NHS
Suffolk and
North East Essex
Integrated Care Board

Legacy Suffolk and North East Essex ICB Clinical Priorities Policy - NOT YET ALIGNED

Document information

Target audience
Optometrists, secondary care consultants, referral service triagers, service providers, community services, public and patients

Brief description
This policy sets out the funding arrangements for treatments/interventions/procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded. This policy should also be read in conjunction with the ICB Fertility Services Commissioning Policy.

Review and Approval

Reviewed/Approved	Date	Amendment
ICB Clinical Priorities Team	August 2022	Policy rolled over from previous CCGs (NEE, IES and WS) with individual policy type clarifications.
Extended review date – Agreed by Quality Committee	12 Sept 2024	Extended from December 2023 to July 2025
Updated document	Sept 2025	**Following policies archived and removed from document:** Bobath Therapy Policy, Communications Support Policy, Gastroelectrical Stimulation Policy, Laser Treatment for Rosacea Policy, Penile Prosthesis Policy, Elective Caesarean Section Policy **Following polices have been amended:** Cataract Surgery Policy, Ear Wax Removal Policy.
Updated document	Dec 2025	**Following policies archived and removed from document:** Bariatric Surgery, Tier 3 Weight Management. **Following polices have been added:** Interim Complex Obesity Service
Updated document	Jan 2026	**Following policies have been added:** Misophonia, Epiphora **Following policies have been reviewed and amendments made:** Vision Therapy and Related Interventions, Female Sterilisation, Chalazia Removal, Benign Skin Lesions
Updated document	Feb 2026	**Following document:** Updated review date for Interim Complex Obesity Service

Updated document: May 2026

Following policies now harmonised and moved to Knowledge NoW Website:
Acne Vulgaris - Scar Revision
Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain
Blepharoplasty
Body Contouring
Bone healing ultrasound system - EXOGEN
Carpal Tunnel Syndrome Surgery
Cataract Surgery
Chalazia Removal
Complementary and Alternative Therapies
Cryopreservation of Sperm, Oocytes and Embryos
Dilatation and curettage (D&C) for heavy menstrual bleeding
Diagnostic Medial Branch Block +/- Radiofrequency Denervation
Diagnostic Sacroiliac Joint Injection, +/- Radiofrequency Denervation of the Sacroiliac Joint
Dupuytren's Contracture
Dysthyroid Eye Disease
Ear Lobe Repair
Epiphora
Face Lift
Female Sterilisation
Fenton's Procedure
Functional Electrical Stimulation
Ganglion Excision
Grommets for Otitis Media with Effusion in Children
Gynaecomastia Surgery
Haemorrhoids – Surgical Treatment
Hallux Valgus (Bunions) or Hallux Rigidus Surgery
Hip Injections
Hip Replacement
Hip Resurfacing
Hysterectomy for Heavy Menstrual Bleeding
Interim Complex Obesity Service
Knee Replacement
Labiaplasty and Vaginoplasty
Lymphoedema Services
Male Circumcision
Misophonia
Nasal Surgery including Septorhinoplasty and Rhinoplasty
Nipple Inversion
Pinnaplasty in Children
Reversal of Sterilisation
Rhinophyma
Scar Revision
Shoulder Arthroscopy for conditions other than pure Subacromial Shoulder Impingement Sleep Systems (for posture)
Snoring Surgery in Adults
Standing Frames (Bespoke)
Subfertility Investigation and Treatment in Secondary Care
Tattoo Removal
Temporomandibular Joint Replacement
Temporomandibular Joint Retainers and Appliances
Tinnitus
Tonsillectomy
Trigger Finger - Surgical Release
Urinary Incontinence and Symptomatic Pelvic Organ Prolapse in Secondary Care (Treatment of Female)
Uterine Artery Embolisation Varicose Vein Interventions
Vasectomy under General Anaesthetic
Vision Therapy and Related Interventions, Coloured Filters and Tinted Lenses Weight Management and Smoking Cessation Prior to Elective Surgery
Wireless Capsule Endoscopy and Double Balloon Enteroscopy

Contents

Statement of Overarching Principles

All Policies, Procedures, Guidelines and Protocols of the SNEE ICB are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

Executive Summary, Purpose and Definitions

This policy sets out the funding arrangements for treatments/ interventions/ procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded.

This policy covers the following types of treatments/ interventions/ procedures:

Threshold & Prior Approvals – Those procedures which may be offered on a routine basis but only for patients who meet defined criteria agreed in a clinical protocol.

The responsibility for adherence to these policies lies with the referring and accepting clinicians and prior approval should be sought from the ICB (see below) where this is part of the contracting arrangements.

Individual Funding Requests (IFR) - Those procedures which are not routinely provided by the ICB and where provision is only possible on an individual patient basis.

For these procedures, the criteria listed form provide guidance to referring clinicians and the ICB commissioner. In instances in which eligibility is unclear the final decision is made through the application of the Exceptional Cases process.

Exceptional Clinical Circumstances (ECC) – These are procedures which are only funded in exceptional circumstances, (e.g. breast augmentation).

Applications for these procedures should be made to the Clinical Priorities Team and should only be made where the patient demonstrates exceptionality.

The Exceptional Clinical Process cannot be offered where legal restrictions apply (e.g. Surrogacy).

Principles

Please read before making any referral.

In line with national health promotion messages and the Heath Education England messages in making every contact count the ICB policy is to promote the message that individuals can make changes to their own lifestyle which will significantly reduce the risk of ill health in the long and short term not just in relation to a referral for any elective treatments. We therefore actively encourage the promotion of stop smoking services, weight management opportunities and alcohol support services as part of all contacts for primary and secondary health services. Please refer to the Weight Management and Smoking Cessation Prior to Elective Surgery Policy.

General

The use of scoring tools prior to referral should be undertaken as a guide only however we request that the tool accompany referrals as part of a holistic understanding of the patient's symptoms and impacts on the activities of daily living.

All patients being considered for joint replacement must be offered at least the core treatments for osteoarthritis (as per NICE guidance see recommendation 1.2.5), and give them information about:

- the benefits and risks of surgery and the potential consequences of not having surgery

- recovery and rehabilitation after surgery
- how having a prosthesis might affect them
- an understanding of how care pathways are organised locally to support their recovery

Please be advised that revision/cosmetic surgery will not be funded for purely aesthetic reasons or for predictable changes following pregnancy, including revisions following surgery as the result of pregnancy. Please refer to the "**Cosmetic Interventions: General Principles**" Commissioning Statement within this Policy Document. on the SNEE ICB website. Applications for these procedures should be made to the Exceptional Clinical Case Team and should only be made where the patient demonstrates exceptionality.

Benign Skin Lesions - Management

Policy properties	Information relating to this policy
Policy name	Benign Skin Lesions - Management
Policy type	Threshold
Included intervention(s)	Removal of benign skin lesions
Included indication/ condition(s)	Benign skin lesions identified in this policy
Date produced	January 2021
Planned review date	Dec 2027
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T28: Management of benign skin lesions in secondary care T37: Treatment of benign perianal skin lesions in secondary care
NEE CCG policy	Benign skin lesions

Interventions covered by this policy
Removal of benign skin lesions.

Summary

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 applies to all providers, including GPs, GPs with an enhanced role, independent providers, and community or intermediate services.

GPs providing Minor Surgery as an Additional Service (curettage and cautery and, in relation to warts, verrucae and other skin lesions e.g. seborrhoeic keratosis, cryocautery) or Minor Surgery as a Directed Enhanced Service (DES) under GMS/APMS contracts must adhere to the restrictions as detailed within this service restriction policy. Although these services are commissioned by NHS England, GPs should note that removal of benign skin lesions for purely cosmetic reasons will **not be funded** by NHS England under this DES and as such should apply this policy.

Conditions to be considered for treatment under this policy
This policy refers to the following benign lesions when there is diagnostic certainty:

- 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 (fibro epithelial 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

Eligibility criteria for provision of the intervention
Removal of one of the benign skin lesions listed above should only be considered if they meet at least **one** of the following criteria:

- 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) OR
- There is repeated infection requiring 2 or more antibiotic courses per year OR
- The lesion bleeds (more than twice weekly for at least four weeks) in the course of normal everyday activity OR
- The lesion causes pain requiring long-term daily medication OR
- The lesion is obstructing an orifice or impairing the field of vision OR
- The lesion significantly impacts on function e.g. restricts joint movement OR
- 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. OR
- If left untreated, more invasive intervention would be required for removal OR
- Facial viral warts causing significant psychological distress (e.g. school avoidance), in those aged under 18 years who are unable to tolerate cryotherapy OR
- Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.

Exclusions
This policy does not cover:

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

Additional notes
This policy is based on Evidence-Based Interventions Guidance published by NHS England, 2018 (reviewed September 2024) https://ebi.aomrc.org.uk/
All adult referrals for elective surgery should refer to Policy ‘Weight management and smoking cessation prior to elective surgery’.
All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement ‘Cosmetic interventions: general principles’.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for removal of benign skin lesions.

There is little evidence to suggest that removing benign skin lesions to improve appearance is beneficial. Risks of this procedure include bleeding, pain, infection and scarring. Though in certain specific cases as outlined by the criteria above, there are benefits for removing skin lesions, for example, avoidance of pain and allowing normal functioning.

Compliance with NICE guidance
This policy complies with relevant NICE guidance.

References

- National Institute for Health and Clinical Excellence. Cancer Service Guideline (CSG) 8 - Improving outcomes for people with skin tumours including melanoma https://www.nice.org.uk/guidance/csg8 [Accessed 17.11.25]
- National Institute for Health and Clinical Excellence. NICE guideline (NG) 12 – Suspected cancer: recognition and referral. https://www.nice.org.uk/guidance/ng12 [Accessed 17.11.25]
- Kerr OA, Tidman MJ, Walker JJ *et al.* The profile of dermatological problems in primary care. *Clin Exp Dermatol*. 2010; (4):380-3
- http://www.patient.co.uk/doctor/minor-surgery-in-primary-care [Accessed 06.01.25]
- George S, Pockney P, Primrose J *et al.* A prospective randomised comparison of minor surgery in primary and secondary care. The MiSTIC trial. *Health Technology Assessment* 200 8;12(23): iii-iv, ix-38.
- Centers for disease control and prevention (CDC). 2010 STD Treatment Guidelines. *Ge nital warts.* https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm [Accessed 06.01.25]
- Bouguen G, Siproudhis L, Bretagne JF, Bigard MA, Peyrin-Biroulet L. Nonfistulizing Perianal Crohn's Disease: Clinical Features, Epidemiology, and Treatment. Inflammatory Bowel Diseases, Vol16. Is8. p1267–1446 (2010).

Additional guidance referred to in production of ICS policy.

- NHS England, 2018 (reviewed 2024). Evidence-Based Interventions Guidance https://ebi.aomrc.org.uk/ [Accessed 17.11.25]

Appendix

NICE recommendations on referral for suspected skin cancer
(National Institute for Health and Care Excellence, 2015. Suspected cancer: recognition and referral https://www.nice.org.uk/guidance/ng12)
NICE recommend the following groups should be referred using a suspected cancer pathway referral:

People with suspected **malignant melanoma** if they have a suspicious pigmented skin lesion and a score of 3 or more on the following checklist:
Major features of the lesions (scoring 2 points each):

- Change in size
- Irregular shape
- Irregular colour

Minor features of the lesions (scoring 1 point each):

- Largest diameter 7 mm or more
- Inflammation
- Oozing
- Change in sensation

OR

- if dermoscopy suggests melanoma of the skin OR
- if they have a pigmented or non-pigmented skin lesion that suggests nodular melanoma OR
- People with a skin lesion that raises the suspicion of **squamous cell carcinoma**

People with a skin lesion that raises the suspicion of a **basal cell carcinoma** ONLY if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size; otherwise, routine referral.

Breast Implants - Surgery to remove or replace

Policy properties	Information relating to this policy
Policy name	Breast Implants - Surgery to remove or replace
Policy type	Exceptional Clinical Circumstances for removal/ replacement of implant Threshold for removal of implant with rupture
Included intervention(s)	Surgical removal or removal and replacement of breast implants
Included indication/ condition(s)	Breast implant(s) for which removal or removal and replacement is being sought
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	PE 114. Surgery to remove or replace breast implants
NEE CCG policy	Breast reconstruction

Interventions covered by this policy

Surgery to remove or remove and replace breast implants.

Conditions to be considered for treatment under this policy

Breast implant(s), for which removal or removal and replacement is being sought.

Eligibility criteria for provision of the intervention

Breast implant removal or removal and replacement for the sole purpose of changing the cosmetic appearance of the breast are considered low priority procedures and will not normally be funded.

Exclusions

This policy does not apply to breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management).

Additional notes

Surgery for breast enlargement, breast ptosis or breast asymmetry (which may include the insertion of a breast implant) are covered in Policy 'Breast surgery (excluding cancer-related surgery)'.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Referral may be made to the ECC Panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery.

The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria):

- Funding for breast implant removal may be considered where there is a clear clinical need and where specialist clinical opinion is that the benefit of the procedure outweighs the risk of harm. Clinical need may include:
    - Pain due to capsular contracture grade III/IV on Baker classification[1]
    - Silicone implant leakage or rupture
    - Implants complicated by recurrent infection
    - Breast disease, where implant removal is required for diagnosis and/or management
    - In order to comply with any national guidance relating to removal of specific types of implant
- Where funding for removal is approved, SNEE ICB may wish to consider funding the replacement of implants if the original procedure was funded by the NHS AND the patient remains eligible for breast augmentation in accordance with current policies
- Patients who have had implants inserted privately should be directed back to the private provider in the first instance

The ECC Panel may also wish to consider the following general guidance regarding surgical breast procedures, as appropriate:

- Requests should only be considered in women aged 21 and over as this will allow time for them to receive the necessary support and counselling to arrive at an informed decision once breast development is completed
- BMI should be stable and sustained below 30kg/m^2 for at least 1 year prior to referral (unless there are urgent clinical indications for implant removal)
- The panel should consider the impact on the breasts of any likely changes associated with pregnancy and breast feeding
- If patients are suffering psychological distress, appropriate referrals should have been made and other potential causes of psychological distress should be appropriately evaluated and treated. Documentation of mental health status should be provided
- Patients who smoke should be offered support to stop smoking as an opt-out, in line with the 'Weight management and smoking cessation prior to elective surgery' policy

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy/ Policies.

- Rocco N, Rispoli C, Moja L, Amato B, Iannone L, Testa S, Spano A, Catanuto G, Accurso A, Nava MB. Different types of implants for reconstructive breast surgery. Cochrane Database of Systematic Reviews 2016, *Issue* 5. *Art. No.: CD010895. DOI: 10.1002/14651858.CD010895.pub2.*
- NHS Choices http://www.nhs.uk/conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx
- Spear SL, Baker JL., Jr Classification of capsular contracture after prosthetic breast reconstruction. Plast Reconstr Surg. 1995; 96:1119–1123
- Headon H, Kasem A, Mokbel K. Capsular Contracture after Breast Augmentation: An Update for Clinical Practice. Archives of Plastic Surgery. 2015; 42(5):532-543. doi:10.5999/aps.2015.42.5.532.
- NHS Digital Breast and Cosmetic Implant Registry (BCIR) http://content.digital.nhs.uk/bcir
- NHS Modernisation Agency. Action on plastic surgery: Information for Commissioners of Plastic Surgery Services. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

[1] Baker classification system (see Association of breast clinicians, 2010)
I - the breast is normally soft, and looks natural
II – the breast is a little firm, but appears natural (minimal contracture)
III – the breast is firm, and is beginning to appear distorted in shape (moderate contracture)

IV – the breast is hard, and has become quite distorted in shape (severe contracture)

- Lancashire North CCG http://www.lancashirenorthccg.nhs.uk/download/governing-body-papers/Agenda%20Item%2010.5.%20Commissioning%20Policy%20for%20Breast%20Implant%20Removal%20and%20Replacement.pdf.
- Devon CCG https://northeast.devonformularyguidance.nhs.uk/referral-guidance/commissioning-policies/breast-implants---removal-and-replacement
- NHS Kernow CCG http://policies.kernowccg.nhs.uk/DocumentsLibrary/KernowCCG/IndividualFundingRequests/Policies/RemovalAndReplacementBreastImplantsPolicy.pdf
- Gloucestershire CCG www.gloucestershireccg.nhs.uk/.../Removal-and-replacement-of-breast-implants.doc
- East Midlands commissioning policy for cosmetic procedures www.southernderbyshireccg.nhs.uk/EasySiteWeb/GatewayLink.aspx%3FalId%3D3284+&cd= 8&hl=en&ct=clnk&gl=uk

Additional guidance referred to in production of ICS policy.

- Association of breast clinicians, 2010. Best practice diagnostic guidelines for patients presenting with breast symptoms. https://www.evidence.nhs.uk/document?id=2013590&returnUrl=search%3Fq%3Dhc11%26sp%3Don&q=hc11
- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101

Breast Reduction

Policy properties	Information relating to this policy
Policy name	Breast Reduction
Policy type	Prior approval
Included intervention(s)	Breast reduction surgery
Included indication/ condition(s)	Breast hyperplasia (enlargement)
Date produced	January 2021
Planned review date	April 2027
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	PE 110: Breast reduction
NEE CCG policy	Breast reduction

Interventions covered by this policy

Breast reduction surgery.

Conditions to be considered for treatment under this policy

Breast hyperplasia (enlargement) where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects on quality of life.

Eligibility criteria for provision of the intervention

Breast reduction surgery should only be considered if **all** the following criteria are met:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain
  AND
- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided
  AND
- The patient's breast size results in functional symptoms that require other treatments/ interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache; soft tissue indentations at site of bra straps)
  AND
- The breast reduction is planned to be 500gms or more per breast or at least 4 cup sizes (as assessed by a specialist)
  AND
- The patient's body mass index (BMI) is <27kg/m^2 and has been stable for at least twelve months
  AND
- The woman has been provided with written information to allow her to balance the risks and benefits of breast surgery, and if relevant has been informed that breast reduction surgery can cause permanent loss of lactation

Unilateral breast reduction may be considered for breast asymmetry if:

- there is a difference of 150-200gms size as measured by a specialist
  AND
- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain
  AND
- In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided

AND

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

AND

- The woman has been provided with written information to allow her to balance the risks and benefits of breast surgery, and if relevant has been informed that breast reduction surgery can cause permanent loss of lactation

Exclusions

This policy does not cover:

- Breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management)
- Breast reduction in gynaecomastia.
- Suspected malignancy, when referral should be made through the appropriate route

Additional notes

This policy is based on Evidence-based interventions: guidance for CCGs published by NHS England, 2018.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Please refer to Policy that covers breast surgery (other than cancer-related surgery) including mastopexy, breast augmentation and augmentation surgery for breast asymmetry.
Please refer to Policy that covers breast implant removal or removal and replacement.
Please refer to Policy that covers breast reduction in gynaecomastia.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for breast reduction.

One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery. Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring.

Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes.

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy / policies.

- GP notebook. http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20120513155707778590NHS Choices http://www.nhs.uk/conditions/breast-reduction/Pages/Introduction.aspx
- Royal College of Surgeons / BAPRAS commissioning guide breast reduction surgery http://www.rcseng.ac.uk/healthcare-bodies/docs/breast-reduction-commissioning-guide/view
- Adult Exceptional Aesthetic Referral Protocol (AEARP) September 2011 NHS Scotland. http://www.sehd.scot.nhs.uk/mels/CEL2011_27.pdf
- Breast reduction surgery for hypermastia: clinical effectiveness and guidelines. Ottawa: Canadian Agency for Drugs and Technologies in Health (CADTH). Rapid Response. 2014 https://www.cadth.ca/breast-reduction-surgery-hypermastia-clinical-effectiveness-and-guidelines
- North and East London Commissioning Support Unit Procedures of Limited Clinical Value 2013-2014 WELC (Waltham Forest, East London and City) Clinical Commissioning Groups http://www.cityandhackneyccg.nhs.uk/Downloads/About%20Us/Plans%20Strategies%20and%20Forms/POLCV-2013-14-WELC.pdf
- North Durham CCG Value Based Commissioning http://www.northdurhamccg.nhs.uk/wp-content/uploads/2013/07/Value-Based-Clinical-Commissioning-APRIL-2015.pdf
- South East London Treatment Access Policy http://www.lewishamccg.nhs.uk/about-us/Who-weare/Governing%20Body%20papers/Enc%2020.1%20SE%20London%20Treatment%20Access%20Policy.pdf
- O'Hare PM, Frieden IJ. Virginal Breast Hypertrophy. Pediatr Dermatol. 2000 Jul-Aug; 17(4):277-81.

Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101
  (this replaces CG80)

Breast surgery (excluding cancer-related surgery)

Policy properties	Information relating to this policy
Policy name	Breast surgery (excluding cancer-related surgery)
Policy type	Exceptional Clinical Circumstances
Included intervention(s)	Mastopexy, breast augmentation, augmentation surgery for breast asymmetry
Included indication/ condition(s)	Patients seeking breast lift, breast augmentation or augmentation surgery for breast asymmetry
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	PE 109. Breast augmentation PE111. Mastopexy (breast lift) PE116. Surgery for breast asymmetry
NEE CCG policy	Breast surgery (excluding cancer related surgery)

Interventions covered by this policy

Breast augmentation refers to an operation whereby breasts are made larger by inserting an implant underneath the breast tissue or the muscle below the breast. Implants have a variable life span and the need for replacement or removal in the future is likely in young patients.

Mastopexy or breast lift surgery refers to an operation whereby the breasts are reshaped and remodelled by removing surplus skin and if required repositioning the nipple. This is usually done as a treatment for breast ptosis, or drooping.

Surgery for breast asymmetry usually involves augmentation of one breast by inserting an implant, and/or reduction in the size of one breast.

Conditions to be considered for treatment under this policy

Surgery to enlarge the breasts may be sought by patients who consider their breasts are smaller than they would wish. In some cases this may be a consequence of congenital failure of breast development, endocrine abnormalities, or trauma during or after breast development.

Breast ptosis (droopiness) is a normal female process with pregnancy, breast feeding, gravity, weight change and the menopause all possibly contributing to the skin stretching, alongside changes to the supportive tissue which helps maintain the youthful breast shape.

Breast asymmetry may happen as part of development when breasts first form, with underdevelopment or overdevelopment of one breast, a difference in shape or difference in position of the nipple. Some degree of breast asymmetry is very common; very few people have breasts that are exactly identical.

There is no medical advantage associated with any of the above procedures for these conditions, but they may have positive psychological effects in some circumstances.

Eligibility criteria for provision of the intervention

Breast augmentation surgery, mastopexy or breast lift surgery, and augmentation surgery for breast asymmetry, are all considered low priority procedures and will not normally be funded.

Exclusions

This policy does not apply to breast surgery following treatment for breast cancer. Patients receiving treatment for breast cancer as part of the breast cancer treatment pathway

should be offered reconstruction surgery in line with NICE NG101 (Early and locally advanced breast cancer: diagnosis and management).

Additional notes

All referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

Please refer to Policy that covers breast implant removal or removal and replacement.
Please refer to Policy that covers breast reduction (including reduction for asymmetry)
Please refer to Policy that covers breast reduction in gynaecomastia.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for surgery.

The following are offered as advice to potential referrers and ECC panels (note: these are **not** referral criteria):

- Requests should only be considered in women aged 21 and over as this will allow time for them to receive the necessary support and counselling to arrive at an informed decision once breast development is completed
- BMI should be stable and sustained below 35kg/m^2 for at least 1 year prior to referral
- The panel should consider the impact on the breasts of any likely changes associated with pregnancy and breast feeding
- If patients are suffering psychological distress, appropriate referrals should have been made and other potential causes of psychological distress should be appropriately evaluated and treated. Documentation of mental health status should be provided
- Patients who smoke should be offered support to stop smoking as an opt-out, in line with the 'Weight management and smoking cessation prior to elective surgery' policy

Taking into account the above guidance, funding for bilateral breast augmentation may be considered in cases of:

a) Congenital amastia / amazia – developmental failure resulting in bilateral absence of breast tissue
b) Bilateral loss of breast tissue or failure of breast tissue to develop as the result of burns or trauma

Funding for breast asymmetry surgery may be considered in cases of:

a) Developmental failure resulting in unilateral absence of breast tissue
b) Patients with gross asymmetry (defined as a difference greater than 3 standard cup sizes, as assessed by a specialist or professional bra fitting service) which has a significant impact on the patient's physical or mental health, and all reasonable steps have been taken to address this

Patients for whom funding is approved should be appropriately counselled regarding the risks of the procedure and (where applicable) the risks associated with the use of implants.

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy / policies.

Breast augmentation:

- NICE CG 80 Early and locally advanced breast cancer: diagnosis and treatment https://www.nice.org.uk/guidance/CG80/chapter/1-Guidance#breast-reconstruction
- NHS choices http://www.nhs.uk/conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx
- Guidance for Doctors Who Offer Cosmetic Interventions, GMC, 2016 http://www.gmc-uk.org/guidance/ethical_guidance/28687.asp
- The Royal College of Surgeons Professional Standards for Cosmetic Surgery guidance published in April 2016 https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/service-standards/cosmetic-surgery/
- NHS Modernisation Agency Action on Cosmetic Surgery http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

Mastopexy:

- British Association of Aesthetic and Plastic Surgeons Mastopexy https://baaps.org.uk/patients/procedures/5/breast_uplift_mastopexy
- Medscape Breast Mastopexy http://emedicine.medscape.com/article/1273551-overview#showall
- *Surgery for breast asymmetry*:
- Crerand, Canice E, Magee, Leanne Cosmetic and reconstructive breast surgery in adolescents: psychological, ethical, and legal considerations. Seminars in plastic surgery, vol. 27, no. 1, p. 72-78, 1535-2188 (February 2013)
- Queen Victoria Hospital Breast Asymmetry http://www.qvh.nhs.uk/wp-content/uploads/2015/09/Breast-Asymmetry-Rvw-Oct-17.pdf
- NICE Clinical Guidance CG80 https://www.nice.org.uk/guidance/CG80
- NHS Dorset Clinical Commissioning Group Breast Surgery Criteria Access Based Protocol http://www.dorsetccg.nhs.uk/Downloads/aboutus/Policies/Clinical/Policies%20from%20Sept%202014/Criteria%20Based%20Access%20Protocol%20-%20Breast%20Surgery.pdf
- Bristol CCG Breast surgery https://www.bristolccg.nhs.uk/media/medialibrary/2016/09/breast_surgery_female.pdf
- Hull CCG Breast surgery http://www.hullccg.nhs.uk/uploads/policy/file/4/Hull_CCG_breast_surgery_January_2015.pdf
- Bury CCG aesthetic breast surgery http://www.buryccg.nhs.uk/Library/Your_local_nhs/CCGPlanspoliciesandreports/EURpolicies/Aesthetic%20Breast%20Surgery%20Policy%20-%20April%202014.pdf
- Camden CCG http://www.camdenccg.nhs.uk/Downloads/ccg-public/Publications/policies/NCL-Procedures-of-Limited-Clinical-Effectiveness-PoLCE-Policy-June-2015-2016.pdf

Additional guidance referred to in production of ICS policy.

- NICE guideline NG101, 2018. Early and locally advanced breast cancer: diagnosis and management. https://www.nice.org.uk/guidance/ng101
  (This replaces CG80)

Cosmetic Interventions: General Principles

Policy properties	Information relating to this policy
Commissioning statement	**Cosmetic Interventions: General Principles**
Included intervention(s)	Surgery and other procedures which are carried out to improve appearance.
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	N/A
NEE CCG policy	Cosmetic surgery general principles Cosmetic surgery on mental health grounds

Interventions covered by this commissioning statement

Surgery and other procedures which are being proposed for reasons which are considered to be primarily cosmetic (that is, to improve appearance).

Conditions to be considered under this commissioning statement

A wide range of conditions may lead patients to request interventions to change their appearance. These include (but are not restricted to):

- Scars which are considered unsightly (which may be a consequence of surgery, trauma or conditions such as acne)
- Dissatisfaction with body shape, size or appearance, which may follow weight gain, weight loss, pregnancy or changes associated with age
- Dissatisfaction with facial appearance
- Dissatisfaction with appearance of the skin or hair

Principles

A number of the conditions and interventions to which this commissioning statement applies are also covered by separate policies, which should be referred to in individual decision-making.

Cosmetic interventions undertaken exclusively to improve appearance are considered low priority procedures and should not usually be funded in adults.

Cosmetic interventions undertaken primarily with the aim of improving psychological distress or mental ill health should not usually be funded in adults. There is generally insufficient evidence to support the effectiveness of cosmetic interventions in the treatment of mental health conditions.

Where there is a possible underlying medical condition, such as an endocrine, congenital or other condition, this should be fully investigated by an appropriate specialist prior to consideration of any cosmetic intervention.

Surgery should be supported for patients who were accepted onto an NHS waiting list prior to taking up residence in Suffolk or North East Essex, providing the existing clinical evidence has remained the same.

Referrals for the revision of treatments originally performed outside the NHS should first be made to the practitioner who carried out the original treatment for resolution, where this does not endanger the health of the individual. Referrals within the NHS for the revision of

treatments originally performed outside the NHS will not usually be funded unless the patient meets local criteria for the original treatment, or a failure to refer within the NHS would endanger the health of the individual.
Interventions to treat conditions secondary to body piercing, including ear piercing or any other body adornments will not usually be funded.

Interventions to treat conditions secondary to predictable changes associated with age or pregnancy will not usually be funded.

Exceptional circumstances

Referral may be made to the ECC panel for patients who do not meet the relevant conditions above or the criteria specified in any relevant policy, in whom there are considered to be exceptional circumstances supporting the need for the cosmetic intervention. The referral will need be supported by evidence of the exceptional clinical circumstances and the patient's capacity to benefit from the intervention.

Examples of exceptional clinical circumstances which may be considered to support the case for funding may include:

- Conditions which result from previous trauma, disease or congenital deformity
- Conditions due to an adverse outcome of previous NHS funded treatment, for example resulting from complications or technical difficulties with the original procedure

Note: these examples are intended as supporting guidance only and are **not** referral criteria.

Children and young people

Children and young people are generally defined in Suffolk and North East Essex policies as those aged 18 and under, in line with the definition used in The National Service Framework for Children. Funding for cosmetic interventions for this age group should only be considered if there is a problem which is judged to be likely to impair normal emotional development.

The child's ability to be involved in decisions about their health and healthcare will be influenced by a range of factors including their age, understanding and development. Requests for referrals, particularly of younger children, may reflect concerns expressed by the parents rather than the child, and this should be taken into consideration prior to referral. Older children may be able to take responsibility for decisions about their health and healthcare, including whether they wish to have a cosmetic intervention, and can consent to treatment without a parent's involvement if they are judged to be 'Gillick competent'. This recognises that children aged under 16 years can consent to medical treatment or intervention if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. There is no lower age limit for Gillick competence to be applied, but it is considered that it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent's involvement.

References

References included in original Suffolk/NEE policy/policies.

- DH, October 2014. National Service Framework for Children, Young People and Maternity Services

Additional guidance referred to in production of ICS policy.

- CQC, 2018. Nigel's surgery 8: Gillick competency and Fraser guidelines. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines

Ear Wax Removal in Secondary Care

Policy properties	Information relating to this policy
Policy name	Ear Wax Removal in Secondary Care
Policy type	Threshold
Included intervention(s)	Ear wax removal in secondary care
Included indication/ condition(s)	Impacted ear wax
Date produced	January 2021
Planned review date	July 2027
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T52: Ear wax removal in secondary care
NEE CCG policy	Microsuction/ ear wax removal

Interventions covered by this policy

Referral to secondary care for removal of ear wax.

Conditions to be considered for treatment under this policy

Earwax is a normally-occurring substance made up of dead cells, hair, external material such as dust, and cerumen wax. In some people earwax can become impacted and cause problems including pain, loss of hearing, itching, tinnitus and vertigo.

Eligibility criteria for provision of the intervention

Patients with impacted earwax giving rise to symptoms may be referred for removal in secondary care if they meet either of the following criteria:

- Irrigation or microsuction has been attempted twice (after the use of ear drops) but has not been successful
  OR
- Irrigation is not clinically appropriate for this patient for one of the following reasons:
  - The person has (or is suspected to have) a chronic perforation of the tympanic membrane.
  - There is a past history of ear surgery.
  - There is a foreign body, including vegetable matter, in the ear canal.
  - There is a visible tympanic membrane perforation
  - Ear drops have been unsuccessful and irrigation is contraindicated because the patient has one of the conditions listed below:
    - A history of any previous problem with irrigation (pain, perforation, severe vertigo).
    - Current perforation of the tympanic membrane.
    - A history of perforation of the tympanic membrane in the last 12 months.
    - Grommets in place.
    - A history of any ear surgery (except extruded grommets within the last 18 months, with subsequent discharge from an Ear Nose and Throat department).
    - A mucus discharge from the ear (which may indicate an undiagnosed perforation) within the past 12 months.
    - A history of a middle ear infection in the previous 6 weeks.
    - Cleft palate, whether repaired or not.
    - Current symptoms of acute otitis externa with an oedematous ear canal and painful pinna.
    - Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness.

- Confusion or agitation, as they may be unable to sit still.
- Inability to cooperate, for example young children and some people with learning difficulties.

NOTE: urgent advice from an ENT specialist should be sought if:

- Infection is present and the external canal needs to be cleared of wax, debris, and discharge
- The patient experiences severe pain, deafness, or vertigo occur during or after irrigation.

Exclusions

None

Additional notes

Removal of ear wax by irrigation after the use of ear drops can usually be carried out in primary care or a community setting (including non-NHS provision), but in some cases this is unsuccessful or contraindicated. Self-care should be the first line of treatment and the need for irrigation may be avoided by the use of drops. Occasional complications of irrigation include otitis externa, perforation of the tympanic membrane, damage to the external auditory meatus, pain, vertigo and nausea, and otitis media due to water entering the middle ear when there is a previous perforation. Procedures for removal in secondary care include microsuction and removal under direct vision.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for ear wax removal in secondary care.

Compliance with NICE guidance

There is no relevant NICE guidance.

References

References included in original Suffolk / North East Essex policy / policies.

- NICE Clinical Knowledge Summary. Scenario: Management of earwax. May 2012. Available at http://cks.nice.org.uk/earwax#!scenario
- NICE Clinical Knowledge Summary. Scenario: Ear irrigation http://cks.nice.org.uk/earwax#!scenariorecommendation:5

Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Clinical Knowledge Summary: Earwax. https://cks.nice.org.uk/earwax

Hip Arthroscopy

Policy properties	Information relating to this policy
Policy name	Hip Arthroscopy
Policy type	Threshold
Included intervention(s)	Hip arthroscopy as a therapeutic intervention
Included condition/ indication(s)	Femoro-acetabular impingement, labral tears, loose bodies.
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T48: Hip arthroscopy
NEE CCG policy	Hip arthroscopy

Interventions covered by this policy

This policy covers the use of hip arthroscopy as a therapeutic intervention.

Conditions to be considered for treatment under this policy

Femoro-acetabular impingement, which results from abnormalities of the femoral head or the acetabulum. It can be caused by jamming of an abnormally shaped femoral head into the acetabulum, or by contact between the acetabular rim and the femoral head–neck junction. Symptoms may include restriction of hip-joint movement, pain and 'clicking' of the hip, and are typically exacerbated by hip flexion or prolonged sitting.

Labral tears; the labrum is the ring of cartilage that follows the outside rim of the socket of the hip joint, which may be torn due to trauma.

Loose bodies within the hip joint.

Eligibility criteria for provision of the intervention

Hip arthroscopy will be funded in the following conditions if the specified criteria are met, and none of the conditions listed below are present

Femoro-acetabular impingement (FAI)

- The patient has evidence of FAI as demonstrated by clinical assessment/radiological investigation
  AND
- The patient has severe symptoms typical of FAI (hip pain that is worsened by flexion activities e.g. squatting or prolonged sitting), that significantly limit activities, with a duration of at least six months
  AND
- The patient's symptoms have not improved with all available conservative treatment options including activity modification (e.g. restriction of athletic pursuits and avoidance of symptomatic motion), pharmacological intervention and physiotherapy
  AND
- Other treatment options if clinically relevant and appropriate such as hip replacement or resurfacing have been considered and excluded
  AND
- The patient is aged between 18 and 50 years, OR the patient is outside this age range and in the consultant's expert opinion this will be the best option for the patient.

Labral tears

- The patient has labral tears that have been identified by radiological investigation AND
- There is no evidence of osteoarthritis or FAI in the joint

Loose bodies

- The patient has one or more loose bodies in the hip joint that have been identified by radiological investigation

Conditions in which hip arthroscopy will not be funded include the following:

- As a diagnostic intervention, for example when there are suspected loose bodies
- Advanced degenerative osteoarthritis (Tonnis grade 2 or more) or severe cartilage injury within the hip joint
- Joint space on plain radiograph <2mm wide along the length of the sourcil
- Patients who are candidates for total hip replacements
- Evidence of hip dysplasia or considerable protrusion
- Osteonecrosis with femoral head collapse
- Grade III or IV heterotopic bone formation
- Sepsis and accompanying osteomyelitis or abscess formation
- Joint ankyloses
- Generalised joint laxity e.g. Ehlers Danlos or Marfans Syndrome
- Osteogenesis Imperfecta

Exclusions

None

Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hip arthroscopy.

Patients who meet criteria for funding must be added to the national non-arthroplasty hip registry: http://www.nahr.co.uk/

Arthroscopic femoro–acetabular surgery for hip impingement syndrome should only be carried out by surgeons with specialist expertise in arthroscopic hip surgery.

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy /policies.

- http://orthoinfo.aaos.org/topic.cfm?topic=a00571 Accessed on 23/05/16
- Arthroscopic femoro–acetabular surgery for hip impingement syndrome NICE interventional procedure guidance [IPG408] Published date: September 2011
- Wall PDH, Brown JS, Parsons N, Buchbinder R, Costa ML, Griffin D. Surgery for treating hip impingement (femoroacetabular impingement). Cochrane Database of Systematic Reviews 2014, Issue 9. Art. No.: CD010796. DOI: 10.1002/14651858.CD010796.pub2.
- Nord RM, Meislin RJ. Hip arthroscopy in adults. Bulletin of the NYU Hospital for Joint Diseases 2010; 68(2):97-102 97

- Moin Khan et. al. Arthroscopy Up to Date: Hip Femoroacetabular Impingement Arthroscopy: The Journal of Arthroscopic and Related Surgery, Vol 32, No 1 (January), 2016: pp 177-189
- Gupta A, Redmond JM, Stake CE, Dunne KF, Domb BG. Does Primary Hip Arthroscopy Result in Improved Clinical Outcomes?: 2-Year Clinical Follow-up on a Mixed Group of 738 Consecutive Primary Hip Arthroscopies Performed at a High-Volume Referral Center. Am J Sports Med. 2016 Jan;44(1):74-82. doi: 10.1177/0363546514562563. Epub 2015 Jan 28.
- Park MS, Yoon SJ, Kim YJ, Chung WC. Hip arthroscopy for femoroacetabular impingement: the changing nature and severity of associated complications over time. Arthroscopy. 2014 Aug; 30(8):957-63. doi: 10.1016/j.arthro.2014.03.017. Epub 2014 May 14
- Niroopan et. Al. Hip Arthroscopy in Trauma: A Systematic Review of Indications, Efficacy, and Complications Arthroscopy April 2016Volume 32, Issue 4, Pages 692–703.e1
- Darren et. al. Efficacy of Hip Arthroscopy for the Management of Septic Arthritis: A Systematic Review, Arthroscopy: The Journal of Arthroscopic & Related Surgery Volume 31, Issue 7, July 2015, Pages 1358–1370
- Nusem I, Jabur MK, Playford EG. Arthroscopic treatment of septic arthritis of the hip. Arthroscopy. 2006 Aug; 22(8):902. e901-3
- Domb BG, Linder D, Finley Z, Botser IB, Chen A, Williamson J, Gupta A. Outcomes of hip arthroscopy in patients aged 50 years or older compared with a matched-pair control of patients aged 30 years or younger. Arthroscopy. 2015 Feb; 31(2):231-8. Doi: 10.1016/j.arthro.2014.08.030. Epub 2014 Nov 6.
- The National Non-Arthroplasty Hip Surgery Register (NAHSR) And Femoro-Acetabular Impingement surgery. https://www.britishhipsociety.com/uploaded/2011_NAHR_Archive/NAHSR%20and%20FAI%20surgery.pdf

Additional guidance referred to in production of ICS policy.

- British Hip Society. The non-arthroplasty hip registry http://www.nahr.co.uk/
- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: pain arising from the hip in adults. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html

Knee Arthroscopy in conditions other than Osteoarthritis

Policy properties	Information relating to this policy
Policy name	Knee Arthroscopy in conditions other than Osteoarthritis
Policy type	Threshold
Included intervention(s)	Knee arthroscopy
Included condition/ indication(s)	Various conditions involving internal derangement of the knee joint, or continuing diagnostic uncertainty
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T35: Knee arthroscopy
NEE CCG policy	Knee arthroscopy

Interventions covered by this policy

Knee arthroscopy involves the insertion of an arthroscope attached to a video camera through a small incision, with further intervention as clinically indicated.

Conditions to be considered for treatment under this policy

Internal derangement of the knee joint: meniscal tear, articular cartilage pathology, synovial pathology, impingement or patellofemoral maltracking.
Continuing diagnostic uncertainty

Eligibility criteria for provision of the intervention Therapeutic knee arthroscopy

Therapeutic knee arthroscopy may be considered in the following circumstances, when the specified criteria apply.

- There is clear evidence of *internal joint derangement*, as demonstrated by a competent clinical examination and/or MRI scan. Internal joint derangement may be: meniscal tear, articular cartilage pathology, synovial pathology, impingement (amenable to treatment e.g. by notchplasty, removal of cyclops lesion or excision of infrapatellar fat pad) or patellofemoral maltracking

AND

- Where clinically appropriate a trial of at least three months' conservative treatment has failed and not addressed the symptoms. Conservative treatment may include adequate analgesia, physiotherapy/ exercise programmes, and losing weight if necessary.

Diagnostic knee arthroscopy

Knee arthroscopy should not usually be considered a diagnostic tool. It may be considered when there is continuing diagnostic uncertainty and:

- The diagnostic uncertainty has not been resolved by competent clinical examination and non-invasive investigations (e.g. MRI)

OR

- there are valid clinical reasons why it is not possible to carry out non-invasive investigations such as MRI

Exclusions

This policy does not cover:

- Patients undergoing urgent treatment due to acute trauma
- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.

- Arthroscopy carried out in conjunction with open surgery

Additional notes

Please refer to the policy that covers 'Knee arthroscopy in osteoarthritis'.
All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.
Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee arthroscopy.

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy / policies.

- Onyema C, Oragui E, White J, Khan W. Evidence-based practice in arthroscopic knee surgery. Journal of perioperative practice 2011; 21(4): 128-34
- Allum R. Complications of arthroscopy of the knee. Journal of Bone and Joint Surgery 2002; 84(7): 937
- NICE. IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. National Institute for Health and Clinical Excellence Interventional Procedures Programme, August 2007.
- NICE CG177 Osteoarthritis: the care and management of osteoarthritis in adults. National Institute for Health and Clinical Excellence (NICE), Feb 2014.
- Kirkley A et al. A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee. The New England Journal of Medicine. 2008 Sep 11;359(11):1097-107
- Sing DC, B.S. TFL, Feeley BT, , M.D. ALZ. Is Obesity a Risk Factor for Adverse Events After Knee Arthroscopy? J Arthrosc Relat Surg. 2016;32(7):1346–1353. http://www.arthroscopyjournal.org/article/S0749-8063 (16)00047-5/abstract. (Accessed 13/09/16)
- HEALTH EVIDENCE REVIEW COMMISSION (HERC). COVERAGE GUIDANCE: KNEE ARTHROSCOPY FOR OSTEOARTHRITIS.; 2014. http://www.oregon.gov/oha/herc/CoverageGuidances/Knee-Arthroscopy-11-13-14.pdf.
- Werner BC,, MD MTB, , MD WMN, , PhD JAB. Total Knee Arthroplasty Within Six Months After Knee Arthroscopy Is Associated With Increased Postoperative Complications. J Arthroplasty. 2015;30(8):1313–1316. http://www.arthroplastyjournal.org/article/S0883-5403(15)00134-5/fulltext.
- NICE: National Institute for Health and Care Excellence. Arthroscopic radiofrequency chondroplasty for discrete chondral defects of the knee. IPG493. https://www.nice.org.uk/guidance/ipg493. Published 2014.
- Moin Khan M, Nathan Evaniew M, Asheesh Bedi M, Olufemi R. Ayeni, MD MSc Mohit Bhandari MP, Wales YJB for E and. Arthroscopic surgery for degenerative tears of the meniscus: a systematic review and meta-analysis. Can Med Assoc J. 2014;186(14):1057-1064. http://www.cmaj.ca/content/186/14/1057.abstract?sid=c688377f-060c-43fe-817b-ffd7727df795.

Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

Knee Arthroscopy for patients with Osteoarthritis

Policy properties	Information relating to this policy
Policy name	Knee Arthroscopy for patients with Osteoarthritis
Policy type	Threshold
Included intervention(s)	Arthroscopic knee washout (lavage and debridement)
Included condition/ indication(s)	Osteoarthritis of the knee
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T35: Knee arthroscopy
NEE CCG policy	Knee arthroscopy

Interventions covered by this policy

Arthroscopic washout (lavage) of the knee involves the insertion of an arthroscope attached to a video camera through a small incision. Saline is introduced via an arthroscopic cannula to wash out the joint. Washout expels any loose debris through the cannula. Debridement involves using instruments to remove damaged cartilage or bone, and this is often performed at the same time as washout.

Conditions to be considered for treatment under this policy

Osteoarthritis of the knee, which can cause symptoms including pain, stiffness and mechanical locking.

Eligibility criteria for provision of the intervention

Arthroscopic washout (lavage) with or without debridement of the knee should only be considered for patients who have osteoarthritis of the knee who have a clear history of mechanical locking.

Exclusions

This policy does not cover:

- Patients with osteoarthritis of the knee with other symptoms such as morning joint stiffness or ‘giving way’, or X-ray evidence of loose bodies, in the absence of mechanical locking
- Patients with ‘red flag’ conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.

Additional notes

This policy is based on ‘Evidence-based interventions: guidance for CCGs’ published by NHS England in November 2018.

Please refer to the policy that covers ‘Knee arthroscopy in conditions other than osteoarthritis’.

All adult referrals for elective surgery should refer to Policy ‘Weight management and smoking cessation prior to elective surgery’.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee arthroscopy.

Conservative treatments such as adequate analgesia, exercise programmes, and losing weight if necessary, can help in the management of the symptoms of knee osteoarthritis. Where symptoms do not resolve after nonoperative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk/NEE policy / policies.

- Onyema C, Oragui E, White J, Khan W. Evidence-based practice in arthroscopic knee surgery. Journal of perioperative practice 2011; 21(4): 128-34
- Allum R. Complications of arthroscopy of the knee. Journal of Bone and Joint Surgery 2002; 84(7): 937
- NICE. IPG230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis. National Institute for Health and Clinical Excellence Interventional Procedures Programme, August 2007.
- NICE CG177 Osteoarthritis: the care and management of osteoarthritis in adults. National Institute for Health and Clinical Excellence (NICE), Feb 2014.
- Kirkley A et al. A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee. The New England Journal of Medicine. 2008 Sep 11; 359(11):1097-107
- Sing DC, , B.S. TFL, Feeley BT, , M.D. ALZ. Is Obesity a Risk Factor for Adverse Events After Knee Arthroscopy? J Arthrosc Relat Surg. 2016; 32(7):1346–1353. http://www.arthroscopyjournal.org/article/S0749-8063 (16)00047-5/abstract. (accessed 13/09/16)
- HEALTH EVIDENCE REVIEW COMMISSION (HERC). COVERAGE GUIDANCE: KNEE ARTHROSCOPY FOR OSTEOARTHRITIS. 2014. http://www.oregon.gov/oha/herc/CoverageGuidances/Knee-Arthroscopy-11-13-14.pdf.
- Werner BC,, MD MTB, , MD WMN, , PhD JAB. Total Knee Arthroplasty Within Six Months After Knee Arthroscopy Is Associated With Increased Postoperative Complications. J Arthroplasty. 2015;30(8):1313–1316. http://www.arthroplastyjournal.org/article/S0883-5403 (15)00134-5/fulltext.
- NICE: National Institute for Health and Care Excellence. Arthroscopic radiofrequency chondroplasty for discrete chondral defects of the knee. IPG493. https://www.nice.org.uk/guidance/ipg493. Published 2014.
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Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

Specialist Fertility Services including Assisted Conception

Policy properties	Information relating to this policy
Policy name	Specialist Fertility Services including Assisted Conception
Policy type	Threshold
Included intervention(s)	Level 3 fertility services
Included indication/ condition(s)	Infertility
Date produced	20th October 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T39: Fertility
NEE CCG policy	12: Assisted conception using IVF/ICS/IUI for infertility

Interventions covered by this policy

Three levels of fertility treatment services are provided:

- Level 1 services, primary care: initial assessment and investigation and referral to the next level if necessary.
- Level 2 services, secondary and specialist care: specialist investigations, drug treatment and monitoring, other interventions as indicated
- Level 3 services, tertiary specialist care: further specialist investigations and treatment including assisted conception

This policy covers **Level 3 fertility services**, the key procedures being:
In Vitro Fertilisation (IVF): ovarian stimulation, the collection of the resulting eggs and fertilisation with sperm in the lab. If fertilisation is successful, the embryo is allowed to develop for between two and six days and is then transferred back to the woman's womb. Any remaining good quality embryos can be frozen to use later on in a frozen embryo transfer if the first transfer is unsuccessful.

Intracytoplasmic sperm injection (ICSI): instead of mixing the sperm with the eggs, IVF with ICSI involves injecting a single sperm into each mature egg, which maximises the chance of fertilisation.

Conditions to be considered for treatment under this policy

Infertility is defined in this policy as failure to conceive after frequent unprotected intercourse for 3 years in couples of reproductive age in the absence of known reproductive pathology.

For a woman of reproductive age who is using artificial insemination (AI) to conceive (with either partner or donor sperm) infertility is defined as failure to conceive after 12 documented cycles of treatment over a 3-year period.

Eligibility criteria for provision of the intervention

Patients should **only** be referred for level 3 fertility services if they meet **all** of the following criteria at the time of referral (or **all applicable** criteria for same sex couples, also see below*). The number of cycles and number of embryos to be transferred depend on age and number of previous cycles of IVF (see below**).

- They meet the definition of infertility and its duration above appropriate to their situation
- Age of female partner: between 23 and 42 years inclusive
- Age of male partner: between 23 years and less than 55 years

- Women aged 23-39 should have self-funded no more than 2 cycles of IVF previously; women aged 40-42 inclusive should not have had any self-funded cycles of IVF previously (see below**).
- They met the criteria in the Policy 'Subfertility investigation and treatment in secondary care' and have completed further assessments and investigations indicated. As a minimum these should have included:

Female:

- Laparoscopy and/or hysteroscopy and/or hysterosalpingogram or ultrasound scan where appropriate
- Rubella antibodies; the woman must be rubella immune
- Chlamydia screening
- Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
- HIV status
- AMH (anti-Mullerian hormone), which should be >5.4 pmol - Women referred for IVF assessment shall be offered an ovarian reserve test as per NICE guidance to identify and exclude those with low chance of conception. GPs should ensure the patient meets all of the initial criteria within the referral form in the first instance prior to the AMH request being sent to the Fertility Unit. Ovarian reserve testing should only be conducted within the overall context of a fertility assessment carried out by a specialist centre.

Male:

- Preliminary Semen Analysis and appropriate investigations where abnormal (including genetic analysis if indicated)
- Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
- HIV status

- BMI of female partner is 19 or more and less than 30 kg/m^2 at referral and throughout treatment
- BMI of male partner is less than 30 kg/m^2 at referral and throughout treatment
- Both partners are non-smokers at the time of referral from secondary care to specialist fertility services and throughout treatment. Smoking status should be ascertained by carbon monoxide testing in secondary care and specialist IVF services.
- Neither partner has undergone sterilisation in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)
- There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance.
- Both partners are registered with a SNEE ICB GP Practice (within Ipswich and East Suffolk, West Suffolk or North East Essex) and were eligible for NHS care for at least 12 months prior to the referral from primary to secondary care.
- Neither couple has a living child from the current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships.

**Same sex couples (female)*

- A woman who is using AI to conceive should meet the definition of infertility and its duration above. Fertile same sex couples will not be funded for assisted conception methods under this policy. Couples are encouraged to maximise opportunities within AI cycles by exploring the option of both partners undergoing AI.
- Same sex couples will be required to meet relevant eligibility criteria above.
- SNEE ICB will not routinely fund donor sperm, but will fund the associated IVF/ICSI treatment in line with the eligibility criteria within this policy, providing the sperm meets the criteria set out by the treating provider unit.
- The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement

to NHS funded fertility treatment, in line with the criteria for heterosexual couples, and will not be eligible for additional cycles with their partner or any future partners.

Same sex couples (male)

- Same sex male couples will not be able to access fertility treatment within their relationship but will be eligible for appropriate investigation where there is evidence of subfertility. Surrogacy is not commissioned as part of this policy.

***Female partner age, previous cycles of IVF, number of cycles*[4] *and number of embryos transferred*:

Age 23 years or more and less than 40 years:

- will be eligible for TWO full cycles (for women who have self-funded no or one previous cycle of IVF); or ONE full cycle (for women who have self-funded two previous cycles of IVF). If the woman reaches the age of 40 years during treatment, the current cycle will be completed, but no further cycles will be offered.
- one embryo will be transferred during each cycle to reduce the risk of multiple pregnancies. A maximum of four embryo transfers (fresh plus frozen) will be funded. All frozen embryos should be used before a fresh cycle is funded. Where couples have previously self-funded a cycle then the couples must utilise the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again.

Age 40 years to 42 years inclusive:

- will be eligible for ONE full cycle providing all the following criteria are met:
  - Never previously had IVF treatment
  - There is no evidence of low ovarian reserve
  - There has been a discussion of the additional implications of IVF and pregnancy at this age
- Up to two embryos may be transferred during each cycle. A maximum of two embryo transfers (one fresh plus one frozen) will be funded.

Exclusions

This policy does not cover:

- Gamete storage, preimplantation genetic diagnosis and intrauterine insemination
- Couples with a known clinical cause of absolute infertility which precludes any possibility of natural conception, and who meet other eligibility criteria, will have immediate access to NHS funded assisted reproduction services
- Treatment may be denied on other medical ground not explicitly covered in this policy

Additional notes

- Read in conjunction with the subfertility investigation and treatment in secondary care.
- Read in conjunction with the cryopreservation of sperm, oocytes or embryos for patients about to undergo treatments which pose a risk to their fertility.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral for specialist fertility services.

It is expected that 84% of couples in the general population having regular unprotected

[4] A full cycle comprises one round of ovarian stimulation and the transfer of resultant fresh embryo(s). Where an excess of embryos is available following a fresh cycle, these embryos may be frozen for future use, and subsequently thawed and transferred to the patient as a frozen cycle within the 'full cycle'.

intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment (NCCWCH 2013).

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- Unexplained infertility (no identified male or female cause) (25%)
- Ovulatory disorders (25%)
- Tubal damage (20%)
- Factors in the male causing infertility (30%)
- Uterine or peritoneal disorders (10%).

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. It is estimated that infertility affects 1 in 7 heterosexual couples in the UK (NICE, 2017).

Criteria – additional information

Women with a **BMI** over 30 kg/m^2 take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. The RCOG advises that losing weight will increase the chances of conception. NICE CG156 also recommends that 'men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility'. Couples who require it should be offered advice and support to achieve weight loss, and should be informed of the weight criterion in relation to NHS funded assisted reproduction services at the earliest appropriate opportunity in their progress through infertility investigations in primary care and secondary care.

Women with a low BMI are also likely to have reduced fertility and NICE recommend that 'women who have a BMI of less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception'.

Criteria for minimum maternal and paternal **age** in this policy have been set with reference to the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. The upper age limit of 42 years for women accessing infertility services is recommended by NICE.

There is significant association between reduced fertility and **smoking** in both men and women, and there are also risks associated with smoking and passive smoking during pregnancy. Couples who smoke will not be eligible for NHS funded specialist assisted reproduction assessment or treatment, and should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary care and secondary care, provided with information about the negative impacts of smoking, and offered support to stop.

NICE CG156 gives advice on initial **assessment and investigation** of patients with concerns regarding fertility. Prior to referral to level 2 or 3 services all patients should have been given advice about increasing the chances of conception (NICE CG 156 section 1.2) including with respect to the timing of sexual intercourse, lifestyle including smoking, alcohol and healthy weight, and offered initial assessment and investigations including semen analysis, review of menstrual cycle and maternal blood testing to determine ovulation.

Patients undergoing male or female **sterilisation** should have provided informed consent and been counselled that the procedures are regarded as permanent and irreversible.

The Human Fertilisation and Embryology (HFE) Act 1990 states that 'a woman shall not be provided with treatment services unless account has been taken of the **welfare of any child** who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth'.

Treatment components – additional information

Couples will not be allowed to pay for any **additional interventions** as part of the treatment within a cycle of NHS fertility treatment. This includes, but is not limited to, any drugs (including drugs prescribed by the couple's GP), recommended treatment that is outside the scope of the service specification agreed with the Secondary or Tertiary Provider or experimental treatments. Where a patient meets the SNEE ICB eligibility criteria, but agrees to commence treatment on a privately funded basis, they may not retrospectively apply for any associated payment relating to the private treatment.

The SNEE ICB will fund **embryo storage** as part of assisted conception treatment for one year only. Patients must be counselled by the clinician and infertility counsellor to this effect. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple. If any fertility treatment results in a live birth, then the couple will no longer be considered childless and will not be eligible for further NHS funded fertility treatments, including the implantation of any stored embryos.

Egg, sperm and embryo storage for patients undergoing cancer treatments are covered under separate arrangements.

Egg donation where no other treatment is available will be available to women who have undergone premature ovarian failure (longer than six months amenorrhoea and AMH greater than 5.4 pmol due to an identifiable pathological or iatrogenic cause, before the age of 40 years, or to avoid transmission of inherited disorders to a child where the couple meets the other eligibility criteria. The patient may be able to provide an egg donor; alternatively, the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.

Donor insemination may be indicated where:

- the male partner is likely to pass on an inheritable genetic condition;
- severe rhesus incompatibility has been a problem because of the male partner's homozygous status;
- the male partner does not produce suitable sperms (quantity or quality) and, therefore, ICSI is not possible

Anovulatory women can have ovulation induction prior to donor insemination. A maximum of six cycles of donor insemination will be funded followed by IVF with donor sperm if all other eligibility criteria are met. The need to prevent transmission of sexually transmitted diseases (including HIV) by donor insemination has led to the mandatory quarantine of donor sperm for six months by cryopreservation prior to its use in the UK.

Due to poor clinical evidence, **intra uterine insemination** (IUI) will only be offered in exceptional circumstances.

Interventions to prevent the **transmission of blood borne viruses** in fertile serodiscordant couples (for example, where one partner has HIV or Hepatitis C) where all

other criteria are met is commissioned from specialist centres. Sperm washing will not be offered for men with Hepatitis B.

Surrogacy (including part funding) is not commissioned as part of this policy. As advised by the Department of Health 2018.

Compliance with NICE guidance

NICE CG 156 states that women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination), should be offered 3 full cycles of IVF, with or without ICSI.

The decision to maintain waiting times as per the previous policy (i.e. 3 years rather than 2) for women with unexplained fertility was made based upon moderate to low quality evidence presented by NICE and the difficulties in justifying additional spend in constrained NHS resources. The decision to reduce the number of cycles from 3 to 2 was made to partially mitigate the extra resource needed to increase the age limit. The decision to include access for women aged 40-42 who meet specific criteria was based on high to low quality evidence presented by NICE but recognizes the improved success rates of IVF. NICE CG156 also recommend that IUI can be used in some circumstances.

References

References included in original Suffolk / North East Essex policy / policies.

- Clinical threshold policy: Infertility. March 2014.
- National institute for clinical and health excellence. Fertility: assessment and treatment for people with fertility problems. Clinical guideline 156. February 2013.
- Kidd SA, Eskenazi B, Wyrobek AJ “Effects of male age on semen quality and fertility: a review of the literature” Fertil Steril (2001); 75(2): 237
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Additional guidance referred to in production of ICS policy

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Spinal Surgery for Non-Acute Lumbar Conditions

Policy properties	Information relating to this policy
Policy name	Spinal Surgery for Non-Acute Lumbar Conditions
Policy type	Threshold
Included intervention(s)	Surgical discectomy, spinal decompression surgery
Included condition/ indication(s)	Low back pain and radicular pain/ sciatica
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T17: Spinal surgery for acute (sic) lumbar conditions PE117: Spinal surgery
NEE CCG policy	Spinal surgery for non-acute lumbar conditions

Interventions covered by this policy

Spinal decompression and/or surgical discectomy.

Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

Most low back pain and radicular pain improves over time with conservative treatments. This policy considers the surgical management of severe low back pain and radicular pain for which non-surgical treatments have failed.

Eligibility criteria for provision of the intervention

Spinal decompression and/or surgical discectomy will be considered as clinically indicated in patients with severe low back pain and radicular pain in whom:

- Imaging findings are concordant with the patient's symptoms (for example, indicating intervertebral disc prolapse or spinal stenosis)

AND

- Conservative approaches to management have not improved pain or function. These should have included:
  - advice and information, encouragement to continue usual activities and take appropriate exercise
  - pain management including adequate analgesia with anti-neuropathic medication
  - manual therapies (including physiotherapy)
  - psychological interventions as part of a treatment package
  - a combined physical and psychological treatment programme, where appropriate.

AND for patients with chronic low back pain:

- If they meet the criteria in the relevant policy (**Diagnostic medial branch block +/- radiofrequency denervation**), they should have been assessed for suitability for radiofrequency denervation and received the intervention if considered appropriate, but this has not resolved the problem.

AND for patients with radicular pain:

- If they meet the criteria in the relevant policy (**Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica))**, they should have been considered

for nerve root block/ epidural and received the intervention if appropriate, but this has not resolved the problem.

Exclusions

This policy does not cover:

- children and young people (aged 16 and under)
- patients with back pain due to acute conditions such as fracture or dislocation
- patients with 'red flag' conditions requiring urgent referral, such as an abnormal or progressive neurological deficit, associated sphincter problems, symptoms or signs suggestive of tumour or infection.

Additional notes

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

The risk of surgical site infection in spinal surgery has been shown to be higher in patients who are older and have a higher BMI.

Spinal Stenosis is a condition that develops as a result of narrowing of the spinal canal leading to compression of the nerve roots. This is a result of age related changes. The vast majority of patients present with back & leg symptoms resulting in a reduced walking distance. Spinal stenosis may cause sciatica.

The following specific interventions will not be routinely funded as NICE states that current evidence on their safety and efficacy does not appear adequate for them to be used without special arrangements for consent and for audit or research purposes:

- Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica
- Endoscopic laser foraminoplasty
- Percutaneous endoscopic laser thoracic discectomy
- Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica
- Therapeutic endoscopic division of epidural adhesions

Spinal fusion for chronic low back pain should only be offered as part of a randomised controlled trial (NICE, 2016).

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for spinal surgery.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk / North East Essex policy / policies.

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Additional guidance referred to in production of ICS policy.

- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59
- (This replaces CG88)
- National Institute for Health and Care Excellence, 2013 (updated 2019). Neuropathic pain in adults: pharmacological management in non-specialist settings (CG173) https://www.nice.org.uk/guidance/cg173
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf
- National Institute for Health and Care Excellence, 2017. Lateral interbody fusion in the lumbar spine for low back pain (IPG 574) https://www.nice.org.uk/guidance/ipg574
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Surgical Repair of Hernias - Elective

Policy properties	Information relating to this policy
Policy name	Surgical Repair of Hernias - Elective
Policy type	Threshold
Included intervention(s)	Surgical repair of hernias
Included condition/ indication(s)	Inguinal hernias, Incisional hernias, Umbilical hernias
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T32. Surgical treatment of hernias
NEE CCG policy	Hernia – elective surgical repair

Interventions covered by this policy

Elective surgical repair of hernias, which may involve open or laparoscopic techniques.

Conditions to be considered for treatment under this policy

A hernia is defined as a protrusion through a weakness in the abdominal wall of a sac of peritoneum, often containing intestine or other abdominal contents. It usually presents as a lump and patients may experience pain or discomfort that can limit daily activities. A hernia is reducible if the lump disappears when the patient is reclining or when the contents are manually pushed back within the abdominal cavity. If a hernia becomes irreducible the blood supply of the contents may be compromised, and a hernia may present as a surgical emergency should the bowel strangulate or become obstructed.

An *inguinal hernia* is a protrusion of the contents of the abdominal cavity or preperitoneal fat through a defect in the groin area, and may be indirect (following the inguinal canal) or direct (due to defect or weakness in the fascia in the inguinal area).
An *incisional hernia* results from the protrusion of abdominal contents through a defect caused during surgery.
An *umbilical hernia* protrudes through the umbilicus and a paraumbilical hernia protrudes above or below the umbilical ring.

Eligibility criteria for provision of the intervention

For patients with asymptomatic or minimally symptomatic inguinal, incisional or umbilical hernias, a watchful waiting approach is recommended, under informed consent. If the patient is a smoker, stop smoking support must be offered and details of local smoking cessation support given to the patient. Other conservative measures include avoiding heavy lifting.

For *inguinal hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation or wind symptoms that interfere with work or activities of daily living

OR

- The hernia is difficult or impossible to reduce

OR

- The hernia is an inguino-scrotal hernia

OR

- The hernia increases in size month on month

OR

- There is a history of incarceration

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

For *umbilical hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation that interfere with work or activities of daily living

OR

- The hernia increases in size month on month

OR

- To avoid incarceration or strangulation of bowel

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

For *incisional hernias*, surgical treatment should only be offered when one of the following criteria is met:

- The hernia is symptomatic, including pain, discomfort, nausea or persistent constipation that interfere with work or activities of daily living

AND

- Appropriate conservative management has been tried first, e.g. weight reduction where appropriate, and this has not resolved the symptoms

OR

- The patient is currently asymptomatic but works in a heavy manual occupation and there is an increased risk of strangulation and future complications

Exclusions

This policy does not cover:

- Children and young people aged 16 and under
- Femoral hernias; all patients with a suspected femoral hernia should be referred to secondary care due to the risk of strangulation
- Hernias where emergency treatment might be required, for example suspected strangulation

Additional notes

All adult referrals for elective surgery should refer to Policy ‘Weight management and smoking cessation prior to elective surgery’.

Watchful waiting is advocated as an acceptable option for men with asymptomatic or minimally symptomatic inguinal hernias. The European Hernia Society guidelines (Simons et al, 2009) base this recommendation on the findings of two randomised controlled trials. Watchful waiting was not defined but in one trial men were given written instructions to watch for hernia symptoms and contact their physician if problems developed; in addition, they were examined at 6 months and yearly after enrolment (Fitzgibbons et al, 2006). A large cohort study of patients with incisional and umbilical hernias concluded that watchful waiting is also safe for patients with these conditions (Kokotovic et al, 2016).

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

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References included in original Suffolk/NEE policy / policies.

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Additional guidance referred to in production of ICS policy.

None

Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica)

Policy properties	Information relating to this policy
Policy name	Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica)
Policy type	Prior approval
Included intervention(s)	Epidural injection or nerve root block
Included condition/ indication(s)	Radicular pain (sciatica)
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T42: Therapeutic epidural injections for persistent (chronic) radicular pain
NEE CCG policy	Spinal injections (therapeutic) for pain related to the lumbar spine

Interventions covered by this policy

An epidural injection is the injection of local anaesthetic and steroid into the epidural space (the space within the spinal canal, outside the dura mater, which contains the spinal nerve roots, fat, connective tissue and blood vessels).
A nerve root block is an injection which targets a specific lumbar nerve.

Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

This policy applies to the use of epidural injection or nerve root block in people with radicular pain.

Eligibility criteria for provision of the intervention

Therapeutic epidural injection or nerve root block will be considered for the following patients with radicular pain:

Patients with radicular pain which is severe and acute

- The patient has severe, acute radicular pain (present for a period of less than 3 months)

AND

- the pain has not responded to conservative therapy. This may have included:
  - Advice and information, encouragement to continue usual activities and take appropriate exercise
  - Pain management including adequate analgesia with anti-neuropathic medication
  - Manual therapies (including physiotherapy)
  - Psychological interventions as part of a treatment package
  - A combined physical and psychological treatment programme, where appropriate.

OR

Patients with moderate or severe radicular pain

- The patient has moderate or severe radicular pain

AND

- the patient wishes to avoid, or is not suitable for surgery

AND

- The patient is not able to participate effectively in conservative pain management, or the pain has not responded to conservative therapy. This may have included:
    - Advice and information, encouragement to continue usual activities and take appropriate exercise
    - Pain management including adequate analgesia with anti-neuropathic medication
    - Manual therapies (including physiotherapy)
    - Psychological interventions as part of a treatment package
    - A combined physical and psychological treatment programme, where appropriate

Repeat injection (up to a total of 3 injections in 6 months) may be commissioned for patients with moderate or severe radicular pain meeting the above criteria if:

- a specialist pain clinician taking account of multi-disciplinary team assessment, concludes that benefits outweigh harms

AND

- The patient has been clinically assessed as having a substantial and sustained benefit from their first injection

AND

- The patient has been assessed as continuing to be unable to benefit from conservative management.

Exclusions

This policy does not cover:

- Children and young people (aged 16 and under)
- Conditions of a non-mechanical nature, including;
    - Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
    - Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
    - Neurological disorders (including cauda equina syndrome or mononeuritis)
    - Adolescent scoliosis
- Conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
- Other conditions including pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.
- Neurogenic claudication in people who have central spinal canal stenosis.

Additional notes

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for therapeutic epidural injection or root block.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk / North East Essex policy / policies.

- Manchikanti L et al. (2013) An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician, 04 2013, vol./is. 16/2 Suppl (S49-283), 1533-3159;2150-1149 (2013 Apr)
- Chou R; Atlas SJ; Stanos SP; Rosenquist RW (2009) nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice Guideline. Spine, May 2009, vol./is. 34/10(1078-93), 0362-2436;1528-1159 (2009 May 1)
- Cleeland C (1991) Brief Pain Inventory. Pain Research Group.

Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/
- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

Therapeutic Spinal Injection for Non-Specific Low Back Pain without Radiculopathy

Policy properties	Information relating to this policy
Policy name	Therapeutic Spinal Injection for Non-Specific Low Back Pain without Radiculopathy
Policy type	Prior approval
Included intervention(s)	Spinal injection of local anaesthetic and steroid
Included condition/ indication(s)	Non-specific low back pain without radiculopathy
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	T42: Therapeutic epidural injections for persistent (chronic) radicular pain
NEE CCG policy	Spinal injections (therapeutic) for pain related to the lumbar spine

Interventions covered by this policy

The following injections:

- Facet joint injections
- Therapeutic medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above.

Conditions to be considered for treatment under this policy

Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.

Radicular pain (radiculopathy) is pain radiating down the leg along the course of a spinal nerve root; sciatica refers to radicular pain in the distribution of the sciatic nerve, down the back of the thigh and sometimes into the calf and foot.

This policy applies to the use of the above injections in patients with non-specific low back pain, without radiculopathy.

Eligibility criteria for provision of the intervention

The therapeutic spinal injections specified above should not be offered to patients with non-specific low back pain without radiculopathy.

Exclusions

This policy does not cover:

- Children and young people (aged 16 and under)
- Conditions of a non-mechanical nature, including;
  - Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
  - Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
  - Neurological disorders (including cauda equina syndrome or mononeuritis)

  - Adolescent scoliosis
- Conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)
- Other conditions including pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.

Additional notes

This policy is based on 'Evidence-based interventions: guidance for CCGs' published by NHS England in November 2018.

Referral may be made to the ECC panel for patients in whom there are considered to be exceptional circumstances supporting the need for the specified spinal injections.

Suffolk and NEE policies relating to the management of low back pain with or without radiculopathy are:

Policy	Interventions	Indication	Policy type
Therapeutic spinal injection for non-specific low back pain without radiculopathy	Therapeutic injections including facet joint injection, therapeutic MBB, intradiscal therapy, prolotherapy, trigger point injections, epidural steroid injections	Non-specific low back pain without radiculopathy	ECC
Diagnostic medial branch block +/- radiofrequency denervation	Diagnostic MBB Radiofrequency denervation of facet joint	Chronic low back pain without radiculopathy	PA
Diagnostic sacroiliac joint injection, +/- radiofrequency denervation of the sacroiliac joint	Diagnostic sacroiliac joint injection Radiofrequency denervation of SI joint	Back pain thought to be arising from the sacroiliac joints	ECC
Therapeutic epidural injection or nerve root block for radicular pain (sciatica)	Therapeutic epidural or nerve root block (local anaesthetic or steroid)	Radiculopathy	PA
Spinal surgery for non-acute lumbar conditions	Spinal decompression and/or surgical discectomy	Low back pain and/or radicular pain for which non-surgical treatments have failed	PA

Compliance with NICE guidance

This policy complies with relevant NICE guidance.

References

References included in original Suffolk / North East Essex policy / policies.

- Manchikanti L et al. (2013) An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician, 04 2013, vol./is. 16/2 Suppl(S49-283), 1533-3159;2150-1149 (2013 Apr)
- Chou R; Atlas SJ; Stanos SP; Rosenquist RW (2009) Nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice guideline. Spine, May 2009, vol./is. 34/10(1078-93), 0362-2436;1528-1159 (2009 May 1)
- Cleeland C (1991) Brief Pain Inventory. Pain Research Group.

Additional guidance referred to in production of ICS policy.

- NHS England, 2018. Evidence-based interventions: guidance for CCGs.

https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/

- National Institute for Health and Care Excellence, 2016. Low back pain and sciatica in over 16s: assessment and management (NG59) https://www.nice.org.uk/Guidance/NG59 (This replaces CG88)
- NHS England, 2017. National low back pain and radicular pain pathway. https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

Wide Bore and Open/Upright MRI

Policy properties	Information relating to this policy
Policy name	Wide Bore and Open/Upright MRI
Policy type	Prior approval
Included intervention(s)	Wide bore MRI and open/upright MRI
Included condition/ indication(s)	Patients requiring MRI who are morbidly obese.
Date produced	January 2021
Planned review date	July 2025
Replaces:	N/A
Ipswich & East Suffolk and West Suffolk CCG policy	N/A
NEE CCG policy	Open/ wide bore/ upright MRI

Interventions covered by this policy

Wide bore MRI: wide bore MRI systems have a bore of >60cm, whereas standard narrow bore systems have a bore of ≤60cm.

Open or upright MRI: these may be carried out with the patient standing, sitting or reclining, rather than lying flat within an enclosed space as in standard MRI.

Conditions to be considered for treatment under this policy

Patients requiring MRI who are morbidly obese.

1. **Eligibility criteria for provision of the intervention**

   Morbidly obese patients who require an MRI scan and are not able to use local MRI services because of their size and/or their inability to lie flat for the required period of time may be offered a wide bore or open/upright MRI scan.

Exclusions

This policy does not cover:

- Patients who require a wide bore or open/upright MRI scan urgently for clinical reasons

Additional notes

Patients who are morbidly obese may be too large to fit into a standard narrow bore (≤60cm) scanner, but may be accommodated by a wide bore scanner.

A standard MRI may require the patient to be supine for up to 90 minutes, depending on the type of scan being carried out.

A survey carried out by the Royal College of Radiologists in 2016 of MRI provision in NHS organisations across the UK found that 41% of all MRI systems reported on were wide bore. They did not report on any upright or open MRI systems available within the NHS. Patients with claustrophobia who are not morbidly obese are not eligible for open/ upright MRI.

If the MRI is being carried out prior to a possible referral for elective surgery, please also refer to Policy ‘Weight management and smoking cessation prior to elective surgery’.

Compliance with NICE guidance

No relevant NICE guidance

References

References included in original Suffolk/NEE policy / policies.
None

Additional guidance referred to in production of ICS policy.

- Royal College of Radiologists, 2017. Magnetic resonance imaging (MRI) equipment,operations and planning within the NHS. https://www.rcr.ac.uk/sites/default/files/cib_mri_equipment_report.pdf