arthropathy in Crohn disease [regional enteritis]
M075 Arthropathy in ulcerative colitis
M076 Other enteropathic arthropathies
M080 Juvenile rheumatoid arthritis
M081 Juvenile ankylosing spondylitis
M082 Juvenile arthritis with systemic onset
M083 Juvenile polyarthritis (seronegative)
M084 Pauciarticular juvenile arthritis
M088 Other juvenile arthritis
M089 Juvenile arthritis, unspecified
M090 Juvenile arthritis in psoriasis
M091 Juvenile arthritis in Crohn disease [regional enteritis]
M092 Juvenile arthritis in ulcerative colitis
M098 Juvenile arthritis in other diseases classified elsewhere
M100 Idiopathic gout
M101 Lead-induced gout
M102 Drug-induced gout
M103 Gout due to impairment of renal function
M104 Other secondary gout
M109 Gout, unspecified
M110 Hydroxyapatite deposition disease
M111 Familial chondrocalcinosis
M112 Other chondrocalcinosis
M118 Other specified crystal arthropathies
M119 Crystal arthropathy, unspecified
M120 Chronic postrheumatic arthropathy [Jaccoud]
M121 Kaschin-Beck disease
M122 Villonodular synovitis (pigmented)
M123 Palindromic rheumatism
M124 Intermittent hydrarthrosis
M125 Traumatic arthropathy
M128 Other specific arthropathies, not elsewhere classified
M130 Polyarthritis, unspecified
M131 Monoarthritis, not elsewhere classified
M138 Other specified arthritis
M139 Arthritis, unspecified
M140 Gouty arthropathy due to enzyme defects and other inherited disorders
M141 Crystal arthropathy in other metabolic disorders

M142 Diabetic arthropathy
M143 Lipoid dermatoarthritis
M144 Arthropathy in amyloidosis
M145 Arthropathies in other endocrine, nutritional and metabolic disorders
M146 Neuropathic arthropathy
M148 Arthropathies in other specified diseases classified elsewhere
M151 Heberden nodes (with arthropathy)
M152 Bouchard nodes (with arthropathy)
M153 Secondary multiple arthrosis
M154 Erosive (osteo)arthrosis
M158 Other polyarthrosis
M160 Primary coxarthrosis, bilateral
M161 Other primary coxarthrosis
M162 Coxarthrosis resulting from dysplasia, bilateral
M163 Other dysplastic coxarthrosis
M164 Post-traumatic coxarthrosis, bilateral
M165 Other post-traumatic coxarthrosis
M166 Other secondary coxarthrosis, bilateral
M167 Other secondary coxarthrosis
M169 Coxarthrosis, unspecified
M172 Post-traumatic gonarthrosis, bilateral
M173 Other post-traumatic gonarthrosis
M174 Other secondary gonarthrosis, bilateral
M175 Other secondary gonarthrosis
M238 Other internal derangements of knee (code for knee locking but not specific to this)
C402 Malignant neoplasm: Long bones of lower limb
C408 Malignant neoplasm: Overlapping lesion of bone and articular cartilage of limbs
C409 Malignant neoplasm: Bone and articular cartilage of limb, unspecified
C765 Malignant neoplasm of other and ill-defined sites: Lower limb
C795 Secondary malignant neoplasm of bone and bone marrow
D162 Benign neoplasm: Long bones of lower limb

Additional Exclusions

apcs.der_diagnosis_all not like '%C[0-9][0-9]%' and
apcs.der_diagnosis_all not like '%D0%' and
apcs.der_diagnosis_all not like '%D3[789]%' and
apcs.der_diagnosis_all not like '%D4[012345678]%'
This code captures code in the ranges C00-C99, D00-D09 and D37-D48.
Age range: the codes use the following age ranges 0-18 for children and 19-120 for adults.
— Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Knee MRI when symptoms are suggestive of osteoarthritis (National Evidence Based Intervention)

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

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

This guidance applies to adults aged 19 years and over.

Criteria

In primary care, where clinical assessment is suggestive of knee OA, imaging is not usually necessary. If imaging is required, then weight bearing radiographs are the first-line of investigation.

Where imaging is necessary, 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 in secondary care 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.

Evidence based intervention national coding script

Outpatient

WHEN (Any_Appointment_Procedure LIKE '%U133%'

```
OR Any_Appointment_Procedure LIKE '%U211%')
AND ( Any_Appointment_Procedure LIKE '%Z846%'
OR Any_Appointment_Procedure LIKE '%O132%')
AND (not ( Any_Appointment_Diagnosis LIKE '%M00[01289]%'
OR Any_Appointment_Diagnosis LIKE '%M01[01234568]%'
OR Any_Appointment_Diagnosis LIKE '%M0[25][012389]%'
OR Any_Appointment_Diagnosis LIKE '%M03[0126]%'
OR Any_Appointment_Diagnosis LIKE '%M0[68][0123489]%'
OR Any_Appointment_Diagnosis LIKE '%M07[0-6]%'
OR Any_Appointment_Diagnosis LIKE '%M09[0128]%'
OR Any_Appointment_Diagnosis LIKE '%M10[012349]%'
OR Any_Appointment_Diagnosis LIKE '%M11[01289]%'
OR Any_Appointment_Diagnosis LIKE '%M12[0123458]%'
OR Any_Appointment_Diagnosis LIKE '%M13[0189]%'
OR Any_Appointment_Diagnosis LIKE '%M14[01234568]%'
OR Any_Appointment_Diagnosis LIKE '%M15[12348]%'
OR Any_Appointment_Diagnosis LIKE '%M16[012345679]%'
OR Any_Appointment_Diagnosis LIKE '%M17[2345]%'
OR Any_Appointment_Diagnosis LIKE '%M238%'
OR Any_Appointment_Diagnosis LIKE '%C40[289]%'
OR Any_Appointment_Diagnosis LIKE '%C7[69]5%'
OR Any_Appointment_Diagnosis LIKE '%D162%')
OR Any_Appointment_Diagnosis IS NULL)
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2T_knee_MRI'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status  IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
  AND Any_Appointment_Diagnosis not like '%D0%'
  AND Any_Appointment_Diagnosis not like '%D3[789]%'
  AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
  OR Any_Appointment_Diagnosis IS NULL)

-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Low back pain imaging (National Evidence Based Intervention)

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

Serious underlying pathology includes but is not limited to:

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

This guidance applies to adults aged 19 years and over.

Criteria

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

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

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

For further information please see the following NICE guidance:

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

Evidence based intervention national coding script

```
WHEN ( Any_Appointment_Procedure like '%U05[45]%'
OR (( Any_Appointment_Procedure like '%U13[2356]%'
OR Any_Appointment_Procedure like '%U21[1267]%')
AND ( Any_Appointment_Procedure like '%Z665%'
OR Any_Appointment_Procedure like '%O162%')))
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2S_lower_back_imaging'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Lumbar discectomy (National Evidence Based Intervention)

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

There remains a reasonable body of evidence to show that in carefully selected patients, lumbar discectomy may lead to a greater and quicker improvement in pain scores than in non-operatively treated patients.

In other studies, however, because of the irreversible degenerative changes, surgery has not shown a benefit over non-operative treatment in mid and long-term follow-up.

Lengthy periods of ineffective non-operative care may prompt repeated emergency department attendances, issues with chronic pain, significant neurological dysfunction and time off work.

Criteria

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

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

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

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

This guidance applies to adults aged 19 years and over.

Evidence based intervention national coding script

```
WHEN ( LEFT(Primary_Spell_Procedure,4) in (
'V331','V332','V333','V334','V335','V336','V337','V338','V339'
,'V511','V518','V519','V583','V603')
OR ( LEFT(Primary_Spell_Procedure,4) in
('V521','V522','V525','V528','V529','V588','V589','V608','V609')
AND Any_Spell_Diagnosis LIKE '%Z993%'))
AND ( Primary_Spell_Diagnosis LIKE '%M51[01]%'
OR Primary_Spell_Diagnosis LIKE '%M54[134]%')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2J_Discectomy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Lumbar radiofrequency facet joint denervation (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

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

This guidance applies to adults aged 19 years and over.

Criteria

Lumbar radiofrequency facet joint denervation (RFD) should only be offered in accordance with NICE Guideline NG59 which recommends it as an adjunct in the management of chronic low back pain only when non-operative treatment has failed, and the main source of pain is thought to arise from one or more degenerate facet joints.

Codes

Procedures challenged in this policy

A521, A522, A528, A529, A577, A735, V363, V368, V369, V382, V383, V384, V385, V386, V388, V389, V544, W903, V485, V487
Z675: Lumbar intervertebral joint
Z676: Lumbosacral joint
Z677: Sacrococcygeal joint
Z993: Intervertebral disc of lumbar spine

Relevant diagnoses for this policy

M545 (chronic low back pain)

Diagnoses for which the above procedures are permitted

Codes as recommended in the clinical coding guidelines for spinal policies:
V485 + V55. with a diagnosis code M545

Evidence based intervention national coding script

```
WHEN ( Primary_Spell_Procedure like '%V48[57]%'
AND ( Any_Spell_Procedure LIKE '%Z67[567]%'
OR Any_Spell_Procedure LIKE '%Z993%')
)
AND LEFT(Primary_Spell_Diagnosis,4) IN ('M512','M518','M519','M545','M549')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2K_RFD_back'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: 26 January 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

MRI Scan of the hip for arthritis (National Evidence Based Intervention)

When clinical assessment is suggestive of osteoarthritis (OA) and plain radiographs demonstrate typical OA features, the use of MRI for the investigation of hip pain is not commissioned in primary care.

This guidance applies to adults aged 19 years and over.

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 onward referral may be warranted by secondary care 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).

Evidence based intervention national coding script

```
WHEN ( ( Any_Appointment_Procedure LIKE '%U133%'
OR Any_Appointment_Procedure LIKE '%U211%')
AND ( Any_Appointment_Procedure LIKE '%Z84[389]%'
OR Any_Appointment_Procedure LIKE '%Z902%')
)
AND (NOT ( Any_Appointment_Diagnosis LIKE '%M00[01289]%'
OR Any_Appointment_Diagnosis LIKE '%M01[01234568]%'
OR Any_Appointment_Diagnosis LIKE '%M0[25][012389]%'
OR Any_Appointment_Diagnosis LIKE '%M03[0126]%'
OR Any_Appointment_Diagnosis LIKE '%M0[68][0123489]%'
OR Any_Appointment_Diagnosis LIKE '%M07[0-6]%'
OR Any_Appointment_Diagnosis LIKE '%M09[0128]%'
OR Any_Appointment_Diagnosis LIKE '%M10[012349]%'
OR Any_Appointment_Diagnosis LIKE '%M11[01289]%'
OR Any_Appointment_Diagnosis LIKE '%M12[0123458]%'
OR Any_Appointment_Diagnosis LIKE '%M13[0189]%'
OR Any_Appointment_Diagnosis LIKE '%M14[01234568]%'
OR Any_Appointment_Diagnosis LIKE '%M15[12348]%'
OR Any_Appointment_Diagnosis LIKE '%M16[234567]%'
OR Any_Appointment_Diagnosis LIKE '%M17[0123459]%'
OR Any_Appointment_Diagnosis LIKE '%C40[289]%'
OR Any_Appointment_Diagnosis LIKE '%C7[69]5%'
OR Any_Appointment_Diagnosis LIKE '%D162%')
OR Any_Appointment_Diagnosis IS NULL)
-- Age Between 19 and 120
AND
ISNULL(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2X_hip_MRI'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Musculoskeletal corticosteroid injections

Criteria

NHS Cornwall and Isles of Scilly Integrated Care Board commissions musculoskeletal (MSK) corticosteroid injections in secondary care where patients meet the criteria below. The referral letter and patient's medical record need to clearly evidence how these criteria are met.

- COVID-19 risk counselling discussion has taken place with the patient prior to referral
- if steroid injection has failed in primary care, a referral may be considered to orthopaedic services as per the condition-specific referral management service (RMS) orthopaedic guidelines, for example:
    - the musculoskeletal interface service (shoulder, knee or soft tissue hip); the service can arrange ultrasound-guided injections if deemed necessary
    - other orthopaedic services (hand, elbow, foot or ankle)

The RMS orthopaedic guidelines state the number of steroid injections recommended for each MSK condition prior to referral to secondary care for steroid injection.

For these conditions it is expected that the steroid injection is performed in primary care either by the patient's own GP practice or another practice able to perform the injection, unless:

- the recommended number of landmark-sited injections have been undertaken in primary care and have failed
- a single blind attempt has been made and failed in those with indiscernible landmarks

Practices that are unable to provide an in-house MSK steroid injection can refer to other practices for the MSK steroid injections listed below via inter-practice referral.
Primary care services are available for the following MSK steroid injections:

- hands (trigger finger, tenosynovitis, carpal tunnel syndrome, thumb first carpometacarpal joint osteoarthritis)
- shoulders (gleno-humeral joint, sub-deltoid or acromial space, acromioclavicular joint)
- trochanteric bursa
- knee
- ankle and foot (plantar fasciitis, toe joints, tendon sheaths, bursa, Morton's neuroma)
- elbow (golfer's elbow, tennis elbow)

Steroid injection for these conditions is not routinely recommended and should only be offered for severe refractory symptoms not responding to conservative measures.

This policy is specific to referrals for steroid injection. The RMS guidelines give detailed information about when referral for specialist input may be appropriate.

Exclusions

Children, patients on a cancer pathway, sacrococcygeal injections. Please note that inclusions and exclusions relating to lumbar spine injections including facet joint injections are covered under the NHS Cornwall and Isles of Scilly Integrated Care Board policies spinal injections for sciatica, injections for non-specific low-back pain without sciatica and radiofrequency denervation.

Codes

Procedures challenged in this policy
OPCS code: S521, X382

Diagnoses for which the above procedures are permitted
ICD10 code: M653, M680, M659, M658, G560, M710, M713, M714, M722, M18, G57.6, M533
M65.3 Trigger finger
M68.0 Synovitis and tenosynovitis in bacterial diseases classified elsewhere
M65.94 Synovitis and tenosynovitis, unspecified, Hand
M65.84 Other synovitis and tenosynovitis, Hand
G56.0 Carpal tunnel syndrome
M71.0 Abscess of bursa
M71.3 Other bursal cyst
M71.4 Calcium deposit in bursa
M72.2 Plantar fascial fibromatosis
M70.3 Other bursitis of elbow
M18 Arthrosis of first carpometacarpal joint
G57.6 Lesion of plantar nerve
M70.3 Other bursitis of elbow
M533 Sacrococcygeal injections (conducted in pain clinic under x-ray for coccydnia)

Date approved: April 2018 and July 2021
Review date: July 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Skin surface applied functional electrical stimulation for an orthotic effect to correct foot drop of central neurological origin

Electrical stimulation from skin surface electrodes to the peroneal nerve, timed to the swing phase of step, has been shown to improve walking speed to a greater extent than physiotherapy alone in patients suffering foot drop that persisted at least 6 months following a stroke (NICE Interventional Procedures Guidance IPG278, January 2009).

Criteria

The use of skin surface applied functional electrical stimulation (FES) as an orthotic intervention to improve walking impaired by foot drop of central neurological origin is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met

FES delivered by skin surface electrodes may be offered by service providers under contractual provisions for physiotherapy services to patients for whom ankle foot orthoses (AFO) have not been suitable. This will include assessment by physiotherapists trained to provide FES and AFO as part of the complete physiotherapy service offered; early assessment of benefit; ongoing accessible patient review; and annual audit results communicated to commissioners.

Codes

Procedures challenged in this policy

OPCS code:
A70.8 Other specified neurostimulation of peripheral nerve
Z12.1 Popliteal nerve

Diagnoses challenged in this policy

ICD10 code: M21.37- Wrist or foot drop (acquired), Ankle and foot + one of the following codes:
I69.0 Sequelae of subarachnoid haemorrhage
I69.1 Sequelae of intracerebral haemorrhage
I69.2 Sequelae of other nontraumatic intracranial haemorrhage
I69.3 Sequelae of cerebral infarction
I69.4 Sequelae of stroke, not specified as haemorrhage or infarction

Date approved: January 2018 and January 2022
Review date: January 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Spinal cord stimulation for chronic pain

Spinal cord stimulators stimulate the dorsal columns of the spinal cord with an implanted device, with the aim of modifying the perception of pain.

NICE has assessed them as cost-effective in neuropathic pain, with more recent reviews identifying subgroups where they are cost-effective.

NICE technology appraisal guidance (TA159) spinal cord stimulation for chronic pain of neuropathic or ischaemic origin, 22 October 2008.

Criteria

Spinal cord stimulation as a treatment option for adults with chronic pain of neuropathic origin is commissioned where patients meet the criteria below:

- continue to experience chronic pain (measuring at least 50mm on a 0 to 100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management
- who have had a successful trial of stimulation as part of an assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed

Codes

Procedures challenged in this policy
A483, A487

Relevant diagnoses for this policy
G905, M960, M961, M962, M963, M964, M965, M966, M968, M969, R521, R522

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018
Review date: April 2020 or earlier if new guidance is issued
JCIA: Yes, completed

Spinal injections for sciatica

Sciatica is used to describe leg pain secondary to lumbosacral nerve root pathology and includes radicular pain and radiculopathy.

Assessments and interventions should be undertaken in line with NICE guideline, NG59.

The list of non-recommended non-pharmacological and pharmacological interventions listed in the NICE guideline NG59 are not routinely commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board.

NICE guidance for sciatica considers epidural injection, whether administered under image guidance or without, is a relatively safe and routinely used procedure for which there is some evidence of the effectiveness of local anaesthetic and steroid demonstrated by placebo-controlled trials. There is evidence suggesting that epidural injection may reduce the number of people with severe sciatica requiring surgical intervention. The NHS getting it right first time (GIRFT) spinal services report (2019) recommends that epidural injections and nerve root blocks should only be repeated if 6 months of pain relief and functional improvement is achieved.

NG59 only mentions epidural injection, but nerve root blocks are included within the NICE endorsed national low back pain and radicular pain pathway.

Criteria

Epidural or nerve root block is routinely commissioned in Cornwall and Isles of Scilly when patients meet the following criteria:

- patient has severe sciatica with or without low back pain
- patient has sciatica consistent with the level of spinal involvement based on clinical assessment and concordant diagnostic imaging
- the use of non-pharmacological (including self-management) and pharmacological interventions has failed to control symptoms
- the injections are part of an MDT management plan

Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

A maximum of 2 epidurals or nerve root blocks (including diagnostic) will be funded before case discussion in the appropriate MDT meeting.

Spinal injections for sciatica should not be routinely repeated if the previous procedure was performed less than 6 months earlier.

For patients with persistent sciatica (pain for more than 6 months) where there is a concordant surgical target on imaging and the patient wishes to explore surgical intervention, the patient should be discussed in the appropriate MDT meeting and directed to the most clinically appropriate service and/or intervention.

Alternative, less invasive options to spinal injections such as exercise programs, behavioural therapy, and attending a specialised pain clinic have been shown to be successful for patients with acute and severe sciatica.

Codes

Procedures challenged in this policy

A521, A522, A528, A529, A577, A735, V363, V368, V369, V382, V383, V384, V385, V386, V388, V389, V544, W903, V485.

Relevant diagnoses for this policy

M541, M511 +G55.1 (radiculopathy and lumbar and other intervertebral disc disorders with radiculopathy)

Diagnoses for which the above procedures are permitted

A521, A522, A577 + Z07.1 – Cervical spine, Z07.2 – Thoracic spine, Z07.3 – Lumbar spine, Z07.8 – Other specified with a diagnosis code M541, M511 +G55.1

Date approved: 26 January 2021
Review date: 26 January 2024 or earlier if new guidance issued
JCIA: Yes, completed

Trigger finger release in adults (National Evidence Based Intervention)

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

Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but sometimes the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

Criteria

Mild cases 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 which are typically successful (strong evidence), but the problem may recur, especially in diabetics

OR

- splinting of the affected finger for 3-12 weeks (weak evidence).

Surgery should be considered if:

- triggering persists or recurs after one of the above measures (particularly steroid injections)

OR

- the finger is permanently locked in the palm

OR

- the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods

OR

- the patient is diabetic following a trial of 1 steroid injection

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).

Codes

Procedures challenged in this policy
T692+HAND, T691+HAND, T698+HAND, T699+HAND, T701+HAND, T702+HAN D, T718+HAND, T719+HAND, T723+HAND, T728+HAND, T729+HAND, Z894+HA ND, Z895+HAND, Z896+HAND, Z897+HAND

Relevant diagnoses for this policy
M653 and patient age is between 18 and 120.

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN
('T691','T692','T698','T699','T701','T702','T711','T718','T719','T723','T728','T729')
AND ( Primary_Spell_Diagnosis like '%M653%'
OR Primary_Spell_Diagnosis like '%M6584%'
OR Primary_Spell_Diagnosis like '%M6594%')
-- Age Between 19 and 120
AND
(ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120)
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'P_trigger_fing'
Exclusions

 WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: August 2017, March 2018, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Vertebral augmentation for painful osteoporotic vertebral fractures (National Evidence Based Intervention)

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

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

The alternative to vertebral augmentation is conservative management. This consists of pain relief, bracing, and manual therapy, although the evidence for bracing and manual therapy has shown to be of no benefit. Bone healing can take place over 2-12 weeks. Hospitalisation, immobility and opioid pain medication often have significant side effects, particularly in older patients.

The majority of older hospitalised patients treated conservatively still have significant pain at three months and over one third at six months.

This guidance applies to adults aged 19 years and over.

Criteria

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

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

NICE TAG 279 delegates the eligible timeframe for intervention to the clinician. However, evidence from a 2016 randomised controlled trial (RCT) offers evidence that older

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

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) in ('V444','V445')
AND Primary_Spell_Diagnosis LIKE '%M80[01234589]%'
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2V_vertebroplasty'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Urological genitary problems

Artificial urinary sphincters for men with post-prostatectomy incontinence

Urinary symptoms following prostatic surgery should be managed with involvement of specialist continence services. Initial management may include coping strategies, pelvic floor muscle re-education, bladder retraining and appropriate pharmacotherapy.

Some men are left with intractable stress incontinence for which an artificial urinary sphincter (AUS) is a potential treatment option. The AMS 800 device is designed to mimic the 2 functions of the biological urinary sphincter by providing a competent closed bladder outlet during urinary storage and an open unobstructed outlet to permit voluntary voiding. It is reserved for treatment of complex or severe stress urinary incontinence. It consists of an inflatable cuff that compresses the urethra, connected to a control pump usually placed in the scrotum that can be activated by the patient.

Criteria

Artificial urinary sphincters for men with post-prostatectomy incontinence is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

- men who suffer intractable stress incontinence following prostatectomy

The balance between benefit and disadvantages in other patient groups will need to be assessed on case-by-case basis.

Codes

Procedures challenged in this policy
M642

Relevant diagnoses for this policy
Primary diagnosis code of N393 + Y83.6 in a secondary position

Diagnoses for which the above procedures are permitted
No appropriate codes for the clinical criteria.

Date approved: April 2018 and March 2021
Review date: March 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Assisted conception (includes IVF)

NHS Cornwall and Isles of Scilly Integrated Care Board will commission specialist assisted reproduction techniques in accordance with the criteria outlined in this policy. In the context of limited resources, the purpose of this policy is to make the provision of fertility treatment fair, clear and explicit. Treatment is aimed towards those with the most need and the greatest chance of success.

The specialist fertility treatments within the scope of this policy include superovulation and intrauterine insemination (SO/IUIIn), vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI), donor Insemination (DI), egg donation, and cryopreservation to preserve fertility.

The specialist fertility services considered within this policy are deemed level 3 (tertiary) services. Preliminary services (levels 1 and 2) are provided and commissioned within primary and secondary care (such as acute trusts). Before referral to specialist level 3 services all couples should undergo the appropriate investigations and assessments in level 1 and 2.

Referral to level 3 services will be via a consultant gynaecologist. Referring and treating clinicians should ensure that couples meet the criteria contained within this policy. Couples will be offered a choice of designated providers that have been commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board. Providers who are not

directly commissioned by NHS Cornwall and Isles of Scilly Integrated Care Board should seek prior approval from NHS Cornwall and Isles of Scilly Integrated Care Board before assessing and treating the couples (full details can be found on the NHS Cornwall and Isles of Scilly Integrated Care Board website).

Criteria

Fertility assessment and treatment will be commissioned where the clinical criteria are met as outlined below.

Section 1: Fertility assessment

Referral for fertility assessment
A woman who has not conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be referred to secondary care for further clinical assessment and investigation.

A woman who is using artificial insemination to conceive should be referred to secondary care for further clinical assessment and investigation, if she has not conceived after 6 cycles of treatment within the past 12 months, in the absence of any known cause of infertility.

Patients should not be referred to secondary care outside these limits, unless there is a known clinical cause of infertility or a history of predisposing factors for infertility (such as amenorrhoea or oligomenorrhoea, pelvic inflammatory disease, undescended testes, previous treatment for cancer).

Recurrent miscarriage
Recurrent miscarriage is not an indication for patients to access fertility services although patients should be considered for referral for gynaecological investigations and treatments as appropriate.

Section 2: Fertility treatment for eligible couples

Referral for specialist fertility treatment
All couples must undergo the fertility investigations in primary and secondary care appropriate to them before eligibility for NHS funded assisted reproduction services in tertiary care is considered.

Couples with unexplained infertility who meet the criteria of this policy may be considered for specialist treatments if:

- they have not conceived after 2 years of regular unprotected intercourse
- they are using artificial insemination to conceive and have not become pregnant after 12 cycles (where 6 or more are by intrauterine insemination)

Treatment plan
Fertility treatment should be offered in the least invasive format appropriate: investigation and assessment, followed by assisted conception (SO/IUI) and finally IVF or ICSI. Up to 4 cycles of SO/IUI and 1 cycle of IVF may be funded per couple, who would be expected to have a more than 10% chance of live birth per cycle.

All couples must follow the agreed algorithm, not just progress to IVF without going through the other stages first, unless clinically indicated.

Ovarian reserve assessment
At the time of treatment, the prospective mothers' overall chance of successful pregnancy should be assessed to predict the likely ovarian response to gonadotrophin stimulation. The preferred test is anti-Mullerian hormone (AMH). The results can be used in conjunction with other clinical measures as an indication that the chance of live birth is less than 10% per cycle. Treatment should not be provided where the clinician believes the chance of live birth is less than 10% per cycle.

SO/IUI
Each couple to be offered up to 4 treatment cycles of SO/IUI, where the clinician believes the chance of live birth is in the region of 10% per cycle.

IVF
1 full cycle of IVF will be offered to couples where other assisted conception techniques have failed, and the clinician believes the chance of live birth is more than 10% per cycle. For the purposes of this policy, a cycle of IVF is defined as 1 fresh and 1 frozen implantation of embryos.

A full IVF treatment cycle includes:

- diagnostic tests, scans and pharmacological therapy
- counselling session
- stimulation of prospective mother's ovaries to produce oocytes
- harvesting of the oocytes
- fertilisation using IVF (assisted hatching is not provided)
- 1 fresh embryo transfer
- a follow up consultation with fertility services post IVF treatment

If the fresh embryo transfer is unsuccessful a frozen embryo transfer will be available from the remaining frozen embryos if deemed clinically appropriate. A frozen embryo transfer will only be available where embryos suitable for freezing were generated from the fresh cycle

The NHS in Cornwall and the Isles of Scilly will fund cryopreservation of embryos remaining because of IVF treatment for up to 1 year. Patients who wish to store embryos beyond 1 year will be required to fund the storage themselves.

Embryo transfer strategies in IVF

- When considering the number of fresh and frozen embryos to transfer in IVF treatment, single embryo transfer should be undertaken if 2 or more top quality embryos are available
- Consider double embryo transfer only if there are no top-quality embryos
- No more than 2 embryos should be transferred per transfer episode

ICSI

Couples should only be offered ICSI if:

- there are few sperm in the man's semen, or they are of poor quality
- there are no sperm in the man's semen (either because of a blockage or another cause) but there are sperm in their testes which can be recovered surgically
- they have already tried IVF but there was no fertilisation of the eggs or no embryos suitable for transfer (see abandoned IVF or ICSI cycles)

Donor insemination

Donor insemination is funded where there is:

- severe male factor infertility
- severe deficits in semen quality in couples who do not wish to undergo ICSI (intracytoplasmic sperm injection)
- a high risk of transmitting a genetic disorder to the offspring
- where there is a high risk of transmitting infectious disease to the offspring or woman from the man
- severe rhesus isoimmunisation
- also, following IVF egg retrieval when there is no living sperm produced on the day of treatment. NHS funding covers transport of sperm and storage for the NHS funded cycle only
- use of donor sperm should follow the same algorithm as outlined above

Receiving egg donation

The use of egg donation is funded where there is:

- premature ovarian failure
- gonadal dysgenesis including Turner syndrome
- bilateral oophorectomy
- ovarian failure following chemotherapy or radiotherapy
- a high risk of transmitting a genetic disorder to the offspring

Egg donors

Egg donors must meet Human Fertilisation and Embryology Authority (HFEA) criteria. Donation must be altruistic: the NHS will not fund the payment of egg donors. Egg sharing is funded if the NHS does not subsidise treatment for the donor beyond that which is required for treatment of the recipient.

Abandoned SO/IUI cycle
An additional SO/IUI cycle will be funded where an SO/IUI cycle has been abandoned, and the clinician believes the chance of live birth is in the region of 10%.

Abandoned IVF or ICSI cycle
An additional IVF or ICSI procedure will be funded where:

- the cycle has been abandoned for clinical reasons prior to egg retrieval
- there was failed fertilisation of the eggs or no embryo suitable for transfer

1 further fresh IVF cycle will be funded after an abandoned cycle. ICSI may be offered if clinically appropriate (see ICSI for criteria). Further IVF cycles will not be funded after any subsequent abandoned cycle.

Abandoned fresh embryo transfer
If a fresh embryo transfer is not possible after oocyte retrieval for clinical reasons, storage (cryopreservation) for up to 1 year and up to 2 frozen embryo transfers will be funded.

Abandoned frozen embryo transfer
If a frozen embryo transfer was intended but is not possible for clinical reasons and the treatment is cancelled prior to warming the embryo, storage (cryopreservation) for up to 1 year and 1 further transfer of up to 2 frozen embryos will be funded.

Surrogacy
If required due to congenital absence of the uterus or malignancy. Funding is approved for the creation of eggs or embryos and storage for 5 years or until 1 implantation has been performed (whichever is the sooner). Funding is not approved for finding a suitable surrogate, implantation in the surrogate mother or subsequent treatment.

Same sex couples
If a same sex couple has a diagnosed fertility problem on investigation, then their sub fertility will be treated but NHS funding will not be available for either donor insemination (for same sex female couples) or for funding of surrogacy arrangements (for same sex male couples). This is on the basis that unless they are medically sub fertile their childlessness is due to the absence of gametes of the opposite sex and not due to both a medical cause and related healthcare need. The clinician should discuss with the couple the feasibility and preparedness of the other partner trying to conceive before proceeding to interventions involving the sub-fertile partner.

Other medical grounds
Assisted conception treatment may be denied on other medical grounds not explicitly covered in this document.

Section 3: General principles

Eligibility criteria for NHS funded assisted conception.

Residency
Both partners should be registered with a GP in the NHS Cornwall and Isles of Scilly Integrated Care Board area.

Stable relationship
All couples must have been in a stable, financially interdependent relationship for a period of 2 years. A stable relationship is defined as 2 years, to fit with the definition of infertility.

Previous children
Assisted conception treatment is restricted to couples where:

- there are no living children from the current relationship
- at least 1 partner does not have any living children from previous relationships

This includes biological and legally adopted children and offspring who are adults.

Welfare of the child
The welfare of any resulting children is paramount. In order to take into account, the welfare of the child, the clinician should consider factors which are likely to cause serious physical, psychological or medical harm. This is a requirement of the licencing body, the HFEA. There is an explicit and recorded assessment that the social circumstances of the family unit have been considered within the context of the assessment of the welfare of the child. This will include consideration of factors such as parental smoking, alcohol and recreational drug use.

Age
Assisted conception treatment is restricted to women aged up to 40 years.

Body mass index (BMI)
Men and women must have a BMI of between 19 and 29.9 at the time of referral for specialist assisted reproduction assessment and at the time of any specialist treatment. Women with a BMI below 19 or individuals with a BMI above 29.9 should be offered advice and support on increasing or decreasing their weight via their GP.

In individuals with a BMI between 30 and 34.9 where there is a question regarding lean muscle mass, requests for funding may be submitted to the individual funding request (IFR) panel for review. Please include:

- BMI
- waist measurement with the following guidance:
    - find bottom of ribs and top of hips
    - measure waist between these points
    - breathe out naturally before taking measurement
- photographs optional and with patient consent, should exclude face (front and side breathe out naturally)

Smoking
Couples and individuals who smoke (including use of e-cigarettes) will not be eligible for assisted conception treatment. Individuals should be strongly encouraged to stop smoking. Self-referral to stop smoking advisors via their GP surgery is recommended. Both partners must be able to declare that they have ceased smoking for at least 6 months before either partner is offered treatments. If the 6 months takes them outside the age criteria a clinical decision may be taken to proceed with treatment earlier.

Previous assisted conception
Assisted conception treatment is restricted to couples where neither partner has had previous NHS funded specialist fertility treatment. No couple may receive an NHS funded IVF cycle if they have previously received a total of 3 self-funded cycles. This is because the overall chance of a live birth following IVF treatment falls as the number of unsuccessful cycles increases.

Previous sterilisation
Assisted conception will not be funded where 1 or both partners have previously been sterilised even if self-funded reversal has been successful.

Section 4: Cryopreservation to preserve fertility

Cryopreservation is a technique used to preserve fertility by banking gametes (eggs or sperm) or embryos prior to a treatment which may make a patient permanently infertile.

NHS funded cryopreservation may be done by banking gametes (eggs or sperm), or embryos for future fertility treatment. The request for cryopreservation must be supported by the NHS consultant providing the patient's care.

Cryopreservation
Routinely funded for patients under 40 years old who are about to start treatment:

- where there is a significant likelihood, the patient may become permanently infertile as an unwanted effect of the treatment, for example chemotherapy for cancer; radical surgery; or transgender pathway
- which causes harmful effects on sperm or egg production, impotence or has possible teratogenic effects, which is likely to continue for their reproductive life and in whom stopping treatment for a prolonged period of time to enable conception is not an option
- there is no lower age limit applied in this policy, however all individuals including those aged under 16 years must be able to understand the procedure being carried out and considered competent to give informed consent

Not routinely funded for individuals who:

- have previously been sterilised, even if sterilisation has been reversed

- have living offspring and therefore do not qualify for NHS funding for fertility treatment as defined in previous children section; an adopted child has the same status as an individual's biological child
- request cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive; this includes concerns over future fertility (for example. low ovarian reserve)
- have previously received an NHS funded cycle of fertility treatment or a total of 3 self-funded IVF cycles (and therefore do not qualify for NHS funding for assisted conception)

Duration of storage and funding

- Funded for an initial period of 5 years, or up to the upper-age threshold of 40, whichever is reached first
- Storage may be renewed in further 5-year periods until the patient reaches the upper-age limit of 40
- Renewal is subject to discussion with the patient's clinician to confirm continued storage is required and that the patient meets all criteria for storage (as detailed in this policy)

NHS funding for storage will cease where:

- the patient reaches the upper age limit (40 years)
- fertility is established through tests
- a live birth has occurred
- the patient has had 1 NHS funded cycle of infertility treatment even if the treatment is unsuccessful (the patient will be given the option of self-funding in line with the fertility provider's policy)
- at the patient's request

Funding for storage will cease twelve months following the death of the patient.

Once the period of NHS funding ceases, patients or their family can elect to self-fund for a further period, not to exceed appropriate HFEA regulations on length of storage.

Eligibility for NHS funded assisted conception

The funding of cryopreservation does not automatically entitle people to funding for assisted conception. Individuals will be required to meet the eligibility criteria for fertility treatment in place at the time they wish to apply for NHS funded assisted conception.

Codes

Procedures challenged in this policy

Y961, Y962, Y963, Y964, Y965, Y966, Y968, Y969.
There are no specific codes for cryopreservation.
No specific codes to indicate single embryo transfer

Relevant diagnoses for this policy
F640, F641, F642, F648, F649, N970, N971, N972, N973, N974, N978, N979, O028, O029, Q103, Q108, Q109, Z302, Z312, Z313

Diagnoses for which the above procedures are permitted
No appropriate codes for the clinical criteria.

Date approved: November 2016, March 2019 review date extension approved only, July 2019 further review date extension approved only and November 2019
Review date: November 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Cystoscopy for uncomplicated lower urinary tract symptoms (National Evidence Based Intervention)

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

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

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

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

In the context of male LUTS, cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example). However, no evidence was discovered in preparing NICE guideline CG97 to suggest any benefit, in terms of outcome, related to performing cystoscopy in men with uncomplicated LUTS (for example LUTS with no clinical evidence of underlying bladder pathology). The consensus opinion of the NICE guideline development group therefore aligned with the position that unless likely to uncover other pathology, cystoscopy should not be performed in men presenting with LUTS.

The European Association of Urology guideline on the management of nonneurogenic male LUTS summarises evidence demonstrating a lack of clear correlation between findings on cystoscopy and findings on investigations into bladder function (urodynamic assessment).

Criteria

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

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

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

- recurrent infection
- sterile pyuria
- haematuria
- profound symptoms

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

- smoking history
- travel or occupational history suggesting a high risk of malignancy
- previous surgery

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

Codes

Procedures challenged in this policy

M45.1 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder NEC
M45.2 Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate NEC
M45.3 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder using
M45.4 Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate using
M45.5 Diagnostic endoscopic examination of bladder using rigid cystoscope
M45.8 Other specified diagnostic endoscopic examination of bladder
M45.9 Unspecified diagnostic endoscopic examination of bladder

Diagnoses for which the above procedures are permitted

LUTS = ICD 10 code R39.8 Other and unspecified symptoms and signs involving the urinary system
Cancer diagnoses are a global exclusion

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) in ('M455','M458','M459')
AND NOT ( Any_Spell_Diagnosis LIKE '%F171%'
OR Any_Spell_Diagnosis LIKE '%N390%'
OR Any_Spell_Diagnosis LIKE '%R31%'
OR Any_Spell_Diagnosis LIKE '%R398%')
AND Any_Spell_Procedure NOT LIKE '%M45[1-4]%'
-- Gender is Male
AND Sex=1
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN '2H_cystoscopy_UTI'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: July 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Dilatation and curettage for heavy menstrual bleeding in women (National Evidence Based Intervention)

Dilatation and curettage (D and C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).

Criteria

Dilatation and curettage for heavy menstrual bleeding is not routinely commissioned.

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

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

Medication and intrauterine systems (IUS) can be used to treat heavy periods. For further information, please see NICE guidance.

Codes

Procedures challenged in this policy

Dominant procedure code starts: Q103
and diagnosis code (any position) is not like: O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Relevant diagnoses for this policy

And diagnosis code (any position) is not like: O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Diagnoses for which the above procedures are permitted

O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN ('Q103', 'Q108')
AND ( Primary_Spell_Diagnosis like '%N92[0124]%'
OR Primary_Spell_Diagnosis like '%N950%')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'B_menstr_D&C'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: August 2017, November 2019 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy

JCIA: Yes, completed

Elective caesarean section for non-clinical reasons

Elective caesarean section for non-clinical reasons is a low priority and will not normally be funded by NHS Cornwall and Isles of Scilly Integrated Care Board. Maternal request is not on its own an indication for caesarean section. Intervention is approved according to criteria established in the guidelines issued jointly by NICE and the National Collaborating Centre for Women and Children's Health.

Criteria

Elective caesarean section for non-clinical reasons is not routinely commissioned.

Codes

Procedures challenged in this policy
R171, R172, R178, R179

Relevant diagnoses for this policy
N92, N920, N921, N922, N923, N924, N925, N926, N927, N928, N929

Diagnoses for which the above procedures are permitted
B20, B20X, B200, B201, B202, B203, B204, B205, B206, B207, B208, B209, B21, B21X, B210, B211, B212, B213, B214, B215, B216, B217, B218, B219, B22, B22X, B221, B222, B223, B224, B225, B226, B227, B228, B229, B23, B23X, B230, B231, B232, B233, B234, B235, B236, B237, B238, B239, B24, B24X, B240, O32, O32X, O320, O33, O330, O34, O34X, O340, O342, Q44, Q44X, Q441, Z21
Please note that this list is not exhaustive.

Date approved: November 2016 and February 2019
Review date: February 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Female sterilisation

Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation for a female normally involves tubal occlusion.

Criteria

Female sterilisation should only be carried out as a stand-alone procedure or during a caesarean section in women who meet all of the following criteria, and this has been documented by the referring or treating clinician. The referral letter and patient's medical record need to clearly evidence how these criteria are met:

- the woman understands that the sterilisation procedure is irreversible, and the reversal of sterilisation operation would not be routinely funded on the NHS
- she is certain that her family is complete OR that she will never want children
- she has sound mental capacity for making the decision*
- she understands that vasectomy in the partner is a valid alternative option
- she has received counselling about all other forms of contraceptives and has undergone a trial of long-acting contraceptives or she has declined a trial of long-acting reversible contraception after counselling
- she understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections

Female sterilisation could also be considered in women who have a medical condition making pregnancy dangerous.

* Additional care must be taken when counselling people under 30 years of age or people without children who request sterilisation; this should include attempts to identify coercion.

Codes

Procedures challenged in this policy
Q271, Q272, Q278, Q279, Q281, Q282, Q283, Q284, Q288, Q289, Q351, Q352, Q353, Q358, Q359, Q361, Q362, Q368, Q369, Q354

Relevant diagnoses for this policy
Z302

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Hydroceles in males

Hydroceles (fluid collection around the testicles) may be present at birth and are common, affecting around 1 male baby in every 10. They do not usually require treatment as they often disappear on their own during the first 2 years of life, NICE.

Less commonly, hydroceles can develop in adult men and may follow infection, injury or radiotherapy.

Referral for another opinion should be made where there is diagnostic uncertainty. For example, in the case of apparent hydrocele in a child that has not been present from

infancy. Such cases should be referred to a consultant urologist who covers paediatric urology.

Hydroceles may occur in both genders; however, this policy only considers hydroceles in males over 2 years old.

Criteria

Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- patient is over 2 years of age
- discomfort and/or disfigurement have resulted in significant functional impairment which prevents the individual from fulfilling work, studying, carer or domestic responsibilities
- in the case of a child, discomfort and/or disfigurement resulting in an inability to participate in normal social, educational or work activity

Hydroceles can vary greatly in size. Consideration for removal of a hydrocele will not be given based on size alone.

Codes

Procedures challenged in this policy
N111, N112, N113, N114, N115, N116, N118, N119

Relevant diagnoses for this policy
N430, N431, N432, N433, P835

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria

Date approved: April 2018 and March 2021
Review date: March 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Hysterectomy for heavy menstrual bleeding (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Hysterectomy is an effective procedure for treatment of heavy menstrual bleeding (menorrhagia) but is associated with more complications compared to treatment with progestogens and should not be used as a first-line treatment.

NICE's Guideline Development Group considered the evidence (including 2 reviews, four randomised control trials and one cohort study comparing hysterectomy with other treatments) as well as the views of patients and the public and concluded that hysterectomy should not routinely be offered as first line treatment for heavy menstrual

bleeding. The Group placed a high value on the need for education and information provision for individuals with heavy menstrual bleeding.

Complications following hysterectomy are usually rare, but infection occurs commonly. Less common complications include intra-operative haemorrhage; damage to other abdominal organs, such as the urinary tract or bowel; urinary dysfunction –frequent passing of urine and incontinence. Rare complications include thrombosis (DVT and clot on the lung) and very rare complications include death. Complications are more likely when hysterectomy is performed in the presence of fibroids (non-cancerous growths in the uterus). There is a risk of possible loss of ovarian function and its consequences, even if their ovaries are retained during hysterectomy. If oophorectomy (removal of the ovaries) is performed at the time of hysterectomy, menopausal-like symptoms occur.

Criteria

Based on NICE guidelines [NG 88] Heavy menstrual bleeding: assessment and management, hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

It is important that healthcare professionals understand what matters most to each individual and support their personal priorities and choices.

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

NICE guideline NG88 1.5 Management of HMB

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 recommendations 1.5.2 and 1.5.3), 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. [2007]

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 in recommendation 5.10.

Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

Codes

Procedures challenged in this policy
Q072, Q074, Q078, Q079, Q082, Q088, Q089

Relevant diagnoses for this policy
And Diagnosis code (any position) is not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99, O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria

Evidence based intervention national coding script

```
WHEN Primary_Spell_Procedure IN
('Q071','Q072','Q073','Q074','Q075','Q076','Q078','Q079','Q081','Q082','Q083','Q088','Q0
89')
AND ( Any_Spell_Diagnosis like '%N92[0124]%'
OR Any_Spell_Diagnosis like '%N950%')
AND Any_Spell_Diagnosis not like '%D25[0129]%'
AND not ( Any_Spell_Diagnosis like '%C52%'
OR Any_Spell_Diagnosis like '%C53[0189]%'
OR Any_Spell_Diagnosis like '%C54[012389]%'
OR Any_Spell_Diagnosis like '%C5[56]%'
OR Any_Spell_Diagnosis like '%C57[01234789]%'
OR Any_Spell_Diagnosis like '%C58%')
-- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
THEN 'J_hysterec'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: November 2016, February 2019, November 2019 and January 2025

Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Investigation and onward referral of women with recurrent urinary tract infections (rUTIs) (National Evidence Based Intervention)

These recommendations aim to reduce variation in care experienced by women with recurrent urinary tract infections (rUTI) by providing guidance for primary care clinicians on when to refer individuals to specialist urology. These recommendations aim to limit harm to patients by reducing harmful and invasive investigative procedures when other alternatives are more appropriate and effective which can be conducted before specialist referral.

This guidance relates to:

- Ciswomen (women who identify as female and were assigned female at birth)
- Some transgender people
- Non-binary people who were assigned female at birth
- Some intersex people

The information has been developed based on guidance and evidence in women. If you are transgender, female-assigned non-binary, or intersex, some of this information is still relevant to you — but your experience may be slightly different.

Please note that for this guidance and to align with the evidence when we use ‘women’ it includes all those above.

Urinary tract infections (UTI) are extremely common in women with over half experiencing at least one in their lifetime. Many women experience recurrent infection, defined as at least 3 UTIs in one year or 2 UTIs in six months. Recurrent UTIs affect approximately 1 in 1,000 women under the age of 65 and can significantly impact quality of life.

Urinary infections can affect the lower urinary tract or the upper urinary tract. Recurrent upper tract infections are uncommon, and these individuals should be reviewed in secondary care. For the remainder of this proposal, we use recurrent UTI (rUTI) to refer to recurrent lower tract infections only.

In the UK, most women with rUTIs present initially to primary care. Recommendations are outlined in NICE guideline NG112 — it also specifies when clinicians should refer or seek specialist advice in those patients where malignancy is suspected or where ‘the underlying cause of rUTI is unknown’.

These recommendations aim to complement NICE guideline NG112 by providing guidance for primary care clinicians on when to refer women with rUTIs to specialist urology services and the investigations that should be performed prior to referral.

A list of important definitions used in this guideline is provided below.

- Recurrent lower urinary tract infection (rUTI) — 2 or more symptomatic lower UTIs in six months or 3 or more symptomatic lower UTIs in one year
- Relapsed urinary tract infection — where the same organism is identified in the urine within two weeks of appropriate antimicrobial treatment. Relapsed or persistent infections should not be counted as 'new' infections when defining a woman with rUTIs. If the same organism is identified more than two weeks after completion of antibiotic therapy, this should be counted as a new infection
- Asymptomatic bacteriuria — the presence of bacteria in the urine of a person without signs or symptoms of UTI. It should not be routinely screened for, or treated, in women who are not pregnant. It does not count as a urinary tract infection
- Complicated urinary tract infection — a UTI that occurs in an individual with predisposing structural or functional abnormalities of the genitourinary tract or host factors that put them at increased risk of pyelonephritis or urosepsis

Criteria

These recommendations provide referral guidance for primary care clinicians when managing non-pregnant women over the age of 18 with recurrent lower UTI.

The recommendations do not cover the management of:

- Suspected malignancy (gynaecological cancer; urological cancer)
- Acute UTI,
- Recurrent or persistent asymptomatic bacteriuria. This is common and should not prompt further investigation or treatment, unless it is a persistent finding in pre-menopausal women

Recommendations:

1. All women with recurrent UTIs should be offered a kidneys, ureters and bladder ultrasound (KUB USS) in primary care. This should include measurement of a postmicturition residual volume as standard

Specialist referral

2. Specialty urology referral should be offered to women where ANY of the following clinical criteria are met:
    - Prior urinary tract surgery, pelvic organ prolapse surgery or trauma.
    - Prior abdominopelvic malignancy.
    - Visible and non-visible haematuria after resolution of infection (this should be managed as per NICE suspected cancer guidance — gynaecological cancer; urological cancer).

- Urea-splitting bacteria on culture (e.g. Proteus, Yersinia) in the presence of a stone, or atypical infections (e.g. tuberculosis, anaerobic bacteria)
- Bacterial persistence or on-going lower urinary tract symptoms after sensitivity-based therapy.
- Pneumaturia or faecaluria.
- Voiding symptoms (straining, weak stream, intermittency, hesitancy).

OR

- if any of the following features are present on renal ultrasound:
- Hydroureter or hydronephrosis.
- Bladder OR ureteric OR obstructive renal stones (for non-obstructive renal stones please use advice and guidance).
- Post-micturition residual volume greater than 150ml.

3. Women who do not meet the above criteria for speciality referral should be managed in primary care where possible. Management will differ depending on menopausal status, may include lifestyle modifications, non-antibiotic, and antibiotic based treatments, and should follow the recommendations set out in NICE guideline NG112.

4. If concerns persist, or symptoms remain uncontrolled despite optimal primary care management, primary care clinicians should use ‘advice and guidance’ to seek specialist advice in the first instance, prior to referral.

Evidence based intervention national coding script

```
 -- Cystoscopy Primary Procedure
WHEN LEFT(der.Spell_Dominant_Procedure,4) IN ('M451','M458','M459')
-- No General Anesthesia Used
AND (APCS.Der_Procedure_All NOT LIKE '%Y80%' OR APCS.Der_Procedure_All IS
NULL)
-- Identifying UTI
AND ( (APCS.Der_Diagnosis_All LIKE '%Z038%' AND APCS.Der_Diagnosis_All LIKE
'%Z874%')
OR APCS.Der_Diagnosis_All LIKE '%R30[09]%'
OR APCS.Der_Diagnosis_All LIKE '%R3[12356]%'
OR APCS.Der_Diagnosis_All LIKE '%R39[18]%'
OR APCS.Der_Diagnosis_All LIKE '%R934%'
)
-- Cancer Exclusion
AND APCS.Der_Diagnosis_All NOT LIKE '%C%'
AND APCS.Der_Diagnosis_All NOT LIKE '%D0%'
AND APCS.Der_Diagnosis_All NOT LIKE '%D3[789]%'
AND APCS.Der_Diagnosis_All NOT LIKE '%D4[012345678]%'
-- Female Only
AND APCS.Sex = 2
-- Age 19+
```

AND (isnull(APCS.Age_At_Start_of_Spell_SUS, APCS.Der_Age_at_CDS_Activity_Date) between 19 AND 120)
-- Not Non-Elective
AND APCS.Admission_Method NOT LIKE '2%'
THEN '4B_Recurrent_UTI_Cystoscopy'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Male sterilisation (vasectomy)

Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation that can be carried out for a male is known as vasectomy.

Criteria

GP based vasectomies under local anaesthetic

GP based local anaesthetic vasectomy for male sterilisation is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- their partner or spouse is not currently pregnant
- they understand the procedure should be considered irreversible
- the patient has been advised that reversal would not be funded by NHS Cornwall and Isles of Scilly Integrated Care Board
- they are able to have the procedure carried out under local anaesthetic

Secondary care-based vasectomies under general anaesthetic

Vasectomies performed under general anaesthetic is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- previous documented adverse reaction to local anaesthesia
- scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or manipulation of the spermatic cord through the skin difficult to achieve
- the patient is on anticoagulation therapy

Codes

Procedures challenged in this policy
N171, N172, N178, N179

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Mirena coils

The IUS (intrauterine system) is a long-acting reversible contraceptive (LARC) method. It works for 5 years and is a small, T-shaped plastic device that is inserted into the womb (uterus) by a specially trained doctor or nurse. The brand name of the IUS used in the UK is Mirena.

Criteria

Referrals should not be made for the routine fitting of Mirena as this should normally be offered in primary care. Exceptions are where fitting, or removal has failed or where there are issues specific to an individual patient that require secondary care insertion. For example, during termination of pregnancy, or as part of an operative procedure such as hysteroscopy.

Codes

Procedures challenged in this policy
P315, Q121, Q122, Q123, Q124, Q128, Q129

Relevant diagnoses for this policy
Z301, Z305

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Needle biopsy of prostate (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Prostate cancer is the commonest non-cutaneous cancer in people assigned male at birth in the UK and Europe. Approximately 48,500 new cases of prostate cancer are diagnosed within the UK each year. In the UK among people assigned male at birth, prostate cancer is the second most common cause of cancer death.

Prostate biopsy is a minimally invasive procedure where a small sample of prostatic tissue is obtained using a spring-loaded biopsy gun to assess for the presence of cancer. Generally prostatic biopsies are obtained by either a transperineal (TP) or transrectal (TR) route. There are different techniques to perform prostate biopsy – systematic or targeted. Targeted biopsy refers to image-guided biopsy of a specific target/lesion within the prostate, whereas in systematic biopsy the whole prostate is biopsied in a systematic way. Biopsies may be performed under general or local anaesthetic.

Criteria

This guidance applies to those 18 years and over.

Triage or one-stop clinic

- All patients with suspected prostate cancer, based on clinical examination and/or Prostate Specific Antigen (PSA) level, should be offered urgent clinical triage by a suitable member of the clinical team (within two weeks), preferably via remote triage consultation (either video or telephone). Offer face-to-face consultations where remote consultations are not considered appropriate
- Following initial triage, mpMRI should be considered to enable a fully informed discussion regarding the role of prostate biopsy based on clinical examination, mpMRI findings and other risk factors. One-stop clinics could be considered, where feasible
- In addition to PSA, digital rectal examination and mpMRI findings, other risk factors such as PSA density, should be considered for clinically suspected cases of prostate cancer

Pre-biopsy mpMRI

- Offer mpMRI as the first line investigation for people with suspected non-metastatic prostate cancer. mpMRI should not routinely be offered to people with prostate cancer who are not suitable for radical treatment
- Consider omitting a prostate biopsy for people whose mpMRI Likert or Prostate Imaging and Data System (PI-RADS) v2.1 interpretation score is 1 or 2, and the PSA density is less than 0.15, but only after discussing the risks and benefits with the person and reaching a shared decision. If a person opts to have a biopsy, offer a systematic prostate biopsy

- Prostate biopsy should be offered for patients with PSA density >0.15 on mpMRI specified volume assessment, a strong family history of prostate cancer (e.g. multiple relatives at a young age) or an abnormal prostate on examination, even if Likert or PI-RADS v2.1 score is 1 or 2
- Patients with a Likert or PI-RADS v2.1 score of 3 should be considered for prostate biopsy. This should be following consideration of clinical assessment, PSA density and prostate cancer risk factors, and after discussing the risks and benefits with the patient and reaching a shared decision
- Offer prostate biopsy to all patients with a Likert or PI-RADS v2.1 score of 4 or 5, unless otherwise clinically contraindicated

Biopsy route and setting

- Biopsies may be performed by transperineal (TP) or transrectal (TR) routes
- Preferably offer transperineal biopsy under local anaesthetic (LATP) as a first line investigation
- All centres involved in the diagnosis and management of prostate cancer should aim to offer LATP as an option

If LATP is not appropriate, then offer alternative options such as general anaesthetic transperineal biopsy or local anaesthetic transrectal ultrasound scan (TRUS) biopsy, based on patient specific factors.

The use of general anaesthetic should be minimised. However, indications may include:

- Patient is unable to tolerate biopsy under local anaesthetic
- Biopsy involves multiple entry points — Repeat biopsy (e.g. following an inconclusive result)
- Prostatic anatomical variation

Visible lesions should be targeted. If there is a lesion, both targeted and systematic biopsies should be offered. Target biopsies should be performed initially, followed by systematic biopsies and sent separately for histological analysis.

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('M702', 'M703')
AND ( Any_Spell_Diagnosis LIKE '%R798%')
AND (NOT (Any_Spell_Diagnosis LIKE '%Z804%')
OR Any_Spell_Diagnosis IS NULL )
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3I_Needle_Biopsy_Prostate'
```

Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
Outpatient

WHEN Any_Appointment_Procedure LIKE '%M70[23]%'
AND (NOT (Any_Appointment_Diagnosis LIKE '%Z804%')
OR Any_Appointment_Diagnosis IS NULL)
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3I_Needle_Biopsy_Prostate'
Exclusions

WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND ((Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'

Date approved: January 2025
Review date: There are no plans for further reviews
JCIA: Yes, completed

Non-visible haematuria (National Evidence Based Intervention)

Non-visible haematuria (blood in the urine) can be present in people with a urological cancer, in particular bladder cancer. However, it can also be present in a number of benign urological conditions, such as urinary tract infection, renal or ureteric stones or an enlarged prostate, as well as in the presence of kidney disease. Non-visible haematuria is common and the majority of people, if investigated, will not turn out to have a cancer or any other urological cause found for their symptoms.

The typical initial investigation of people with non-visible haematuria who are referred to secondary care involves imaging and cystoscopy. Further investigations may be indicated depending on the findings of these.

Imaging practice varies, with most centres using ultrasound as their first line modality. While computed tomography (CT) urography has higher sensitivity for upper tract cancers than ultrasound, it carries a high dose of ionising radiation.

Cystoscopy is a diagnostic procedure used to examine the lining of the bladder and urethra. Either a flexible or rigid endoscope may be used, under local or general anaesthesia, respectively. Typically, flexible cystoscopy under local anaesthesia is used as first line to investigate non-visible haematuria.

Criteria

This guidance applies to those 18 years and over.

Patients should be referred from primary care to secondary care for investigation of nonvisible haematuria in line with guideline NG12 from the National Institute for Health and Care Excellence (NICE).

Refer people to secondary care using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are:

- Aged 60 and over
- Have unexplained non-visible haematuria
- Either dysuria OR a raised white cell count on a blood test.

Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection.

The NICE guidance also includes recommendations on patient information and support, safety netting and the diagnostic process which are applicable both to patients who do and who do not meet the above referral criteria.

Secondary care urological investigation of non-visible haematuria should consist of:

- Imaging
- Ultrasound scan (USS) should be first line imaging modality
- DO NOT routinely perform CT urography if USS is normal

AND

- Cystoscopy
- Flexible cystoscopy under local anaesthesia should be the preferred approach unless patient choice or other factors make this inappropriate

AND

- A discussion regarding the rationale, risks, benefits and likely outcomes of investigation with patients as part of a shared decision-making process

Where, following investigation with imaging and cystoscopy, no cause for non-visible haematuria is found, patients should be discharged from secondary care follow up. They should not be referred or investigated again for future episodes of non-visible haematuria unless there is a change in their symptoms or signs (most notably the development of visible haematuria in the absence of urinary tract infection).

Evidence based intervention national coding script

Admitted Patient Care

```
WHEN ( Any_Spell_Procedure LIKE '%U12[34]%'
OR Any_Spell_Procedure LIKE '%U372%'
OR (Any_Spell_Procedure LIKE '%U21[26]%'
AND ( Any_Spell_Procedure LIKE '%Z41[123489]%'
OR Any_Spell_Procedure LIKE '%Z421%')
)
)
AND ( Any_Spell_Diagnosis LIKE '%R31%'
OR Any_Spell_Diagnosis LIKE '%N02[0123456789]%'
)
AND (NOT ( Any_Spell_Diagnosis LIKE '%R300%'
OR Any_Spell_Diagnosis LIKE '%R72%'
OR Any_Spell_Diagnosis LIKE '%N390%')
OR Any_Spell_Diagnosis IS NULL )
-- Only Elective Activity
AND APCS.Admission_Method NOT LIKE '2%'
-- Age between 18 and 120
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3H_Non_visible_Haematuria'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
Outpatient

WHEN ( Any_Appointment_Procedure LIKE '%U12[34]%'
OR Any_Appointment_Procedure LIKE '%U372%'
OR (Any_Appointment_Procedure LIKE '%U21[26]%'
```

```
AND ( Any_Appointment_Procedure LIKE '%Z41[123489]%'
OR Any_Appointment_Procedure LIKE '%Z421%')
)
)
AND ( Any_Appointment_Diagnosis LIKE '%R31%'
OR Any_Appointment_Diagnosis LIKE '%N02[0123456789]%'
)
AND (NOT ( Any_Appointment_Diagnosis LIKE '%R300%'
OR Any_Appointment_Diagnosis LIKE '%R72%'
OR Any_Appointment_Diagnosis LIKE '%N390%')
OR Any_Appointment_Diagnosis IS NULL )
-- Age Between 19 and 120
AND isnull(OPA.Age_at_Start_of_Episode_SUS,OPA.Der_Age_at_CDS_Activity_Date)
between 18 AND 120
THEN '3H_Non_visible_Haematuria'
```

Exclusions

```
WHERE 1=1
-- Patient Has Attended Appointment
AND Attendance_Status IN (5,6)
-- Cancer Diagnosis Exclusion Codes
AND (( Any_Appointment_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Appointment_Diagnosis not like '%D0%'
AND Any_Appointment_Diagnosis not like '%D3[789]%'
AND Any_Appointment_Diagnosis not like '%D4[012345678]%')
OR Any_Appointment_Diagnosis IS NULL)

-- Private Appointment Exclusion
AND opa.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: There are no plans for further reviews
JCIA: Yes, completed

Penile Circumcision (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT and UHP)

Penile circumcision is the surgical removal of the foreskin. It is performed as a day case procedure and requires general anaesthetic. While penile circumcision may be undertaken for religious, cultural, or medical reasons, the focus of this guideline is on the medical indications for penile circumcision.

Most foreskin conditions can be managed with simple advice and reassurance. There are a range of treatment options available for foreskin conditions and it's important that children and their parents are informed of these options prior to the decision to perform a penile circumcision, which cannot be reversed once performed.

While major morbidity and mortality following medical penile circumcision is very rare, these could be reduced and potentially avoided if surgical indications were more stringently applied.

Criteria

Medical penile circumcision is rarely indicated as a primary treatment. Most children and young people presenting with penile problems require no intervention other than reassurance.

This guidance applies to children and young people under 16 years.

This guidance excludes children and young people with congenital penile conditions such as hypospadias.

Penile circumcision should only be performed for:

- Prevention of urinary tract infection (UTI) in patients with recurrent UTIs or at high risk of UTI

OR

- Pathological phimosis (balanitis xerotica obliterans /lichen sclerosus)

OR

- required as part of the treatment for carcinoma of the Penis

OR

- For persistent phimosis in children approaching puberty, following an attempted a trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed

OR

- Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis

ALL patients must have a formally documented discussion of the risks and benefits of foreskin preserving surgery versus penile circumcision using a shared decision-making framework.

Codes

Procedures challenged in this policy

There are no appropriate codes.

Relevant diagnoses for this policy

D07.4, D40.7, D29.0, N47.X, N48.0, N48.1, N48.6, C60. or C60.0 C60.1 C60.2 C60.8 C60.9

Diagnoses for which the above procedures are permitted

There are no appropriate codes.

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN ('N303')
AND Any_Spell_Diagnosis LIKE '%N47%'
AND (NOT( Any_Spell_Diagnosis LIKE '%N390%'
OR Any_Spell_Diagnosis LIKE '%N48[01]%'
OR Any_Spell_Diagnosis LIKE '%Q54[0123489]%'
OR Any_Spell_Diagnosis LIKE '%Q55[345689]%'
)
OR Any_Spell_Diagnosis IS NULL
)
-- Age between 0 and 15
AND (isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 0 AND 15
OR isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
BETWEEN 7001 AND 7007)
THEN '3J_Penile_Circumcision'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: November 2016, April 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Percutaneous tibial nerve stimulation for urinary incontinence

Criteria

Percutaneous tibial nerve stimulation for urinary incontinence is not routinely commissioned.

There is currently insufficient evidence of clinical and cost effectiveness of this treatment.

Codes

Procedures challenged in this policy
A70.4 + Z12.2 percutaneous tibial nerve stimulation.

Relevant diagnoses for this policy
N393, N394, R32X

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: April 2018 and April 2021
Review date: April 2024 or earlier if new guidance is issued
JCIA: Yes, completed

PSA Testing for men aged 80 years and above (National Evidence Based Intervention)

These recommendations aim to maximise shared decision making between men who are 80 years old or older and primary care clinicians in relation to the investigation and diagnosis of prostate cancer. By developing a clear understanding of the potential outcomes to PSA testing for this group it will begin to address the harm associated with overdiagnosis and overtreatment and the wide variance in care delivery across the country. It provides clarity and guidance to primary care providers on when it is appropriate to refer a concerned patient aged over 80 to a secondary specialist care following a PSA test.

This guidance relates to those who have a prostate, this includes:

- Cismen (men who identify as male and were assigned male at birth)
- Trans women (women who identify as female and were assigned male at birth)
- Non-binary people who were assigned male at birth
- Some intersex people
- The information has been developed based on guidance and evidence in men. If you are a trans woman, male-assigned non-binary or intersex, some of this information is still relevant to you — but your experience may be slightly different

Please note for the purposes of this recommendation and to align with the evidence when we use ‘men’ it refers to all those with a prostate.

Prostate cancer is common, up to 1 in 8 men are diagnosed during their lifetime with over 45,000 cases diagnosed each year in England and Wales. It is a common cause of cancer-related death globally. In the UK, prostate cancer diagnosis typically begins in primary care with a blood test for serum prostate specific antigen (PSA) and/or a digital rectal examination. A PSA test may be performed in asymptomatic patients concerned about the risk of prostate cancer or in individuals with symptoms localised to the urinary tract or indicative of metastatic disease, who are defined as ‘symptomatic’ in national

guidance. The PSA level that should prompt specialist referral is defined at a fixed threshold for asymptomatic men and at age-specific thresholds for ‘symptomatic’ men. An age-specific PSA threshold is not defined for men aged over 80 in NICE guideline NG12 due to the lack of evidence in this group; instead ‘clinical judgement’ is advised. In the absence of specified value for this age-group, individual cancer alliances have devised their own numerical thresholds with significant regional variation. Screening and monitoring PSA levels in men over 80 can create health anxieties and unnecessary hospital visits. Simple numerical cut-offs can miss the bigger picture, including what a referral for suspected prostate cancer is likely to involve, and what factors are important in treatment decisions.

PSA testing of men over 80 is often offered to men with lower urinary tract symptoms (LUTS) in line with national guidance, although LUTS are not a reliable indicator of localised prostate cancer and are common in this age-group due to other causes. In fact, prostate cancer confined to the prostate gland often does not have any symptoms. Many of these men could be considered ‘asymptomatic’ with the PSA test therefore constituting a form of screening. PSA testing is known to have a poor specificity in this age-group, meaning many with a raised test will not have cancer. This can result in over-investigation, including prostate biopsy, which carries significant risk. The need for a biopsy has partly been mitigated by the introduction of multi-parametric prostate magnetic resonance imaging (MRI), but this is resource intensive.

Evidence shows there is a particular risk of over-diagnosing prostate cancer and overtreating prostate cancer in men over 80 where the prevalence of cancer is highest, but the proportion of cancers which are clinically significant is lowest. For many patients although they may have cancer, it will not cause symptoms in their lifetime or impact their life expectancy. Tests and treatments may in fact expose the patient to additional risks and unnecessary anxiety. Studies have shown that men aged between 50-70 years old are most likely to benefit from PSA testing. Individuals would need to have a further life expectancy of at least 10 years to benefit from radical treatment for localised prostate cancer. This will not be true for many, with the median life expectancy at only 8 years for a man turning 80 in the UK. The diagnosis and radical treatment of prostate cancer carries a significant risk of side effects that can negatively impact quality of life and it is important that these are avoided where treatment will not improve quality of life or survival. Active surveillance can be a safe and effective for managing patients with prostate cancer and localised disease, giving more time for men to make decisions on radical treatment. Clinicians and patients are both poor predictors of life expectancy, meaning that some patients with slow growing cancers but a high level of comorbidity are ‘overtreated’.

PSA testing is a highly complex and contentious area, and it is important that primary care clinicians and patients are appropriately supported to allow shared decision making together.

This guideline aims to complement NICE guideline NG12 by providing detail on the principles that should inform a shared decision-making process in men over 80 who are considering, or who have had, a PSA test.

These recommendations aim to ensure:

- Localised prostate cancer is diagnosed in all individuals who would benefit from radical treatment
- Over-diagnosis and overtreatment are minimised in those who don't have cancer or have clinically insignificant prostate cancer where radical treatment is unlikely to be of benefit and could cause harm
- Men with metastatic prostate cancer are identified and offered treatment where appropriate
- Improving the quality of life for men over 80 with slow growing prostate cancer.
- Support shared decision making between primary care clinicians and patients in relation to PSA testing

Criteria

PSA testing: Framework for shared decision making prior to testing
1. Before a PSA test is performed a shared decision-making process should take place between the patient and the primary care clinician where the limitations of the test and the possible consequences of an abnormal result are discussed. The clinician should consider discussing the following points:

About the PSA test
1.1. PSA can commonly be raised in the absence of prostate cancer (false positive) and occasionally be normal where cancer is present (false negative).

About localised prostate cancer
1.2. Prostate cancer confined to the prostate gland is typically asymptomatic — Lower urinary tract symptoms (LUTS) are not a reliable symptom of localised prostate cancer for men over 80 years old.

1.3. Prostate cancer confined to the prostate gland is common, but many cancers diagnosed in this age-group will be clinically insignificant meaning they won't cause symptoms in an individual's lifetime or shorten their life expectancy.

1.4. An individual must live for at least 10 years to benefit from radical treatment of prostate cancer when it is confined to the prostate gland. However, radical treatment can be associated with side effects (e.g. incontinence and erectile dysfunction) that impact quality of life.

About metastatic prostate cancer
1.5. When prostate cancer has spread outside the prostate gland there are effective treatments that may help reduce symptoms (but not cure the disease).

PSA testing: Clinical recommendations on testing

1.6. In men over 80, PSA testing should be encouraged where there are symptoms suggestive of metastatic prostate cancer (such as bone pain, unintended weight loss and fatigue).

1.7. In men over 80 without signs of metastatic disease the benefit of PSA testing is uncertain. A PSA test should only be performed in men who want one after an appropriate shared decision-making process (see above). The potential benefits are greater in those with a life expectancy of more than 10 years.

PSA testing: Interpreting test results
1.8. For men ≥80 years of age who have had a PSA test, offer referral via a suspected cancer pathway if:

- the PSA >20 ng/mL

OR

- the PSA >7.5 ng/mL AND there are symptoms suggestive of metastatic disease (bone pain and/or fatigue and/or significant unintended weight loss).

1.9. If the initial PSA test is between 7.5 – 20 ng/L and there are no symptoms suggestive of etastatic disease, repeat PSA ONCE after 6 months in primary care, prior to any secondary care referral.

1.10. When the PSA is repeated, offer referral via the suspected cancer pathway if:

- either criteria in recommendation 1.8 being met;

OR

- PSA has increased significantly (more than doubled), and the patient has a performance status of 0 or 1

1.11. If patients do not fit the above criteria but concerns remain, seek appropriate support via ‘advice and guidance’.

Evidence based intervention national coding script

There is currently no coding for this intervention

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Reversal of female sterilisation

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

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

Criteria

Reversal of female sterilisation is not routinely commissioned.

Codes

Procedures challenged in this policy
Q291, Q292, Q298, Q299, Q300, Q301, Q302, Q303, Q308, Q309, Q371, Q378, Q379

Relevant diagnoses for this policy
Z310

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2016; November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Reversal of male sterilisation

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.

Criteria

Reversal of male sterilisation is not routinely commissioned.

Codes

Procedures challenged in this policy
N181, N182, N188, N189

Relevant diagnoses for this policy
Z310

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2016, November 2018 and November 2022
Review date: November 2025 or earlier if new guidance is issued

JCIA: Yes, completed

Routine doppler ultrasound of umbilical + uterine artery in antenatal care

Criteria

Routine doppler ultrasound of umbilical and uterine arteries for low-risk pregnancies is not routinely commissioned.

Codes

Procedures challenged in this policy
R421, R422

Relevant diagnoses for this policy
Z35

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed

Sperm washing

Sperm washing is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

- One sperm washing procedure will be funded within the local NHS for couples where the man is HIV positive and either he is not compliant with Highly Active Antiretroviral Therapy (HAART) or his plasma viral load is 50 copies/ml or greater and where the female is HIV negative
- Where the procedure is successful, couples may access IUI or IVF, with or without ICSI, depending on their clinical circumstances, in line with the relevant policy
- In order to access NHS funded sperm washing and subsequent assisted conception treatments, patients will be required to fulfil relevant eligibility criteria
- Sperm washing is normally indicated for couples who wish to have a child where the male is HIV-positive and the female is HIV-negative, or to minimise the risk of transmission of resistant virus in HIV seroconcordant couples. The use of sperm washing has also been proposed in couples where the male is hepatitis C positive, and the female is negative.

According to NICE CG156, the evidence showed that sperm washing appears to be very effective in reducing viral transmission; no cases of seroconversion of the woman or the baby have been documented.

Patients not included in these criteria are:

- Sperm washing is unavailable on the NHS for couples where the male is hepatitis C positive, because NICE CG156 recommends that couples who want to conceive and where the man has hepatitis C should be advised that the risk of transmission through unprotected sexual intercourse is thought to be low

Codes

Procedures challenged in this policy

There are no appropriate codes.

Relevant diagnoses for this policy

B200, B201, B202, B203, B204, B205, B206, B207, B208, B209, B210, B211, B212, B213, B217, B218, B219, B220, B221, B222, B227, B230, B231, B232, B238, B24X, R75X, Z21X

Diagnoses for which the above procedures are permitted

There are no appropriate codes.

Date approved: April 2018 and September 2022
Review date: September 2025 or earlier if new guidance is issued
JCIA: Yes, completed

Surgical intervention for bladder outflow obstruction (BOO) (National Evidence Based Intervention) Criteria based access and prior approval required (UHP)

Bladder outflow obstructive surgery is a therapeutic procedure to treat men with symptomatic lower urinary tract symptoms (LUTS) due to bladder outflow obstruction (BOO). The most common cause for BOO is benign prostatic obstruction (BPO), rarer causes include bladder neck stenosis.

Surgical procedures primarily involve a transurethral endoscopic approach in which prostate tissue is either removed or vapourised to relieve the obstruction. Current recognised approved procedures include:

- Transurethral resection of prostate (TURP)
- Transurethral incision of the prostate (TUIP) or Bladder Neck Incision (BNI)
- Holmium LASER enucleation of the prostate
- 532 nm laser vaporisation of the prostate (e.g. ‘GreenLight’)
- UroLift
- Transurethral vaporisation of the prostate (TUVP)
- Transurethral water vapour therapy (Rezum)
- Aquablation
- Simple robotic prostatectomy

Non-surgical procedures include interventional radiology techniques such as prostate artery embolization.

The most established procedure for the management of bladder outflow obstruction is Transurethral resection of prostate (TURP), a therapeutic procedure involving removal of tissue from the inner aspect of the prostate using diathermy, via an endoscopic approach.

TURP remains a reliable option and is the mainstay of treatment for many patients. It is usually undertaken on an in-patient basis, with a catheter left in-situ for 24-48 hours post-operatively for the purpose of irrigation. TURP may be undertaken under either general or spinal anaesthesia. TURP causes temporary discomfort, occasionally pain, haematuria and is associated with small risks of infection and acute urinary retention after removal of the catheter. There is also a risk of sexual dysfunction following TURP. There are small but important risks of significant harm, including severe fluid and electrolyte imbalances associated with absorption of large volumes of irrigating fluid (TUR syndrome). TUR syndrome can be avoided by using bipolar diathermy, a variant of the standard technology.

There is an emerging suite of minimally invasive surgical treatments (MISTs) which are replacing TURP as the mainstay of treatment. The increased range of treatments has meant that there is now a requirement for specialist assessment to include more complex discussions with patients about their options. A decision aid to support patients through the selection of individualised treatment options is recommended.

Open simple/benign prostatectomy is very rare and is only undertaken in men with very large prostates and problematic symptoms.

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

This guidance relates to those who have a prostate, this includes:

- Cismen (men who identify as male and were assigned male at birth)
- Trans women (women who identify as female and were assigned male at birth)
- Non-binary people who were assigned male at birth
- Some intersex people

The information has been developed based on guidance and evidence in men. If you are a trans woman, male-assigned non-binary or intersex, some of this information is still relevant to you — but your experience may be slightly different.

Please note for the purposes of this recommendation and to align with the evidence when we use ‘men’ it refers to all those with a prostate.

Criteria

Only men with severe voiding symptoms and in which a diagnosis of bladder outlet obstruction (BOO) has been made should be offered surgical intervention. Assessment of BOO should include both a free flow rate and post void residual in men between the ages of 50 and 80.

BOO is defined according to the European Association of Urology where the patient cannot void >150mls, the maximum flow is <10mls/s or with a post void residual >300mls.

Assessment of men with lower urinary tract symptoms should be done in a specialist centre and current best practice is that this should be done in a one stop clinic.

A staged approach to managing BOO in men is recommended:

1. Conservative, or lifestyle interventions should be discussed such a bladder training, hydration management and pelvic floor exercises
2. Drug therapy should be considered, in the context of more persistent LUTS, or LUTS not responding to simple lifestyle interventions
3. Where LUTS persist, or if medical management is not tolerated, intervention should be considered using a shared decision-making approach
4. 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

Initial management of patients should be done in primary care and is covered by NICE guidance CG97. There is evidence of the long-term side effects of medical management, therefore early referral and assessment for appropriate intervention could be considered for some patients.

Part of the consultation process for patients undergoing BOO surgical or non-surgical intervention should include a validated decision aid tool to ensure that the patients' desired outcomes have been considered. This allows for an informed consent process which balances outcomes, potential side effects and the patients' quality of life. The patients preferred treatment option will need to be considered alongside other factors such as their general health. Practical concerns, including the distance required to travel, are important and should also be considered. Appropriate support should be provided to make shared decisions pertinent to physical, emotional, psychological and sexual health. If appropriate, partners and/or carers should be informed and involved. An example of decision aid tool can be found on the NHS website.

This guidance is reflective of current known and approved interventions however in the future, new minimal invasive surgical techniques (MISTs) may be developed. Once the potential new techniques are shown to be safe and effective by NICE, they should be included in the consenting process.

Providers should collaborate to ensure all recognised interventions are available to their populations within a reasonable geographical area. Urological area networks recognised by GIRFT provides a practical solution.

Evidence based intervention national coding script

```
WHEN (   Primary_Spell_Procedure like '%M61[123489]%'
OR Primary_Spell_Procedure like '%M641%'
OR Primary_Spell_Procedure like '%M65[1234589]%'
OR Primary_Spell_Procedure like '%M66[12]%'
OR Primary_Spell_Procedure like '%M68[13]%'
OR Primary_Spell_Procedure LIKE '%M704%'
OR Primary_Spell_Procedure LIKE '%M71[189]%'
OR Primary_Spell_Procedure LIKE '%M68[89]%'
OR (    LEFT(Primary_Spell_Procedure,4) = 'L713'
AND Any_Spell_Procedure LIKE '%Z387%'))
AND Primary_Spell_Diagnosis like '%N40%'
AND NOT (   Any_Spell_Diagnosis LIKE '%C61%'
OR Any_Spell_Diagnosis LIKE '%N13[0-9]%'
OR Any_Spell_Diagnosis LIKE '%N17[01289]%'
OR Any_Spell_Diagnosis LIKE '%N18[123459]%'
OR Any_Spell_Diagnosis LIKE '%N19%')
   -- Gender is Male
AND Sex=1
          -- Age between 19 and 120
   AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
   -- Only Elective Activity
AND APCS.Admission_Method not like ('2%')
   THEN '2I_BPH_surgery'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Surgical removal of kidney stones (National Evidence Based Intervention) Criteria based access and prior approval required (RCHT)

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

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

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

This guidance applies to adults aged 19 years and over.

Criteria

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

Adult renal stones

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

Adult ureteric stones

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

Primary uteroscopy

- Ureteric stones causing significant pain and in the absence of infection. These patients can be offered emergency extracorporeal shockwave lithotripsy. Emergency extracorporeal shockwave lithotripsy could involve several trips to Derriford Hospital, Plymouth over a short period.

Codes

Procedures challenged in this policy

M07.1 Ureteroscopic laser fragmentation of calculus of kidney
M07.2 Ureteroscopic extraction of calculus of kidney NEC
M09.1 Endoscopic ultrasound fragmentation of calculus of kidney
M09.2 Endoscopic electrohydraulic shockwave fragmentation of calculus of kidney
M09.3 Endoscopic laser fragmentation of calculus of kidney
M09.4 Endoscopic extraction of calculus of kidney NEC
M09.8 Other specified therapeutic endoscopic operations on calculus of kidney
M09.9 Unspecified therapeutic endoscopic operations on calculus of kidney
M14.1 Extracorporeal shock wave lithotripsy of calculus of kidney
M14.8 Other specified extracorporeal fragmentation of calculus of kidney
M14.9 Unspecified extracorporeal fragmentation of calculus of kidney
M26.1 Nephroscopic laser fragmentation of calculus of ureter
M26.2 Nephroscopic fragmentation of calculus of ureter NEC
M26.3 Nephroscopic extraction of calculus of ureter
M27.1 Ureteroscopic laser fragmentation of calculus of ureter
M27.2 Ureteroscopic fragmentation of calculus of ureter NEC
M27.3 Ureteroscopic extraction of calculus of ureter
M28.4 Endoscopic catheter drainage of calculus of ureter
M28.5 Endoscopic drainage of calculus of ureter by dilation of ureter
M28.8 Other specified endoscopic removal of calculus from ureter
M28.9 Unspecified other endoscopic removal of calculus from ureter
M31.1 Extracorporeal shockwave lithotripsy of calculus of ureter
M31.8 Other specified extracorporeal fragmentation of calculus of ureter
M31.9 Unspecified extracorporeal fragmentation of calculus of ureter

Relevant diagnoses for this policy

N20.0 Calculus of kidney
N20.1 Calculus of ureter
N20.2 Calculus of kidney with calculus of ureter
N20.9 Urinary calculus, unspecified

Diagnoses for which the above procedures are permitted

Cancer diagnoses are a global exclusion

Evidence based intervention national coding script

```
WHEN LEFT(Primary_Spell_Procedure,4) IN
('M071','M072','M078','M091','M092','M093','M094','M098','M261','M262'
,'M263','M268','M271','M272','M273','M278','M284','M285','M288','M289')
```

AND (Primary_Spell_Diagnosis LIKE '%N132%'
OR Primary_Spell_Diagnosis LIKE '%N20[0129]%')
-- Age between 19 and 120
AND
ISNULL(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2G_kidney_stone_surgery'
Exclusions

WHERE 1=1
-- Cancer Diagnosis Exclusion
AND (Any_Spell_Diagnosis not like '%C[0-9][0-9]%'
AND Any_Spell_Diagnosis not like '%D0%'
AND Any_Spell_Diagnosis not like '%D3[789]%'
AND Any_Spell_Diagnosis not like '%D4[012345678]%'
OR Any_Spell_Diagnosis IS NULL)
-- Private Appointment Exclusion
AND apcs.Administrative_Category<>'02'

Date approved: July 2021 and January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Testicular prosthesis

A testicular prosthesis is a replica testicle made from silicone, which replaces your own testicle(s) if one or both have been removed. The removal of a testicle (orchidectomy) is most commonly performed due to testicular cancer; however, some men have one or both testicles removed for other reasons such as undescended testes, trauma, severe torsion (twisted testicle) or as a treatment option for advanced prostate cancer (Guy's and St Thomas' NHS Foundation Trust, 2014).

Criteria

Insertion of testicular prostheses is not routinely commissioned.

Codes

Procedures challenged in this policy

Bilateral testes excisions N051, N052, N053, N05.8, N05.9
Other or unilateral testis excisions N061, N063, N066, N06.8, N06.9
N10.1 Insertion of prosthetic replacement for testis
N10.2 Removal of prosthetic replacement for testis
N10.8 Other specified prosthesis of testis

Relevant diagnoses for this policy

N44X, N500, Q530, Q531, Q532, Q539, Q550

Diagnoses for which the above procedures are permitted
C620, C621, C629, C61.X Prostate cancer

Date approved: April 2018 and April 2021
Review date: April 2024 or earlier if new guidance is issued
JCIA: Yes, completed

Transurethral resection of bladder tumour (TURBT) single post instillation of mitomycin C (SPI-MMC) (National Evidence Based Intervention)

These recommendations target improvements in how care is delivered to patients with bladder cancer, aiming to reduce cancer recurrence, improve patient experience and reduce unwarranted variation by setting out best practice.

These recommendations outline how mitomycin C (MMC) is best administered posttransurethral resection of bladder tumour (TURBT). The need for prompt administration is guided by best evidence as well as a drive to deliver more TURBTs as day cases where this is clinically appropriate, improving patient experience and optimising the use of resources.

Mitomycin C (MMC), a chemotherapy agent, has been in use in urology practice for a decade and is recommended as part of the treatment of non-muscle invasive bladder cancer (NMIBC) to reduce recurrence. It is theorised that MMC kills cancer cells floating in the bladder, cells at the resection site and any missed tumours. This reduces recurrence and the need for further invasive and expensive interventions. Mitomycin C is instilled into the bladder after transurethral resection of bladder tumour (TURBT), a process which is termed ‘single post TURBT instillation of mitomycin C’ (SPI-MMC).

There is a wide variation in clinical practice relating to SPI-MMC. The Getting It Right First Time (GIRFT) urology programme identified variation in the proportion of patients being offered SPI-MMC, and when offered, variation in the timing and clinical setting in which it was administered. Exemplar units had functioning pathways that allowed installation of MMC in the operating theatre or recovery area, maximising the chance of a day case pathway for the patient. Where MMC was not given in theatre, patients were often reliant on administration on the ward and this could often lead to delays or, in some cases, missed doses. The most common reason cited for not being able to perform SPI-MMC in theatre related to local pharmacy guidelines on chemotherapy. Training was occasionally an issue, though this was usually easier to overcome.
Single dose MMC is used after first TURBT to reduce the likelihood of tumour recurrence.

Some patients having subsequent TURBTs are also prescribed SPI-MMC but those patients are outside the scope of this guidance. It is important that patients are consented for the administration of MMC prior to their first TURBT procedure and those with known intolerance or allergy to MMC do not receive it. At the time of the procedure, SPI-MMC should be administered where the operating surgeon identifies a bladder

tumour that does not invade the muscle layer and there are no contraindications (perforation of the bladder, need for deep resection or need for irrigation due to ongoing gross haematuria). Histological examination of the tumour specimen is used to assess whether further intravesical chemotherapy may be required, but these subsequent procedures are not covered in this guideline.

Single dose MMC works best when delivered soon after TURBT. Best practice is for the operating surgeon / suitably qualified healthcare professional to administer the dose of chemotherapeutic agent in theatre as it reduces the risk of MMC being missed, minimises the need for patients to stay overnight and likely increases clinical efficacy. MMC is also administered in other locations including the recovery unit and the inpatient ward. In the 'non-theatre' setting, any appropriately trained medical practitioner can administer single dose MMC; in practice, this is normally a urology nurse specialist or a ward nurse with urology experience.

Criteria

This recommendation applies to all patients undergoing their initial TURBT for a new nonmuscle invasive bladder cancer, who meet the clinical criteria for single dose mitomycin C administration as outlined in NICE guideline NG23.

It excludes patients with contraindications, such as allergies/intolerance to mitomycin C, bladder perforation/deep resection or significant post-operative bleeding.

Recommendations
1. Single dose mitomycin C should be administered within the theatre or theatre recovery setting for all eligible patients following TURBT.
2. Where this is not possible, single dose mitomycin C should be administered within 6 hours of the TURBT procedure being completed
3. Mitomycin C should only be administered by appropriately trained practitioners.
4. The use of closed systems (e.g. Mito-In or similar) is preferable for the delivery of mitomycin C

These recommendations are in line with the GIRFT best practice day case TURBT pathway.

Evidence based intervention national coding script

```
-- Identifying initial TURBT Episode
-- Query 1 AS TURBT
WHERE APCE.Administrative_Category <>'02'
AND FCE_Dominant_Procedure = 'M421' -- TURBT

-- Query 2
-- Joined by Pseudo NHS Number to APCE and APCS to Identify Mitomycin C injections after 6 hours (max 31 days)
```

```
INNER JOIN [NHSE_SUSPlus_Live].[dbo].[tbl_Data_SEM_APCE] APCE WITH
(NOLOCK)
ON TURBT.Der_Pseudo_NHS_Number = APCE.Der_Pseudo_NHS_Number
AND TURBT.Episode_End_Date <= APCE.Episode_Start_Date
-- Mitomycin C applied within 31 days of initial TURBT appointment
AND DATEDIFF(day, TURBT.Episode_End_Date, APCE.Episode_Start_Date) <= 31
AND APCE.Der_Financial_Year >= TURBT.Der_Financial_Year
-- Theraputic Substance injected into bladder
AND APCE.Der_Procedure_All LIKE '%M494%'
-- Substance was Chemotheraphy Drug (Implied Mitomycin C)
AND APCE.Der_Procedure_All LIKE '%X722%'
--============================
-- Limits on extracted spells
--============================
WHERE
( -- Mitomycin C Administered more than 1 day after TURBT *In case Episode time not
filled*
DATEDIFF(day, TURBT.Episode_End_Date, APCE.Episode_Start_Date) >= 2
-- If time filled, Mitomycin C Administered more than 6 hours after TURBT
OR (DATEDIFF( minute,
CAST(TURBT.Episode_End_Date AS varchar)+'T'+TURBT.Episode_End_Time,
CAST(APCE.Episode_Start_Date as varchar) +'T'+APCE.Episode_Start_Time) >= 360)
)
AND isnull(APCS.Age_At_Start_of_Spell_SUS,APCS.Der_Age_at_CDS_Activity_Date)
BETWEEN 19 AND 120
-- Current Spell is not second TURBT
AND APCS.Der_Procedure_All NOT LIKE '%M421%'
-- Not private
AND APCS.Administrative_Category<>'02'
```

Date approved: January 2025
Review date: No plans for further reviews unless evidence-based intervention programme issue updates to policy
JCIA: Yes, completed

Equality impact assessment

The impact assessment for each individual commissioning policy is available on request.

Pre-ratification checklist

The NHS Cornwall and Isles of Scilly Integrated Care Board commissioning policies have been drafted in line with the NHS Cornwall and Isles of Scilly Integrated Care Board planned care team standard operating procedure for commissioning policy ratification.