NHS
Lincolnshire
Integrated Care Board

NHS Lincolnshire Integrated Care Board (ICB) Prior Approval Policy

ICB document reference:	**ICB CLINICAL 003**
Name of originator/author:	Samantha Jones
Date of approval:	May 2025
Name of responsible Committee:	Clinical Policies Sub-Group
Responsible Director/ICB Officer:	Chief Nurse
Category:	Clinical
EIA undertaken:	April 2025
Date issued:	May 2025
Review date:	May 2026
Target audience:	All staff members, including ICB Board Members and practice representatives, involved in the ICB's policy-making processes, whether permanent, temporary or contracted-in (either as an individual or through a third-party supplier)
Distributed via:	Email, Website, Intranet and Board Portal

Document Control Sheet

Document Title	Prior Approval Policy
Version	3.12
Status	Ratified
Authors	Emma Bowler, Melissa Washington, Samantha Jones
Date	May 2025

Document history			
Version	**Date**	**Author/s**	**Comments/Key headlines**
Legacy Policy Versions 1 – 8	January 2010 – April 2019	Andrew Rix Sarah Brinkworth	Reviewed and amended to reflect organisational changes. Updated in line with relevant NHS National Evidence-Based Interventions and relevant NICE Guidance, together with local commissioning pathways and policies.
1.1 –1.17	February 2023	Andrew Rix Lynda Stockwell Emma Bowler Melissa Washington Kate Hooban	New and updated prior approval policy. The policy has been re-branded as Version 1, in line with other East Midlands Commissioning ICB organisations. This policy is formatted in line with new ICB Policy document template and reflecting the organisational change to an ICB. This policy has been updated in line with relevant NHS National Evidence-Based Interventions, relevant NICE Guidance, together with local commissioning pathways and policies.
2.1 – 2.6	October 2024	Emma Bowler Samantha Jones Anthony McGinty	1. Change of Responsible Director/ICB Officer from Andrew Rix to Chief Nurse. 2. Section 9.0, Cosmetic surgery & non-surgical cosmetic treatment policies criteria, Removal of Skin Lesions – Lipoma criteria, amended to include consideration of rare skin conditions. 3. Bariatric criteria on page 55, amended to provide clarity for the Tiers for weight management, support options for Tier 2, referral via the EACH and reflect the updated criteria for the ICB's commissioned provider, and moved into a new Section titled Lifestyle, Obesity and Weight Management 4. Contents and Sections updated to reflect new Section

3.0-3.5	April 2025	Emma Bowler Melissa Washington Samantha Jones Anthony McGinty Robyn Wight	1. Policy updated and criteria's reviewed and appropriate changes made to reflect: amendments in EBI, to ensure links are up to date and references applied (as appropriate) and criteria's amended/moved to different Sections of the policy to reflect the ICB current position.
3.6-3.11	April 2025	Samantha Jones	1. Amended the structure taking into account CSS process/onward referral flow. 2. Front sheet amended to reflect Clinical Policy Sub-group rather than SMODG as the responsible committee. 3. Review date will be 12 months following discussion at Clinical Policy Sub-group committee.
3.12	May 2025	Emma Bowler Melissa Washington Samantha Jones	1. Policy updated to provide clarity of referral processes. 2. Criteria's updated to reflect requirement for Prior Approval in some CSS procedures

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1.0 Introduction

Like all other public services, NHS and social care resources are likely to be significantly constrained over the coming years. The NHS Constitution for England establishes the principles and values of the NHS in England, and sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. Working with patients and the public we need to find new, more efficient ways to care effectively for our population and to make difficult choices about where we invest resources to deliver the greatest benefit.

As the statutory body responsible for NHS spend and performance within the Lincolnshire system, it is imperative that NHS Lincolnshire Integrated Care Board (the ICB) seeks to maximise value for money and the number of patients treated within a sustainable financial envelope. This means only evidence-based, clinically effective services will be commissioned. The introduction of the Community Surgical Scheme (CSS) continues the move towards using the allocated budget effectively in a community setting.

1.1 Background

Across the country most, if not all, ICBs have a set of policies and procedures for limiting the number of low clinical value interventions. Procedures of Limited Clinical Value (PLCV) first came into effect in Lincolnshire in 1995, is aims was to ensure:

- Individuals receive the right treatment, in the right place and at the right time
- Procedures with no, or a very limited, evidence base are not used
- Procedures with minimal benefits to health are restricted
- Procedures which might have been undertaken in the past are now reviewed more thoroughly for each individual patient because clinical evidence explaining the potential benefits or negative effects has improved

The Evidence-based Interventions programme (EBI) Home - EBI (aomrc.org.uk) began in 2018 in partnership with the Academy of Medical Royal Colleges, NHS Clinical Commissioners, the National Institute for Health & Excellence (NICE), NHS England & Improvement, Royal Colleges, specialist societies, commissioners, providers and the public. It's aim is to improve the quality of care, ensuring healthcare providers focus only on interventions known to be effective, based on the best available medical evidence. As well as improving outcomes, a further aim of the EBI Programme is to free up valuable resources so they can be put to better use elsewhere in the NHS. This approach is even more important as the NHS works to reduce the backlog in urgent and elective care.

Following EBIs implementation, the prior approval policy is periodically reviewed. This approach is aligned to NHS England's Getting It Right First Time (GIRFT) national programme Getting It Right First Time - GIRFT designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

1.2 Policy Statement

Using both PLCV and EBI, this policy sets out a consistent approach by the ICB and makes explicit the treatments which will or will not be commissioned from providers and the criteria and thresholds to be applied and includes treatments where prior approval is required for progression to Secondary care, treatments where prior approval is not required but must be delivered in line with criteria and treatments that are not routinely commissioned. This should be read in conjunction with the ICB's Individual Funding Requests (IFR) Commissioning Policy (IFR) which further sets out the processes for prior approval and IFR, should a healthcare provider wish to undertake a treatment, or where a clinician wishes to refer to a healthcare provider, which is not commissioned to provide the treatment.

Treatments and services referred to in this policy should not be undertaken/provided without prior approval being obtained or as indicated. Where prior approval has not been appropriately obtained, then any treatments or services provided will not have been legitimately delivered and will not be paid for by the ICB. The list is not exhaustive, and it should not be assumed if something is not included in this policy that the treatment may be undertaken. Treatments which fall under the remit of NHS England do not form part of this policy. The ICB reserves the right to challenge activity and requires the provider to correct charging. If a provider undertakes one of the procedures contained within this policy that requires prior approval and has not gained approval the commissioner will not pay for the procedure. If a provider undertakes one of the procedures contained within this policy that requires retrospective audit and is found not to meet the criteria when the audit is undertaken commissioners will not pay for the procedure.

2.0 Purpose

The contents of the Prior Approval Policy forms part of the contract between the ICB and all providers for the registered population of Lincolnshire as defined in Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers NHS England » Who Pays?

3.0 Scope

This policy applies to all staff members, including the ICB Board Members and practice representatives involved in the ICB's policy-making processes, whether permanent, temporary or contracted-in (either as an individual or through a third-party supplier). This policy should be read in conjunction with the ICB's IFR Commissioning Policy for detailed guidance on all the processes and procedures for Prior Approvals and IFRs.

3.1 Dissemination and Resource implication

This policy will be distributed to healthcare providers in primary and secondary care, as it will set out what will and will not be commissioned. There are no additional costs incurred through commissioned services in relation to the implementation of this policy.

4.0 Roles & Responsibilities

The strategic responsibility for the implementation, delivery, monitoring, and review of the Prior Approval Policy is the ICB. The operational responsibility for the management and delivery of the policy sits with the Individual Funding Request Service, provided by NHS Arden & Greater East Midlands Commissioning Support Unit (Arden & GEM CSU) as designated by the ICB.

5.0 Lifestyle principles for Prior Approval treatments

In line with the NHS Prevention Programme, in making every contact count, this policy promotes the message that individuals can make changes to their lifestyle which will significantly reduce the risk of ill health in both the long and short term, not just in relation to elective treatments. We therefore actively encourage the promotion of NHS stop smoking services, NHS weight management opportunities and NHS alcohol support services as part of all contacts for primary and secondary health services. Support for health, wellbeing, lifestyle changes, weight management and smoking cessation is available to Lincolnshire patients through One You Lincolnshire

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6.0 Prior Approval process

The responsibility to request prior approval resides with a referring healthcare professional. The Prior Approval processes and procedures are fully detailed within the ICB's IFR policy, see examples below:

Prior approval is required

- Where a patient requires treatment in Secondary care (including Independent Sector Providers (ISPs)) for which prior approval is required, then the referring healthcare professional should ensure the criteria is met and prior approval is obtained.

Significant functional impairment

- This is defined as severe restrictions in activities of daily living, such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing, and eating food). This defines a disability as any long-term limitation in activity resulting from a condition or health problem.

Prior approval not required

- Where a patient requires treatment in Secondary care for which prior approval is not required, but treatment must be undertaken in line with the criteria, then the referring healthcare professional should ensure the criteria is met, but prior approval is not required.

Individual Funding Request

- Where a consultant in secondary care receives a referral asking for a review and/or clinical opinion of a patient, if the consultant determines the patient requires treatment that does not meet criteria listed in the Prior Approval Policy or is not a commissioned treatment, then an Individual Funding Request (IFR) should be completed using the IFR form, setting out the case of need and the clinical evidence of effectiveness.
- For an IFR request to be considered, it must first be demonstrated that the patient fulfils the strict criteria for exceptionality. Determination of this focuses on the following:
    - Are there any clinical features of the patient's case which make the patient significantly different to the general population of patients with the condition in question at the same stage of progression of the condition?
    - Would the patient be likely to gain significantly more benefit for the requested intervention that might be normally expected for the general population of patients with the condition at the same time of the progression of the condition?

IFRs must be submitted to the IFR team via email by the completion of an IFR form. It is the responsibility of the referring healthcare professional to ensure that they obtain the patients' explicit consent to share information with the IFR team or other healthcare professionals for the purpose of the funding request. The IFR process is detailed within the ICB's IFR Commissioning Policy.

Medical Opinion

- Where a healthcare professional wishes to refer to Secondary care for a medical opinion only, then prior approval is not required.

Retrospective Requests

- Should the occasion arise where a treatment for which prior approval is required and is undertaken without said prior approval the ICB **will not** retrospectively fund the treatment. Please note the ICB reserves the right to audit providers against the criteria set out within this policy and any treatment provided outside of the policy criteria will not be funded.

NICE Guidance

- Any treatment that is not listed within the Prior Approval Policy for which there is NICE Guidance, and the treatment is being delivered in line with the NICE Guidance, then prior approval for funding would not be required. Where the proposed treatment is outside of NICE Guidance, then an IFR form and supporting documentation would need to be submitted for consideration.

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7.0 The Community Surgical Scheme (CSS)

The ICB is committed to providing high-quality community services to meet patients' needs and commissions a CSS which supports best practice in delivering community surgical services to improve equitable access to services in primary care.

7.1 CSS principles – CSS applies to individuals over the age of 16**

Step By Step Guide

1. Prior approval **is required for some treatments/procedures** prior to referral into the CSS, via the Lincolnshire 'EACH' (Elective Activity Coordination Hub).

2. Please refer to Section 7.2. 'Treatments undertaken in the CSS' for specific details as to which treatment/procedure requires Prior Approval prior to referral into the CSS.

3. **On every request**, irrespective of whether prior approval is required prior to referral or not, the healthcare professional **must ensure:**

   A. There is a clinical need for treatment.
   B. The relevant criteria are met and specifically indicated within the CSS referral form.
   C. Evidence is provided as to how this is causing functional impairment to the patient.

4. **Where the clinical need for treatment and criteria are not clearly indicated on the CSS referral form, the Prior Approvals team and the EACH will reject the referral back to the GP.**

Requests by GPs into Secondary care

- Patients **must not** be referred to secondary care until prior approval has been provided.
- Any GP who wishes to have a patient treated in Secondary care for a procedure on the CSS list must request prior approval in line with criteria, advising why the patient is unsuitable to be referred to the CSS, as well as evidence detailing how the relevant criteria are met.

Requests accepted in Secondary care

- Where Secondary care has accepted a referral for a treatment which can be undertaken in the CSS and prior approval has not been given, the healthcare professional must request prior approval advising why the patient is unsuitable to be treated in the CSS, as well as evidence detailing how the relevant criteria are met.

CSS Provider Rejections

- If a patient's clinical need cannot be met by the CSS, the CSS provider will forward the documentation and rejection form to the EACH. The EACH will forward this to the IFR team for consideration via the prior approval process into Secondary care. The onward referral to Secondary care will be made by the EACH.

**Exceptions

- Low & High Risk Basal Cell Carcinoma (BCC) – **only available to patients 24 years and over**
- Microsuction treatment is **only available for patients 18 years and over**. For more information please refer to the full Microsuction criteria:
  - Prior approval is required for Level 1 for 4th treatments in a 12-month rolling period and for all Level 2 & 3 referrals into Secondary care.
  - Prior approval is not required for patients who are eligible for the Adult Hearing Loss Service at any level.

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7.2 Treatments undertaken in the CSS

Please see the individual treatment criteria(s) within the specific sections of the Prior Approval Policy, together with information as to which treatments/procedures require prior approval prior to referral via the EACH:

Prior Approval section	Treatment/Procedure	Prior Approval Required prior to referral to CSS
Dermatology	**Excision of benign skin lesions/facial skin lesions/cysts**	**YES**
	Low & High Risk Basal Cell Carcinoma (BCC)	NO
ENT	Microsuction (earwax removal)	NO**
General Surgery	Haemorrhoids	NO
	Hernia surgery	NO
Gynaecology	Removal of Deep Contraceptive Implant	NO
Ophthalmology	Eyelid cysts	NO
Orthopaedic	Carpal Tunnel Syndrome surgery	NO
	De Quervain's syndrome (excluding injections in CSS)	**YES**
	Dupuytren's contracture	**YES**
	Excision of Bursae	**YES**
	Morton's neuroma (excluding injections in CSS)	**YES**
	Non-recurrent ganglions	**YES**
	Toenail surgery	**YES**
	Trigger finger/thumb (excluding injections in CSS)	**YES**
	Ulnar nerve release (Cubital Tunnel Syndrome)	NO
Urology	Vasectomy	NO

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7.3 Treatments undertaken in Additional GP services & In-House Minor Surgery Enhanced services

Please see below, the different minor surgery procedures commissioned by the ICB that are undertaken within GP practices, categorised by:

- Additional GP services – undertaken by a GP with usual skills
- GP In House Minor Surgery services – undertaken by a GP with some basic minor surgery training

Additional GP services	**GP In-House Minor Surgery Enhanced service**		
Curettage **Cautery** **Cryotherapy**	**I**	**Injections:**	**Aspirations:**
		Joints Muscles Tendons	Bursa Cysts Hydrocele Joints
	II	**Incisions:**	**Excisions:**
		Abscesses Thrombosed piles	Cysts – depending on size/ Sebaceous/Pilar Cyst Removal/ Biopsy of skin lesion for histology Skin lesions – depending on size, site, complexity (as determined by clinical referrer) Neuro-fibromas Foreign body (present more than 48 hours) Avulsion of toenail

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8.0 Dermatology treatment policies criteria

Laser Treatment
Prior Approval Required
The ICB **will only** fund laser treatment for the following conditions: • Port wine stains - on the face only (not scalp or neck) only where the criteria for 'Congenital pigmented lesion on the face' is met • Extensive and severe iatrogenic telangiectasia • Congenital pigmented lesions on the face • Rare genodermatoses e.g., Tuberose Sclerosis • Translocation of hair bearing skin during surgery but **not** for excessive hair growth (hirsutism) • Intractable and recurrent pilonidal sinus • Tattoo removal, but only for tattoos which are less than a year old and either iatrogenic e.g., radiotherapy tattoo and dirt tattoo or inflicted without patient consent **PLUS,** documentation which must include: • Evidence of functional problems experienced • Details of the condition • Photographic evidence to support the application, if required **For more information please refer to:** • East Midlands Commissioning Policy 2014: EAST MIDLANDS COMMISSIONING POLICY • Leicestershire policy - LLR Policy for Laser Treatment - LLR ICB

Low Risk Basal Cell Carcinoma (BCC) removal

Prior Approval Required for Secondary Care

BCC REMOVAL PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals aged of 24 years and over and treatment to be carried out in line with the criteria detailed below.

All low risk BCC removal have to be undertaken in line with NICE guidance CSG8 Improving outcomes for people with skin tumours including melanoma | Guidance | NICE

The BCC is singular, primary, nodular BCCs, <1cm and below the clavicle.

- The patient is not:
    - Aged 24 years or younger (that is, a child or young adult)
    - Immunosuppressed or has Gorlin syndrome
- The lesion:
    - Is located below the clavicle (that is, not on the head or neck)
    - Is 1 cm clinical diameter or less with clearly defined margins
    - Is not a recurrent BCC following incomplete excision
    - Is not a persistent BCC that has been incompletely excised according to histology
    - Is not morphoeic, infiltrative or basosquamous in appearance and is not located:
        - Over important underlying anatomical structures (for example, major vessels or nerves)
        - In an area where primary surgical closure may be difficult (for example, digits or front of shin)
        - In an area where difficult excision may lead to a poor cosmetic result
        - At another highly visible anatomical site (for example, anterior chest or shoulders) where a good cosmetic result is important to the patient

For more information please refer to:
NICE guidance, Managing low-risk basal cell carcinomas in the community CG low risk BCC (nice.org.uk)

Please refer to Section 7.1 for full details of CSS guidance.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

High Risk Basal Cell Carcinoma (BCC) removal

Prior Approval Required for Secondary Care

BCC REMOVAL PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals aged 24 years and older and treatment to be carried out in line with the criteria detailed below.

Removal should only be performed by an appropriately qualified General Practitioner with an Extended Role or Consultant Surgeon in the CSS provided the lesion is > 1.5cm and <2.5cm diameter

All high risk BCC removal have to be undertaken in line with NICE guidance CSG8 Improving outcomes for people with skin tumours including melanoma | Guidance | NICE

All patients with a suspicious pigmented skin lesion, with a skin lesion that may be a high-risk BCC, a squamous cell carcinoma (SCC) or a malignant melanoma (MM), or where the diagnosis is uncertain, should be referred to a doctor trained in the specialist diagnosis of skin malignancy, normally a dermatologist, who is a member of either a skin cancer multidisciplinary team (LSMDT) or a Specialist Skin Cancer Multidisciplinary team (SSMDT).

High risk BCC are complex and can cause not only disfigurement in themselves but leave unsightly scars.

For CSS
Surgical consideration/removal of High risk BCC lesions will only be seen in the CSS where the patient meets **any** of the following criteria:

- The patient is aged 24 years and older
- Trunk and Limbs (excluding hands, ankles, feet, genitals, and pre-tibia area) – **Is more than 1cm but not larger than 2.5cm clinical diameter**
- Ears, nose, periorbital, jawline, perioral and chin – **Is up to 1cm clinical diameter**
- Cheeks, forehead, scalp and neck – **Is up to 1cm clinical diameter**
- Clearly or unclearly defined borders/margins
- Primary and Recurrent lesion
- Immunosuppressed, or have Gorlin Syndrome or on the site of prior Radiotherapy
- Adjacent to major nerves / vessels to be considered

For Secondary care
All High Risk BCC facial lesions above 2.5cm clinical diameter require prior approval before onward referral into Secondary Care.

EXCLUSIONS:
The following should be referred direct to Secondary Care:
There should be **no hesitation** in referring lesions less than 2.5cm to Secondary Care if there are concerns regarding diagnosis, and Prior Approval **is not** required.

Please refer to 7.1 CSS principles for more information on the CSS process

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Removal Benign Skin Lesions

Prior Approval Required for CSS and Secondary Care

THE SKIN LESION/CYST PROCEDURES BELOW ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the following:

- Excision multiple Cyst(s)/Lesions: >1.5cm but <5.0cm
- Excision of benign facial Cyst >1.5cm but <2.5cm

And in line with the criteria detailed below.

Please refer to EBI Guidance Removal of benign skin lesions - EBI (aomrc.org.uk)

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.

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.

Benign skin lesions are not routinely funded for removal via the NHS for cosmetic purposes alone and the lesion must meet a 'lesion type' and the criteria below for NHS funding to be approved for removal (surgical excision or cryotherapy):

Where there is diagnostic certainty for the following lesion types:

- Benign moles (excluding large congenital naevi)
- Corn/callous
- Dermatofibroma
- Epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- Milia
- Molluscum contagiosum (non-genital)
- Neurofibromata
- Non-genital viral warts in immunocompetent patients
- Seborrhoeic keratoses (basal cell papillomata)
- Skin tags (fibroepithelial polyps) including anal tags
- Solar comedones
- Spider naevi (telangiectasia) – although multiple lesions may be a sign of underlying disorders in adults and children best initially addressed through advice and guidance
- Xanthelasmata
- Any other benign skin lesion not listed above

AND

- **Conservative management already attempted: With documented evidence** that conservative management (watch and wait over a period of time – more than 3 months) has been sufficiently tried and failed to resolve the condition. Or If left untreated, more invasive intervention would be required for removal.

AND at least **one** of the following criteria:

- **Trauma or abrasion:** The lesion is unavoidably and significantly traumatised on a regular basis, please provide supporting evidence of regular bleeding (more than twice weekly for at least four weeks caused by everyday activities i.e. not due to picking)

- **Repeated Infection:** There is repeated infection which results in the patient requiring 2 or more courses of antibiotics (oral or intravenous) per year

- **Bleeding:** The lesion bleeds (more than twice weekly for at least four weeks) during normal everyday activity, such as the fastening or removal of clothing, use of tools or equipment, please provide supporting evidence of this

- **Continuous Pain:** The lesion causes regular pain, requiring long-term daily medication, which affects or limits daily functioning; please provide supporting evidence of this

- **Obstructing Orifice:** The lesion is obstructing an orifice or impairing field vision, please provide supporting evidence of this

- **Impacts Function:** The lesion significantly impacts on function and causes a reduction in their Activities of Daily Living (ADLs)* or a risk to a critical life sustaining function, and the function would improve after intervention, please provide supporting evidence of this

- **Pressure Symptoms:** The lesion causes pressure symptoms, such as on nerve or tissue, which are unavoidable, cannot be managed conservatively and cause atrophy, please provide supporting evidence of this

Please see below for the EXCLUSIONS that cannot be undertaken in CSS:

The following should be referred direct to secondary care:

- Lesions that are suspicious of malignancy should be treated or referred according to NICE Guidance on Skin cancer QS130 Update information | Skin cancer | Quality standards | NICE

- Any lesion where there is diagnostic uncertainty, pre-malignant lesions (actinic keratoses, Bowen disease) or lesions with pre-malignant potential should be referred to secondary care

- Epididymal Cysts

** Activities of daily living (ADLs) is a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility [NIH, 2023].*

Please refer to 7.1 CSS principles for more information on the CSS process

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

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Removal Benign Skin Lesions – Congenital pigmented lesion on the face

Prior Approval Required

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

The ICB **will only** fund treatment of congenital pigmented lesions on the face only when **all** of the following criteria are met, together with details of the condition:

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

PLUS, documentation which must include:

- Evidence of functional problems experienced
- Details of the condition
- Photographic evidence to support the application, if required

For more information please refer to:

- East Midlands Commissioning Policy 2014: EAST MIDLANDS COMMISSIONING POLICY
- Leicestershire policy - LLR Policy for Laser Treatment - LLR ICB

Removal Benign Skin Lesions – Lipoma removal

Prior Approval Required

Lipoma(s) <5cm should be observed using British Sarcoma Group Organisation Guidance: http://www.britishsarcomagroup.org.uk/wp-content/uploads/2019/01/BSG-guidance-for-ultrasound-screening-of-soft-tissue-masses-in-the-trunk-and-extremity-FINAL-Jan-2019.pdf

Lipoma(s) must meet **at least one** of the criteria for NHS funding to be approved for removal. All reasonable conservative management including self-care advice must have been attempted before the offer of surgery **and evidenced in the request.**

Surgical removal of lipoma(s) will only be funded where all reasonable conservative management undertaken, including self-care advice given **one** of the following criteria are met:

- Lipoma diameter >5cms
- The lesion causes significant functional disability resulting in severe restrictions of activities of daily living or is a function critical to sustaining life; please provide supporting evidence of this
- Causes recurrent trauma due to size and/or position

In certain rare conditions a patient may experience the formation of atypical (*not typical or usual*) lipomas at multiple sites of their body. In these cases, the application of the standard terms of the policy may not be appropriate and the ICB will apply a person specific assessment. This will be based on the clinical presentation described by the referring clinician being explicit as to the atypical nature of the number, distribution and symptoms experienced, within the context of any associated health condition.

Lipomas on the body >5cms, or in a sub-facial position, which have shown rapid growth and/or are painful, or there is suspicion of malignancy should be referred to an appropriate Sarcoma clinic (2-week wait).

For more information please refer to:

- East Midlands Commissioning Policy 2014: EAST MIDLANDS COMMISSIONING POLICY
- Commissioners of Plastic Surgery Services: information-for-commissioners-of-plastic-surgery-services.pdf

9.0 Diagnostics & Pathology treatment guidance

Appropriate colonoscopy management of hereditary colorectal cancer
Prior approval not required but must be delivered in line with criteria
This EBI Guidance Appropriate colonoscopy in the management of hereditary colorectal cancer - EBI (aomrc.org.uk) applies to adults aged 19 years and over. Colorectal carcinoma (CRC) is one of the most common cancers in the UK with more than 40,000 new cases diagnosed each year. An estimated 35% of CRC is due to heritable factors. While colonoscopy is a safe procedure, there is a small risk of complications – including pain, intestinal perforation or major haemorrhage as well as issues related to any sedative used. Colonoscopy should therefore be used appropriately in the management of CRC in people who have been identified with an increased lifetime risk of CRC due to hereditary factors. Follow the British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines | ACPGBI

Blood Transfusions

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Blood transfusion - EBI (aomrc.org.uk) applies to adults (or equivalent based on body weight for children or adults with low body weight) only.

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

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

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

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

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

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

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

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

When using a restrictive RBC transfusion threshold, consider a threshold of 70 g/litre and a haemoglobin concentration target of 70–90 g/litre after transfusion.

For patients with acute coronary syndrome, a RBC transfusion threshold of 80 g/litre should be considered and a haemoglobin concentration target of 80–100 g/litre after transfusion.

For patients requiring regular transfusion for chronic anaemia, NICE guideline (NG24) Published: 18 November 2015 Overview | Blood transfusion | Guidance | NICE advises defining thresholds and haemoglobin concentration targets for everyone.

Cystoscopy for men with uncomplicated lower urinary tract symptoms

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Cystoscopy for uncomplicated lower urinary tract symptoms - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

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

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

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

- Recurrent infection
- Sterile pyuria
- Haematuria
- Profound symptoms

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

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

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

For more information, please refer to:

- Lower urinary tract symptoms in men: management, Clinical guideline **(**CG97**)** Published:23 May 2010 Last updated: 03 June 2015 **Overview | Lower urinary tract symptoms in men: management | Guidance | NICE**

Diagnostic coronary angiography for low-risk stable chest pain

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Diagnostic coronary angiography for low risk, stable chest pain - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

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

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

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

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

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

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

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

For more information, please refer to:

- NICE Guidance for onset chest pain of suspected cardiac origin. Clinical guideline [CG95] Published: 24 March 2010 Last updated: 30 November 2016 Overview | Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis | Guidance | NICE

ERCP in acute gall stone pancreatitis without cholangitis
Prior approval not required but must be delivered in line with criteria
This EBI Guidance Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis - EBI (aomrc.org.uk) applies to adults aged 19 years and over. Early endoscopic retrograde cholangiopancreatography (ERCP) for acute gallstone pancreatitis without cholangitis is not recommended. Early ERCP in the treatment of acute gallstone pancreatitis, should only be performed if there is evidence of cholangitis or obstructive jaundice with imaging evidence of a stone in the common bile duct. Early ERCP refers to ERCP being performed on the same admission, ideally within 24 hours. **For more information, please refer to:** • Pancreatitis, NICE guideline **(**NG104**)** Published: 05 September 2018 Last updated: 16 December 2020 **Overview | Pancreatitis | Guidance | NICE**

Exercise ECG for screening of coronary heart disease (CHD)
Prior approval not required but must be delivered in line with criteria
This EBI Guidance Exercise electrocardiogram (ECG) for screening for coronary heart disease - EBI (aomrc.org.uk) applies to adults aged 19 years and over. Exercise electrocardiogram (ECG) is a type of cardiac stress test that should no longer be used to screen for coronary heart disease (CHD). Exercise ECG has no role in the screening of asymptomatic and low risk patients for coronary heart disease because it has a very low pre-test probability of identifying pathology. Risk calculators, such as Systematic Coronary Risk Evaluation (SCORE), are instead recommended to identify patients who are at greater risk of CHD. Under the guidance of cardiologists, the test has a limited role for diagnosis in selected patients with symptoms suggestive of CHD, and/or where CHD has been diagnosed to confirm functional capacity or severity. **For more information, please refer to:** • NICE Guidance for Recent-onset chest pain of suspected cardiac origin. Clinical guideline (CG95) Published: 24 March 2010 Last updated: 30 November 2016 Overview | Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis | Guidance | NICE

Hip MRI scan for arthritis

Prior approval not required but must be delivered in line with criteria

This EBI Guidance MRI scan of the hip for arthritis - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

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

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

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

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

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

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

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

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

For more information, please refer to:

- NICE Guidance for Osteoarthritis: care and management. NICE guideline (NG226) Published: 19 October 2022 Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE

Knee MRI when symptoms suggestive of Osteoarthritis
Prior approval not required but must be delivered in line with criteria

This EBI Guidance Knee MRI when symptoms are suggestive of osteoarthritis - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

In primary care, where clinical assessment is suggestive of knee Osteoarthritis (OA), imaging is not usually necessary. If imaging is required than weight bearing radiographs are the first line of investigation.

Patients with persistent symptoms should, after three to four months, be referred to secondary care and should have imaging of the knee to investigate for OA and/or other pathology.

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

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

- Patients who have severe symptoms but relatively mild OA on standard x-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee

- In working up a patient for possible High Tibial Osteotomy (HTO) or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments.

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

For more information, please refer to:

- Please see NICE Guidance for Osteoarthritis: care and management. NICE guideline (NG226) Published: 19 October 2022. Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE

Knee MRI for suspected meniscal tears
Prior approval not required but must be delivered in line with criteria
This EBI Guidance Knee MRI for suspected meniscal tears - EBI (aomrc.org.uk) applies to adults aged 19 years and over. Patients with a clear history of a significant acute knee injury and mechanical symptoms or who have a locked knee may have a repairable meniscal tear and should undergo referral to intermediate or secondary care and have MRI investigation. Most patients who initially present in primary care with knee symptoms, no red flags and no history of acute knee injury or a locked knee do not need an MRI investigation and can be treated with non-operative supportive measures. Patients with persistent mechanical knee symptoms should be referred to secondary care and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology.

Pre-Operative ECG

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Pre-operative electrocardiogram (ECG) - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

Pre-operative electrocardiograms (ECG) should not be routinely performed in low risk, non-cardiac, adult elective surgical patients.

However, they may be appropriately performed when the following criteria apply:

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

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

For more information, please refer to:

- Routine preoperative tests for elective surgery, NICE guideline (NG45) Published: 05 April 2016 Overview | Routine preoperative tests for elective surgery | Guidance | NICE

Pre-operative chest x-ray

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Pre-operative chest x-ray - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

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

- Patients undergoing cardiac or thoracic surgery
- Patients undergoing organ transplantation or live organ donation

At the request of the anaesthetist in:

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

For more information, please refer to:

- Routine preoperative tests for elective surgery, NICE guideline (NG45) Published: 05 April 2016 Overview | Routine preoperative tests for elective surgery | Guidance | NICE

Repeat Colonoscopy
Prior approval not required but must be delivered in line with criteria
This EBI Guidance Repeat Colonoscopy - EBI (aomrc.org.uk) applies to adults aged 19 years and over. Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines | ACPGBI **For more information, please refer to:** • Colorectal cancer, NICE guideline (NG151) Published: 29 January 2020 Last updated: 15 December 2021 Overview | Colorectal cancer | Guidance | NICE • Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas, Clinical guideline (CG118) Published: 23 March 2011 Last updated: 20 September 2022 Overview | Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or adenomas | Guidance | NICE

Scan for Shoulder Pain and Guided Injections for Shoulder Pain

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Scans for shoulder pain and guided injections for shoulder pain - EBI (aomrc.org.uk) applies to adults aged 19 years and over.

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

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

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

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

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

For more information, please refer to:

- Shoulder pain: Management Last revised in November 2022 Management | Shoulder pain | CKS | NICE

10 Ear, Nose & Throat (ENT) treatment policies criteria

Continuous Positive Airway Pressure (CPAP)
Prior approval not required but must be delivered in line with criteria
The ICB stipulates that the provision of CPAP is recommended in line with NICE Guidance 5 Implementation | Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome | Guidance | NICE (TA139 Last updated: 20 August 2021) as a treatment option for adults with moderate or severe symptomatic obstructive sleep apnoea/hypopnoea syndrome (OSAHS). This recommendation has been updated and replaced by 1 Obstructive sleep apnoea/hypopnoea syndrome | Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s | Guidance | NICE The diagnosis and treatment of OSAHS, and the monitoring of the response, should be carried out by a specialist service with appropriately trained medical and support staff. **Exclusion:** These criteria do not apply to Paediatrics or Neonates

Grommet for Glue Ear in Children

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Grommets for glue ear in children - EBI (aomrc.org.uk) only applies to children aged under 12.

The NHS should only commission the surgical management of glue ear in children aged under 12 when these criteria are met:

- Have had specialist audiology and ENT assessment, including clinical examination, a hearing test and typanometry, with a reassessment 3 months later*
- Assessment and reassessment indicate:
  - Persistent bilateral otitis media with effusion
  - Unilateral hearing loss if hearing is impacting daily living or communication
- Received advice on strategies to minimise the impact of hearing loss both at home and in educational settings
- Non-surgical management has been considered, such as air or bone conduction devices and /or auto-inflation
- That the benefits and risks of grommets has been discussed with the child and their parents and carers, and a shared decision has been made on use. The risk of perforation of the eardrum, localised atrophy, tympanosclerosis and infection associated with grommets has been explained
- Surgical intervention should be considered in children who cannot undergo standard hearing assessments where there is clinical and tympanographic evidence of persistent glue ear, and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. The guidance is different for children with Down's Syndrome and cleft palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance
- It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum

*In children who are experiencing hearing difficulties that significantly affect day-to-day living, consider intervening earlier than the 3-month reassessment

When planning grommet surgery for the management of glue ear, you may wish to consider an adjuvant adenoidectomy (unless assessment indicates an abnormality with the palate). Please see accompanying EBI Guidance Removal of adenoids for treatment of glue ear - EBI (aomrc.org.uk)

For more information, please refer to:

- Otitis media with effusion in under 12s, NICE guideline (NG233) Published: 30 August 2023 Overview | Otitis media with effusion in under 12s | Guidance | NICE
- NICE guideline NG233 Evidence Review [E] (2023) Otitis media with effusion in under 12s [E] Evidence review for ventilation tubes NG233 Otitis media with effusion in under 12s: Evidence review E 30/08/2023 (nice.org.uk)
- NICE guideline NG233 Supplement 2: Decision Table (2023). Otitis media with effusion in under 12s. Decision table NG233 Otitis media with effusion in under 12s: Decision table 30/08/2023 (nice.org.uk)

Microsuction (Earwax removal)

Prior Approval Required for 4th treatment within the CSS & Level 2 & Level 3 (Secondary care)

MICROSUCTION IS DELIVERED UNDER THE CSS

CSS Microsuction applies to individuals aged 18 years and over and treatment to be carried out in line with the criteria detailed below.

Earwax usually falls out on its own and a plug of earwax is not a serious problem. Therefore, earwax should only be removed if wax build-up is causing symptoms such as pain, tinnitus, vertigo, dulled hearing or problems with a hearing aid.

Scenario: Management | Management | Earwax | CKS | NICE: Microsuction (using a vacuum to suck the wax out under a microscope) or another method of earwax removal (such as manual removal using a probe) may also be considered if the expertise is available and there are no contraindications to the methods.

Level 1 – Referral to the CSS

Prior Approval is not required, except for 4th treatments in a 12-month rolling period. In these cases, Prior Approval is required. Please provide the specific clinical evidence advising the rationale why the patient requires a 4th treatment of Microsuction with a 12-month rolling period.

Patients may be referred for treatment in the CSS, when all levels of self-care as detailed below (also detailed within the Microsuction patient leaflet) have been undertaken, please provide evidence within the referral:

- Earwax usually falls out on its own. If it doesn't and blocks your ear, then ear drops should be used for a minimum of 5 days following the manufacturers' guidelines on use which usually involves application between 2 – 4 times daily. If the ear wax remains very firm, then olive oil may be applied for a further 5 days.

OR

- If olive oil does not work, you can buy sodium bicarbonate drops from pharmacies. You can use these drops for 3-5 days following manufacturers instruction providing you do not have a history suggestive of a perforated eardrum. In addition, you may experience some skin irritation when using these drops.

AND

- Where the above self-care has been unsuccessful and earwax is still totally occluding the ear canal

AND

- The patient has been seen by a clinician again following self-care to confirm wax and symptoms are still present

AND

One of the following criteria are met:

- Substantial hearing loss suspected to be due to earwax
- Chronic earache suspected to be due to earwax
- Tinnitus suspected to be due to earwax
- Vertigo suspected to be due to earwax

- Cough suspected to be due to earwax
- The tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis
- The person wears a hearing aid, wax is present, and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle

Level 2 & Level 3 – Referral to Secondary care

Prior Approval is required

Patients may be referred to secondary care when:

- The patient has been seen by a clinician again following self-care to confirm wax and symptoms still present

AND

One of the following criteria are met:

- Self-care is contraindicated **OR**
- The patient is complex:
    - **Level 2:** Eczematous, perforation, infections – non-complex but potential for complications **OR**
    - **Level 3:** Polyps, keratin, attic pocket – complex

AND

One of the following criteria are met:

- Chronic perforation (or suspected perforation) of the tympanic membrane
- History of ear surgery
- History of recurrent otitis externa
- Foreign body, including vegetable matter, in the ear canal, infection, eczema, dermatitis of the ear canal or external ear
- Polyps, keratin, attic pocket

AND

The patient requires wax removal due to at least one of the reasons below:

- Substantial hearing loss suspected to be due to earwax
- Chronic earache suspected to be due to earwax
- Tinnitus suspected to be due to earwax
- Vertigo suspected to be due to earwax
- Cough suspected to be due to earwax
- The tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis
- The person wears a hearing aid, wax is present, and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle

EXCLUSION:
Please note if a patient meets criteria for the Community Adult (50 yrs+) Hearing Loss service then they do not require referral to CSS for Level 1 wax removal first as the AHL services are commissioned to remove wax for this cohort of patients.

For more information, please refer to:

- The Rotherham NHS Foundation Trust, Guideline for aural instrumentation procedural information, November 2022: Aural instrumentation guidelines 2022.pdf
- CKS: Earwax: Scenario: Management, March 2024: Scenario: Management | Management | Earwax | CKS | NICE

Please refer to 7.1 CSS principles for more information on the CSS process.

Please see above for the 'Exclusions' that do not need to be undertaken in CSS.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

Removal of Adenoids for treatment of glue ear

Prior approval not required but must be delivered in line with criteria

This EBI Guidance Removal of adenoids for treatment of glue ear - EBI (aomrc.org.uk) applies to children aged under 12 years of age.

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

In some circumstances, when a child is undergoing surgery to insert grommets Grommets for glue ear in children., the adenoids may also be partially resected at the same time. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.

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

When planning grommet surgery for the management of glue ear, consider adjuvant adenoidectomy unless assessment indicates an abnormality with the palate.

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

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

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

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

For further information, please refer to:

- NICE guidance [NG233] (2023) Otitis media with effusion in under 12s Overview | Otitis media with effusion in under 12s | Guidance | NICE
- NICE guideline NG233 Evidence Review [F] (2023) Otitis media with effusion in under 12s [F] Evidence reviews for adenoidectomy for children with otitis media with effusion (OME) NG233 Otitis media with effusion in under 12s: Evidence review F 30/08/2023 (nice.org.uk)

Septorhinoplasty/Septoplasty

Prior Approval Required

A Septorhinoplasty/Septoplasty is an operation to straighten the septum (cartilage and bone inside the nose that separates the nostrils) to improve breathing through the nose.

The ICB **will only** fund septoplasty when **one or more** of the following indications are present:

- Continuous nasal airway obstruction that results in significantly impaired nasal breathing associated with septal or lateral nasal wall deformities or vestibular stenosis. This includes post-traumatic deformity or significant congenital deformity, such as cleft palate
- Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures, such as ethmoidectomy

In each case, **all** the following criteria should also be met **and evidenced in the request:**

- Obstructive symptoms persist despite conservative management for three months or longer
- Where there is an external nasal deformity, pre-operative photographs showing the standard 4-way view – base of nose, anterior-posterior, and right and left lateral views
- Relevant history of accidental or surgical trauma, congenital defect or disease, including duration and degree of symptoms related to nasal obstruction

For more information please refer to:

- East Midlands Commissioning Policy 2014: EAST MIDLANDS COMMISSIONING POLICY

Surgical Intervention for Chronic Rhinosinusitis

Prior approval not required but must be delivered in line with criteria

Please refer to EBI Guidance Surgical intervention for chronic rhinosinusitis - EBI (aomrc.org.uk) This guidance applies to adults and children.

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

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

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

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

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

- A clinical diagnosis of CRS has been made in primary care and patient still has moderate/ severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation; please refer to Commissioning guide for Rhinosinusitis | ENT UK

AND

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

OR

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

OR

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

No investigation, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (E.g., x-ray, CT scan) There is no role for prolonged course of antibiotics in primary care.

Patients can be considered for endoscopic sinus surgery when **all** the following criteria are met:

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

AND

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

AND

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

AND

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

OR

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

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

- Any suspected or confirmed neoplasia
- Emergency presentation with complications of sinusitis (e.g., orbital abscess, subdural or intracranial abscess)
- Patients with immunodeficiency
- Fungal Sinusitis
- Patients with conditions such as Primary Ciliary Dyskinesia, Cystic Fibrosis or NSAID-Eosinophilic Respiratory Disease (BSAID-ERD, Samter'sTriad, Aspirin Sensitivity Asthma, CRS)
- Treatment with topical and/or oral steroids contra-indicated
- As part of surgical access or dissection to treat non-sinus disease (e.g., pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)

Tonsillectomy/Obstructive Sleep Apnoea (OSA)
If clinically indicated, then adenoidectomy may be undertaken at the same time

Prior Approval Required

Please refer to EBI Guidance Tonsillectomy for recurrent tonsillitis - EBI (aomrc.org.uk)

The NHS should only commission this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as supported by ENT UK commissioning guidance: Revised ENT UK Tonsillectomy commissioning guide edit to final (002).pdf

This criterion is for surgical procedures to remove the tonsils or adenoids and tonsils. Recurrent sore throats, which are due to acute tonsillitis, in adults and children.

Tonsillitis:
Please provide documented evidence detailing the **specific dates of acute tonsillitis** confirming:

- Sore throats are due to acute tonsillitis **and**
- The risks of tonsillectomy vs active monitoring have been discussed with the adult or child and their family or carers, and a shared decision has been made on whether to have the procedure. This discussion should be documented
- The episodes are disabling and prevent normal functioning **and**
- Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year **or**
- Five or more such episodes in each of the preceding two years **or**
- Three or more such episodes in each of the preceding three years

There are a number of medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the ongoing management. In these instances, tonsillectomy may be considered beneficial at a lower threshold than the criteria set out above, after specialist assessment.

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

Obstructive sleep apnoea (OSA) in children:
Adenotonsillectomy should be considered for children (aged 12 months up to 18 years), where there is documented evidence detailing the specific conditions confirming:

- Clinical features of adenotonsillar hypertrophy (an obstructive condition due to enlarged adenoids)

AND

- Features of OSA such as:

- Snoring and pauses in breathing, which may be followed by a gasp or snort
- Restlessness and sudden arousals from sleep, laboured breathing, unusual sleep posture (for example head bent backwards), and bedwetting
- Daytime symptoms such as changes in behaviour (for example irritability), poor concentration, decreased performance at school, tiredness and sleepiness, failure to gain weight or grow, and mouth breathing

AND

- Sleep studies which support the diagnosis of OSA

EXCLUSIONS:

This policy does not apply to tonsillectomy which may be required as a treatment for the following conditions:

- Suspected cancer (e.g., asymmetry of tonsils), when referral should be made through the appropriate (2 week wait) route
- Recurrent quinsy
- Emergency presentations (e.g., treatment of parapharyngeal abscess)

For more information, please refer to:

- Sore throat – acute, Last revised in September 2024 Sore throat - acute | Health topics A to Z | CKS | NICE
- Making a decision about recurrent tonsillitis in adults and children, 26 September 2023 Making a decision about recurrent tonsillitis in adults and children | ENT UK and NHS_Recurrent_tonsillitis_decision_aid (england.nhs.uk)
- NICE CKS OSA: Obstructive sleep apnoea syndrome.child

11 Gastroenterology treatment policies criteria

Cholecystectomy (Gallbladder, gallstones, cholecystitis, biliary colic)
Prior approval not required but must be delivered in line with criteria

Please refer to EBI Guidance Cholecystectomy - EBI (aomrc.org.uk) This EBI guidance applies to adults aged 19 years and over.

NICE guidance CG188 advises: Gallstone disease occurs when hard fatty or mineral deposits (gallstones) form in the gallbladder. Approximately 15% of the adult population are thought to have gallstone disease, and most of these people experience no symptoms. For a small proportion of people with gallstone disease, the stones irritate the gallbladder or block part of the biliary system, and this can cause symptoms such as pain, infection and inflammation. If these symptoms are left untreated, gallstones can cause more serious and, in some cases, life-threatening conditions such as cholecystitis, cholangitis, pancreatitis and jaundice.

In line with NICE Guidance, the ICB will fund Cholecystectomy for symptomatic gallstones with episodes of:

- Acute cholecystitis or cholangitis

  Or

- Biliary colic

  Or

- Gall stone induced pancreatitis

  Or

- Obstructive jaundice due to gall stones

  Or

- Symptomatic or asymptomatic common bile duct stones

Patients should be informed that smoking increases complications following surgery and should be offered support to stop smoking with a referral to One You Lincolnshire Home | One You Lincolnshire

For more information, please refer to:

- Gallstone disease: diagnosis and management, Clinical guideline (CG188) Published: 29 October 2014 Overview | Gallstone disease: diagnosis and management | Guidance | NICE

Irritable Bowel Syndrome (IBS)

Prior approval not required but must be delivered in line with criteria

NICE guidance CG61 advises: Irritable bowel syndrome (IBS) is a chronic, relapsing and often life-long disorder. It is characterised by the presence of abdominal pain or discomfort, which may be associated with defaecation and/or accompanied by a change in bowel habit. Symptoms may include disordered defaecation (constipation or diarrhoea or both) and abdominal distension, usually referred to as bloating. Symptoms sometimes overlap with other gastrointestinal disorders such as non-ulcer dyspepsia or coeliac disease. People with IBS present to primary care with a wide range of symptoms, some of which they may be reluctant to disclose without sensitive questioning.

Diagnostic tests
In people who meet the IBS diagnostic criteria, Diagnosis | Irritable bowel syndrome | CKS | NICE the following tests should be undertaken to exclude other diagnoses:

- Full blood count (FBC)
- Erythrocyte sedimentation rate (ESR) or plasma viscosity c-reactive protein (CRP)
- Antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG])

In the absence of 'red flag' symptoms of malignancy Alarm symptoms | Irritable bowel syndrome | CKS | NICE, the following tests are not necessary to confirm a diagnosis in adults who meet the IBS diagnostic criteria, and therefore will not be funded:

- Ultrasound
- Rigid/flexible sigmoidoscopy
- Colonoscopy; barium enema
- Thyroid function test
- Faecal ova and parasite test
- Faecal occult blood
- Hydrogen breath test (for lactose intolerance and bacterial overgrowth)

For more information, please refer to:
- Irritable bowel syndrome in adults: diagnosis and management, Clinical guideline (CG61) Published: 23 February 2008 Last updated: 04 April 2017 Overview | Irritable bowel syndrome in adults: diagnosis and management | Guidance | NICE

12 General Surgery treatment policies criteria

Abdominoplasty (Apronectomy/Panniculectomy)
Prior Approval Required
Abdominoplasty irrespective of the cause of the apron or reason for previous weight loss will only be funded when **all** the following criteria are met: • Sexual maturation has been reached (normally 16 years or over and is post pubertal) • An abdominoplasty/apronectomy has not already been performed • Body Mass Index (BMI) as measured by the NHS is between 18.0 and <27.0 and has been within this range for 1 year as measured and recorded by the NHS • Confirmed non-smoker* or documented abstinence validated prior to procedure using an appropriate test, with a minimum goal of 6 months from quit date. (Surgical outcomes, e.g., wound healing, complications, can be adversely affected by smoking, and to ensure the best outcomes patients should have stopped smoking prior to surgery.) • Functionally disabling resulting in severe restrictions in activities of daily living, such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing, and eating food) Patients should be informed that smoking increases complications following surgery. All patients should be offered support to stop smoking with a referral to One You Lincolnshire Home | One You Lincolnshire **Vaping is part of a smoking cessation tool and therefore is classed as non-smoking in line with NICE NG209 Overview | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE* **For more information, please refer to:** • British Association of Plastic Reconstructive and Aesthetic Surgeons and Royal College of Surgeons. UK Commissioning guide: Massive Weight Loss Body Contouring. 2017 Abdominoplasty | BAPRAS • Information for Commissioners of Plastic Surgery Services information-for-commissioners-of-plastic-surgery-services.pdf (bapras.org.uk)

Appendicectomy without confirmation of appendicitis

Prior approval not required but must be delivered in line with criteria

Please refer to EBI Guidance Appendicectomy without confirmation of appendicitis - EBI aomrc.org.uk) This guidance applies to adults aged 19 years and over, and children.

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

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

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

For more information, please refer to:

- Royal College of Surgeons of England (2014) Commissioning Guide: Emergency general surgery (acute abdominal pain) Emergency General Surgery - Commissioning Guide — Royal College of Surgeons (rcseng.ac.uk)
- NICE - Scenario: Managing suspected appendicitis, Last revised in June 2024 Scenario: Managing suspected appendicitis | Management | Appendicitis | CKS | NICE

Frenulotomy of Ankyloglossia (tongue-tie)

Prior approval required

Ankyloglossia (tongue-tie) is a congenital anomaly characterised by an abnormally short lingual frenulum, which may restrict mobility of the tongue. It varies from a mild form in which the tongue is bound only by a thin mucous membrane, to a severe form in which the tongue is completely fused to the floor of the mouth. Breastfeeding difficulties may arise, such as problems with latching, sore nipples and poor infant weight gain. Current evidence suggests that there are no major safety concerns about division of Ankyloglossia.

The ICB **will only** fund Frenulotomy of Ankyloglossia (tongue-tie) for the following indications:

- To improve feeding where the infant has been seen and referred by a specialist infant feeding advisor
- To improve articulation where assessment by a Speech and Language Therapist (SALT) confirms that their speech problems are attributable to the Ankyloglossia

For Frenulotomy for Feeding Difficulty – all the following criteria must be applied:

- The child is under 11 years of age
- Specialist infant feeding advisor confirm that feeding will be improved by the procedure
- A specialist infant feeding advisor report has been completed

For Frenulotomy for Speech Difficulty – all the following criteria must be applied:

- The child is under 11 years of age
- Speech and language therapist confirm that articulation will be improved by the procedure
- A SALT report has been completed

The treatment of Frenulotomy of Ankyloglossia should be carried out in line with NICE Guidance for the Division of ankyloglossia (tongue-tie) for breastfeeding, IPG 149: 3 Further information | Division of ankyloglossia (tongue-tie) for breastfeeding | Guidance | NICE

PLEASE NOTE:

- The procedure must be carried out by an appropriate specialist
- Frenulotomy is only commissioned to children under 11 years of age

Haemorrhoids

Prior Approval Required for Secondary Care

HAEMORRHOID INJECTIONS/BANDING PROCEDURE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI Guidance Haemorrhoid surgery - EBI (aomrc.org.uk)

Haemorrhoids are swellings that develop inside and outside the anus.

The majority of haemorrhoids are not a sign of severe pathology and can be managed conservatively.

Non-operative conservative management of haemorrhoids: especially lower grade haemorrhoids, includes lifestyle changes e.g. avoiding straining, eating more fibre or drinking more water.

The ICB will **only fund** the treatment of haemorrhoids when the following criteria are met:

- The patient has not responded to non-operative conservative measures

AND, in either of the following circumstances:

- Severe (grade 3 or grade 4), which combine internal/external haemorrhoids with persistent pain or bleeding

  OR

- Irreducible and large external haemorrhoids

EXCLUSIONS:
In cases where there is significant rectal bleeding the patient should be examined internally by a specialist in secondary care.

For more information, please refer to:

- Royal College of Surgeons and The Association of Coloproctology of Great Britain and Ireland (2017) Commissioning guide: Rectal Bleeding Commissioning guide: Rectal Bleeding: Royal College of Surgeons (RCS) and ACPGBI, 2017 | ACPGBI

Please refer to 7.1 CSS principles for more information on the CSS process.

Please see above for the exclusions that cannot be undertaken in CSS.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

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Hernia Repair

Prior Approval Required for Secondary Care

HERNIA REPAIR PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI Guidance Repair of minimally symptomatic inguinal hernia - EBI (aomrc.org.uk) This guidance applies to adults aged 19 years and over.

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

Patients with BMI >35:
These patients **cannot be referred to CSS** and require Prior Approval to be referred to secondary care. The decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient for assessment, but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered via One You Lincolnshire Home | One You Lincolnshire

Patients who smoke: should be informed of clinical advice that hernia recurrence rates are 3 times higher in smokers. Patients who smoke should be offered support to stop smoking with a referral to One You Lincolnshire.

Surgical treatment can be considered for the following type of hernia:

- Inguinal hernia
- Femoral hernia
- Spigelian hernia
- Epigastric hernia
- Umbilical hernias
- Para-umbilical hernias

Where **one or more** of the following criteria are met:

- Symptoms of significant pain or discomfort are such that they interfere with activities of daily living

OR
- The hernia is difficult or impossible to reduce

OR
- It is an inguino-scrotal hernia

OR
- The hernia increases in size month on month

EXCLUSIONS:
The following can be referred direct to secondary care:

- Incisional hernia
- Irreducible hernia (including partially reducible)
- Recurrent hernia which has occurred within 12 months of the original hernia repair or are complex repair
- In women, all suspected groin hernias should be referred urgently to secondary care

Please refer to 7.1 CSS principles for more information on the CSS process.

Please see above for the exclusions that cannot be undertaken in CSS.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

Surgical Treatment of Varicose Veins

Prior Approval Required

Please refer to EBI Guidance Varicose vein interventions - EBI (aomrc.org.uk)

Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost-effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery.

In line with NICE Guidance, patients may be referred to a vascular service for a medical opinion for the following:

- Symptomatic (Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching) primary or recurrent varicose veins. Referral of patient with symptomatic and recurrent varicose veins does not mean that surgical intervention is required or appropriate.

The ICB will only fund surgical intervention for varicose veins, if clinically appropriate, where the patient is symptomatic and **at least one** of the following criteria below are met:

- Lower-limb skin changes (such as pigmentation or eczema) thought to be caused by chronic venous insufficiency or an ulcer
- Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks)
- A healed venous leg ulcer
- **Please refer any patient with bleeding varicose veins to a Vascular service immediately**

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

The ICB does not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.

EXCLUSIONS:

- Children and young people (aged 18 and under)
- Treatment of varicose veins during pregnancy

For more information, please refer to:

- NICE Guidance: Varicose veins in the legs Clinical guideline (CG168) Published: 24 July 2013: Recommendations | Varicose veins: diagnosis and management | Guidance | NICE

13 Gynaecology & Fertility treatment policies criteria

Dilation and curettage (D&C) for menorrhagia
Prior approval not required but must be delivered in line with criteria
Please refer to EBI Guidance Dilatation & curettage for heavy menstrual bleeding - EBI (aomrc.org.uk) NICE guidelines recommend that D&C is not offered as a treatment option for heavy menstrual bleeding. There is very little evidence to suggest that D&C works to treat heavy periods and the one study identified by NICE showed the effects were only temporary. D&C should not be used to investigate heavy menstrual bleeding as hysteroscopy and biopsy work better. The ICB will **not** fund D&C as a diagnostic tool or as a therapeutic treatment for menorrhagia (heavy menstrual bleeding). Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods. Medication and intrauterine systems (IUS) can be used to treat heavy periods. **For more information, please refer to:** • NICE Guidance (NG88) on Heavy menstrual bleeding, assessment and management, Published: 14 March 2018, Last updated: 24 May 2021 Overview | Heavy menstrual bleeding: assessment and management | Guidance | NICE

Gamete Storage and Cryopreservation of Sperm, Oocytes and Embryos

Prior approval not required but must be delivered in line with criteria

Cryopreservation involves storage of male or female reproductive tissue for future use in conception via assisted reproductive techniques. Cryopreservation of sperm is a well-established technique used to maintain an individual's fertility. Cryopreservation of eggs requires ovarian stimulation and oocyte collection; this would be followed by in vitro fertilisation (IVF) if cryopreservation of embryos is required.

Conditions to be considered for treatment under this policy are for patients who are receiving NHS-funded treatments which pose a risk to their fertility. This covers all individuals who meet the eligibility criteria regardless of gender, sexual orientation, and marital or relationship status.

All individuals must be **permanently** registered with an NHS Lincolnshire ICB GP practice.

Patients eligible for NHS-funded gamete or embryo cryopreservation should be about to commence treatment (which would be funded by the NHS) that may cause permanent infertility because of their treatment. Conditions considered appropriate for gamete or embryo cryopreservation include, but are not limited to:

- Malignancies or other autoimmune conditions requiring chemotherapy
- Malignancies requiring total body irradiation or radiotherapy that may affect an individual's reproductive organs
- Conditions requiring male urological or female gynaecological surgery (e.g., women with a BRCA 1 gene mutation not in a position to start a family and being prepared for bilateral salpingo-oophorectomy)
- Conditions requiring specialist endocrinology services
- Rare mitochondrial disorders
- Transgender patients who are receiving treatment for gender dysphoria which may cause permanent infertility (hormone therapy, reconstructive surgery etc.) and who are on an NHS transgender pathway. The referring healthcare professional should have confirmation that the patient is on an NHS Gender Dysphoria pathway and correspondence from the NHS Gender Identity Clinic provider who has made a diagnosis of Gender Dysphoria and are recommending a referral for gamete storage

Individuals should also meet the following criteria:

- Females of reproductive age up to 42 years old (stimulation treatment to take place prior to individual's 43rd birthday). This should be read in conjunction with national guidance
- Males of reproductive age up to 55 years old (sperm retrieval to take place prior to individual's 56th birthday). There is no minimum age limit; Patient has not previously been sterilised even if sterilisation has been reversed
- Must have no living children, natural, adopted or from any previous relationship
- Written informed consent to treatment and gamete or embryo storage has been gained

PLEASE NOTE:

- Sperm will normally be stored for a maximum period of 10 years, or until a man reaches the age of 56 years old, whichever is sooner.

- Eggs and embryos will normally be stored for a maximum period of 10 years, or until a woman reaches the age of 43 years old, whichever is sooner.

- Storage of sperm, eggs or embryos will not normally be funded for longer than 10 years. Under existing legislative provisions (the 2009 Statutory Storage Period for Embryos and Gametes Regulations) extending storage beyond 10 years is only possible where a medical practitioner confirms that the person storing eggs, sperm or embryos, or their partner, is or is likely to become prematurely infertile HFEA Briefing | HFEA If patients wish to continue to store their gametes beyond 10 years and they no longer meet the eligibility criteria in this policy, they may choose to self-fund this.

- A single cycle of treatment **only will be funded** i.e., not multiple attempts. Treatment will only be funded at centres licensed by the HFEA. Embryo storage using donor sperm is not routinely commissioned. ·The ICB will not fund any additional costs for the transportation of sperm, eggs or embryos if required.

- Treatment will only be funded for the ICB's Commissioned Providers, who are licensed by the Human Fertilisation and Embryology Authority (HFEA).

- Embryo storage using donor sperm is not routinely commissioned.

- The ICB will not fund any additional costs for the transportation of sperm, eggs or embryos if required.

- All patients should be made aware that provision of gamete preservation is made without prejudice to the future determination of any subsequent fertility treatment. Approval of preservation does not guarantee NHS funding for future fertility treatment (which will be determined by the ICB policy at that time).

For more information, please refer to:

- Fertility problems: assessment and treatment, Clinical Guidance (CG156) Overview | Fertility problems: assessment and treatment | Guidance | NICE
- Human Fertilisation and Embryo Authority (HFEA) HFEA: UK fertility regulator | HFEA
- Derby & Derbyshire ICB Gamete Storage Policy (July 2023) Gamete_Storage_Policy

Hysterectomy for Menorrhagia (Heavy bleeding)

Prior approval not required but must be delivered in line with criteria

Please refer to EBI Guidance Hysterectomy for heavy menstrual bleeding - EBI (aomrc.org.uk) Hysterectomy is the surgical removal of the uterus. Hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.

Treatments for women with no identified pathology, or for Fibroids less than 3cm in diameter or suspected or diagnosed adenomyosis:
In line with NICE Guidance, the ICB will only fund when **all** the following criteria are met:

- After an unsuccessful trial with a levonorgestrel intrauterine system (LNG-IUS – Hormone Coil) for at least 6 months and it has failed to relieve symptoms, or where it is medically inappropriate or contraindicated

  AND

- At least two of the following treatments have:
  - Failed, or
  - Are not appropriate, or
  - Are contraindicated in line with the NICE guidelines:
    - Non-steroidal anti-inflammatory agents
    - Tranexamic acid
    - Other hormone methods (injected progesterone, combined oral contraceptives, Gnrh analogue)

      AND

    - A surgical treatment such as, endometrial ablation, uterine artery embolisation or myomectomy has been offered and has failed to relieve symptoms, or are not appropriate or are contraindicated

For Fibroids of 3cm or more in diameter:
In line with NICE Guidance, consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids 3 cm or more in diameter.

The ICB **will only** fund hysterectomy for heavy menstrual bleeding due to fibroids greater than 3 cm when **all** the following criteria are met:

- Other symptoms (e.g., pressure symptoms) are present

  AND

- There is evidence of severe impact on quality of life

  AND

- Other pharmaceutical options have failed

  AND

- Patient has been offered myomectomy and/or uterine artery embolisation (unless medically contraindicated)

For more information, please refer to:

- NICE Guidance (NG88), Heavy menstrual bleeding, assessment and management Overview | Heavy menstrual bleeding: assessment and management | Guidance | NICE

Specialist Fertility Services – including Assisted Conception
Prior approval not required but must be delivered in line with criteria
In vitro fertilisation (IVF) Patients **will only** be funded for IVF if they meet the agreed criteria as set out in the ICB's policy for Accessing Fertility Treatment: CG - 004 - In Vitro Fertilisation (IVF) Policy (icb.nhs.uk) **Intrauterine insemination (IUI)** Patients **will only** be funded for IUI if they meet the agreed criteria as set out in the ICB's policy for Accessing Fertility Treatment: CG - 001 Intrauterine Insemination (IUI) Policy (icb.nhs.uk)

Removal of Deep Contraceptive Implant

Prior Approval required for Secondary Care

DEEP CONTRACEPTIVE IMPLANT REMOVAL PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

The contraceptive implant is a small flexible plastic rod that's placed under the skin in your upper arm by a doctor or nurse. It releases the hormone progestogen into your bloodstream to prevent pregnancy and lasts for 3 years.

In the removal of a deep contraceptive implant – 'deep' would be described as not easy to palpate/locate and usually deep within the subcutaneous fat or below it.

Please note:
This procedure should ideally be performed under guidance of a simple ultrasound scan. However, if the implant is impalpable, it should not be performed in CSS if ultrasound is not available.

For more information, please refer to:

- NHS Website for England: Contraceptive implant - NHS (www.nhs.uk)
- NICE CKS - This refers to removal of impalpable implant Scenario: Progestogen-only implant | Management | Contraception - progestogen-only methods | CKS | NICE

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

14 Lifestyle, Obesity and Weight Management

Obesity and Specialised Tier 3 and Tier 4 Weight Management services
Prior approval not required but must be delivered in line with criteria

Obesity and Specialised Tier 3 and Tier 4 Weight Management services are only available for adults aged 18 years or over. Please note, Tier 3 and Tier 4 Weight Management services are not appropriate for pregnant and breastfeeding people.

In line with NICE Guidance, the management of overweight and obesity in the NHS is broadly structured into tiered services:

- Tier 1 services provide universal interventions such as population level health promotion and advice
- Tier 2 services include community-based diet, nutrition, lifestyle, and behaviour change advice for up to 12 weeks
- Tier 3 services are a community/primary care based multi-disciplinary team (MDT) to provide an intensive level of input to patients
- Tier 4 service provide similar multidisciplinary team interventions to tier 3, but also manage bariatric surgery and bariatric medicine

Patients should in the first instance be referred and have completed local weight management programmes, for Tiers 1 and 2, which provide the patient with lifestyle and dietary guidance advice.

Please note: The ICB stipulates that Tiers 2, 3 and 4, must involve face to face consultation with the patient.

Tier 1

These are community-based programmes designed to help individuals manage their weight through diet, nutrition, lifestyle, and behaviour changes. There is a free NHS Weight Loss Plan application Lose weight - Better Health - NHS (www.nhs.uk) which is intended for use by adults with a BMI of 25+ (≥23 for people from Black, Asian, and ethnic minority backgrounds).

Tier 2

Following face to face consultation with the patient, GPs should identify a healthcare professional, who will act as the advisor for patients with a BMI of 30+ (≥27.5 for people from Black, Asian, and ethnic minority backgrounds) to each patient assisting them by drawing up a specific programme of non-surgical measures. Regular assessment should be undertaken to review progress. Non-surgical resources are available to control obesity include counselling, psychological assessment and programme, exercise programme and Dietitian input.

There are 3 options for Tier 2 services in Lincolnshire to support patients, and the ICB has developed a specific referral pathway:

1) **Digital Weight Management Programme (DWMP)**
   A free 12-week programme accessible via a smartphone or computer with internet access: NHS Digital Weight Management Tool this is only open to patients:

- Aged 18+
- BMI of 30+ (≥27.5 for people from Black, Asian, and ethnic minority backgrounds)
- Have a diagnosis of diabetes (type 1 or type 2), hypertension or both

The DWMP is only accessible to patients following referral from a GP or Pharmacist Further information (including how to access referral template) and is suitable for patients with complex comorbidities who are waiting to access Tier 3 Weight Management support from the ICB's commissioned provider at University Hospitals of Derby and Burton NHS Foundation Trust; and therefore, we advise that referrals are made for patients to the DWMP, if they are digitally enabled.

DWMP is to be used as a step-up or step-down from the Tier 3 pathway. It is possible that individuals with a higher BMI may receive higher levels of intervention and support from the programme, dependent on their age, sex or ethnicity.

2) **One You Lincolnshire (OYL)**
Patients and GPs can access additional Tier 2 services through Home | One You Lincolnshire where all the following criteria are met:

- Aged 18+
- Registered with a Lincolnshire GP
- Those motivated to lose weight and ready to make a lifestyle change
- Those with a BMI 30+ (≥27.5 for people from Black, Asian, and ethnic minority backgrounds)

3) **NHS Diabetes Prevention Programme (NDPP)**
Known as 'Healthier You' is a national programme aimed at preventing type 2 diabetes in high-risk individuals. This programme is a free service for people living with prediabetes and those who have a history of gestational diabetes. This 9 month programme combines specialist nutrition, psychology and physical activity to promote long term behaviour change, and is available both in person and digitally: NHS England » NHS Diabetes Prevention Programme (NHS DPP) Patients at risk of diabetes are eligible for the NDPP through referral from a healthcare professional where all the following criteria are met:

- Aged 18+
- Registered with a Lincolnshire GP
- Not pregnant (unless you currently have Gestational Diabetes)
- Able to do light/moderate physical activity
- Have not been previously diagnosed with type 2 diabetes

Tier 3

The GP practice will support the patient in a co-ordinated way for Tier 2 **for at least 2 years and must undertake a face to face consultation with the patient** prior to considering a referral to a Tier 3 Weight Management Programme (WMP).

NICE recommends that referrals to Tier 3 services are considered for people in specific circumstances. In exceptional circumstances, an earlier referral to Tier 3 may be considered. This includes, for example, when a patient has a complex disease state or needs that cannot be managed adequately in Tier 2. It is advisable that patients have already completed a Tier 2 weight management program, as these foundational steps are essential to ensure that all less-intensive options have been explored before progressing to the more specialised and intensive support provided in Tier 3.

Any consideration of pharmacotherapy treatment as part of Tier 3 WMP will only be after dietary, exercise and behavioural approaches have been commenced and evaluated, following face to face consultation with the patient.

Patients may be referred to University Hospitals of Derby and Burton NHS Foundation Trust's University Hospitals of Derby and Burton NHS (uhdb.nhs.uk) Tier 3 Weight Management Service **through the EACH** (with the completion of Royal Derby Hospital's Referral form on the NHS e-Referral Service (e-RS)) where the following criteria are met.

For each criteria, please specify the condition and provide supporting evidence:

Please note: All patients referred to Tier 3 will only be accepted if evidence is presented to demonstrate sustained and co-ordinated Tier 1 and 2 community interventions have been tried and failed, for a minimum period of 2 years.

- **The patient is aged 18 years or over**

  AND

Criteria 1
a) BMI > 40 (≥37.5 for people from Black, Asian, and ethnic minority backgrounds)

AND

b) Type 2 diabetes with

AND

c) either one of the following
- Inadequate Control (HBA1c >64mmol/mol) on maximal oral therapy
- Presence of nephropathy (eGFR <45 OR Albumin: Creatinine ratio >10mg/mmol)
- Metabolic dysfunction associated Steatohepatitis (MASH - aka as NASH)
- Onset of diabetes under the age of 40 years old
- Insulin resistance (>2units/kg/day)

Criteria 2
a) BMI >35 (≥32.5 for people from Black, Asian, and ethnic minority backgrounds)

AND

b) Requiring time-sensitive surgery/procedure: e.g. Organ transplant, arthroplasty because of immobility, spinal surgery, cardiac surgery, cancer surgery, limb or sight saving surgery, abdominal wall hernia repair, fertility treatment (N.B. this list is not restrictive and subject to discretion of MDT team)

Criteria 3
a) BMI > 40 (≥37.5 for people from Black, Asian, and ethnic minority backgrounds)

AND

b) at least two of the following significant comorbidities:
- BMI >50 (≥47.5 for people from Black, Asian, and ethnic minority backgrounds)
- Sleep apnoea requiring CPAP
- Systolic or diastolic cardiac dysfunction (i.e. Heart failure)
- Resistant hypertension (3 or more blood pressure tablets)
- Idiopathic intracranial hypertension
- Metabolic dysfunction associated Steatohepatitis (MASH - aka as NASH)
- Atrial fibrillation

Criteria 4
Any rare or monogenic condition where bariatric surgery or drug intervention has been shown to provide significant clinical benefit. Please note, these will be assessed on an individual basis.

PLEASE NOTE: People with a South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean family background use a lower BMI thresholds by 2.5 kg/m2.

Tier 4

Following face to face consultation with the patient, this service is provided by University Hospitals of Derby and Burton NHS Foundation Trust. Patients may be referred to Tier 4 by their Tier 3 specialist, and this approach will be adjusted depending on the patient's clinical needs, in line with NICE Guidance: Overview | Obesity: identification, assessment and management | Guidance | NICE Please note, onward referral to this service is for consideration of an intervention and is not an indication that surgery will be undertaken.

Tier 4 services include specialist care: 1:1 management provided by specialist obesity medical and surgical MDTs with full access to a full range of medical specialists as required. The difference between the medical specialty at tiers 3 and 4 will be a qualitative level of experience in complex patient management. All surgical procedures will take place in Tier 4.

For further information please refer to:

Overweight and obesity management, NICE guideline (NG246), Published: 14 January 2025: Overview | Overweight and obesity management | Guidance | NICE

NICE Obesity prevention, Clinical guideline (CG43) Published: 13 December 2006 Last updated: 13 March 2015: Overview | Obesity prevention | Guidance | NICE

NHS Choices: Overview: Obesity: Obesity - NHS (www.nhs.uk)

Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years, NICE guideline (NG247) Published: 15 January 2025: Overview | Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years | Guidance | NICE

15 Ophthalmology treatment policies criteria

Blepharoplasty/Ptosis surgery
Prior Approval Required
Blepharoplasty and Ptosis surgery **will only be funded** when **all** the appropriate criteria are met. **Blepharoplasty criteria:** • Patient has documented complaints of interference/function with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin or eyebrow looking through the eyelids or seeing the upper eyelid skin **AND** • There is redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead or in the resting position, there is significant eyebrow drooping affecting the upper eyelid position **AND** • Visual field testing has been performed and documented results clearly demonstrate that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly. **Brow lift for brow ptosis criteria:** • Patient has documented complaints of interference/function with vision or visual field related activities such as difficulty reading or driving due to eyebrow drooping, looking through the eyelids or seeing the upper eyelid skin **AND** • In the resting position, there is significant eyebrow drooping affecting the upper eyelid position - with photographic evidence to support this **AND** • Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly. **Eyelid Ptosis criteria:** • Patient has documented complaints of interference/function with vision or visual field related activities such as difficulty reading or driving due to eyelid drooping or looking through the eyelids **AND** • In the resting position, there is significant eyelid drooping affecting the upper eyelid position - with photographic evidence to support this **AND**

- Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly.

EXCLUSIONS:

Prior approval is **not** required to repair defects predisposing to corneal or conjunctival irritation:

- Entropion or ectropion
- Periorbital sequelae of thyroid disease or nerve palsy or trauma
- Prosthesis problems in an anophthalmia socket
- Painful symptoms of blepharospasm

For more information, please refer to:
The British Association of Aesthetic Plastic Surgeons, Eyelid Surgery (Blepharoplasty)
Eyelid Surgery (Blepharoplasty) | The British Association of Aesthetic Plastic Surgeons (baaps.org.uk)

Cataract Surgery

Prior approval not required but must be delivered in line with criteria

Please refer to EBI Guidance Shared decision making for cataract surgery - EBI

Surgery for cataracts, in which the natural lens is replaced by a clear intraocular lens implant.

Patients may benefit from cataract surgery in the first or second eye when:

- They have evidence of significant cataract on assessment (via GOS18 form for opinion and assessment to see if the patient fits the ICB's criteria for cataract surgery)

  and

- Patient with a best corrected visual acuity (VA) of 6/12 or worse in either the first or second eye

  or

- Patient who is a bus or lorry driver (HGV), a best corrected visual acuity of 6/7.5 or worse in their best eye; for more information please see: Driving eyesight rules - GOV.UK (www.gov.uk)

Plus, one or more of the following:

- **Visual disability:** can no longer undertake their usual activities such as reading or watching television, or activities relating to their employment (if applicable)

  Or

- **Visual symptoms attributable to cataract:** e.g., significant glare and dazzle in daylight or difficulties with night vision, due to the lens opacity. (This may particularly affect patients who need to drive at night.)

  Or

- **Asymptomatic risk/disability:** They have difficulty with activities of daily living or self-care, and/or are at increased risk of falls due to impaired vision

  Or

- They are a carer for their partner or other dependent adult and the cataract limits their ability to provide care

Cataract surgery is indicated irrespective of visual acuity for patients who have ocular co-morbidities e.g., glaucoma, diabetic retinopathy or symptomatic anisometropia.

For more information, please refer to:
NICE guidance Overview | Cataracts in adults: management | Guidance | NICE

Eyelid Cysts (or meibomian cyst) – Chalazia

Prior Approval Required for Secondary Care

EYELID CYST PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI Guidance Chalazia removal - EBI (aomrc.org.uk)

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

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

If malignancy (cancer) is suspected e.g., Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions.

For all patients, hospitals may only accept routine referrals where Prior Approval has been provided.

For more information, please refer to:
Meibomian cyst (chalazion), Last revised in April 2024 Meibomian cyst (chalazion) | Health topics A to Z | CKS | NICE

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

16 Physiotherapy treatment policies criteria

Cough Assist/Mechanical Insufflation and Exsufflation (MI-E) device

Prior approval Required

This policy applies to patients (adults and children) who have an ineffective/weak cough due to neuromuscular disease or cervical spinal cord injury.

Treatment:
Cough Assist is a non-invasive therapy that safely and consistently removes secretions in patients with an ineffective ability to cough (peak cough flow <270 l/m). The Cough Assist device clears secretions by gradually applying a positive pressure to the airway, then rapidly shifting to negative pressure. The rapid shift in pressure produces a high expiratory flow, simulating a natural cough. It can be used with a face mask, mouthpiece or with an adapter to a patient's endotracheal or tracheostomy tube. It is approved for home use in adults and children and is available in automatic and manual models.

Benefits:

- Removes secretions from the lungs and a safe, non-invasive alternative to suctioning
- Reduces the occurrence of respiratory infections and the ensuing requirement for antibiotics
- Supports a patient to avoid hospitalisation and need for intubation and tracheostomy
- Lung volume recruitment (LVR) and prevents atelectasis
- Decreases the risk of patient mortality
- Easy for patients and caregivers to operate and approved for home use in adults and children
- Portable so patients can increase independence and clear secretions in community, thereby improving quality of life

Criteria:

Funding **will only** be approved where **all** the following criteria are met:

- The patient must be diagnosed with one of the following conditions:
  - Motor Neurone Disease
  - Spinal Muscular Atrophy
  - Muscular Dystrophy
  - Myasthenia gravis
  - Spinal cord injury
  - Multiple Sclerosis
  - Guillain-Barre Syndrome
  - Post-polio syndrome with respiratory impairment
  - Kypho-scoliosis
  - Syringomyelia
  - Other neuromuscular/neurological disease which is known to cause respiratory muscle weakness or upper airway functional impairment

AND

- In line with the above diagnosis the patient must also be unable to cough or clear secretions effectively:

- PCF (Peak Cough Flow) less than 160 L/min

  OR

- VC (vital capacity) below 1.1L in general respiratory muscle weakness

  OR

- Reduced Peak Cough Flow (PCF) of 270 l/pm or < 270 l/pm and have clinical symptoms

  OR

- A weak cough and therefore require intervention necessary to clear bronchial secretions or infection

AND

- The patient must be assessed by a Specialist Consultant with Specialist Interest in Respiratory with expert clinical knowledge and experience in the use of Cough Assist machines

AND

- A successful trial of a Cough Assist Machine, prior to the patient being supplied with a Cough Assist Machine in the community

Please note:

For each patient funded with a Cough Assist Machine the provider should undertake regular monitoring to ensure there is evidence that continuation of treatment is clinically effective, in line with criteria, and that this is documented.

For more information, please refer to:

- British Thoracic Society British Thoracic Society (brit-thoracic.org.uk)
- Motor neurone disease: assessment and management NICE guideline (NG42) Published: 24 February 2016 Last updated: 23 July 2019 Overview | Motor neurone disease: assessment and management | Guidance | NICE
- Birmingham & Solihull ICB Policy for the use of Mechanical Insufflator/Exsufflator (MI-E) -Cough Assist Machines Policy for the use of Mechanical Insufflator/Exsufflator Cough Assist Machines

17 Trauma & Orthopaedic treatment policies criteria

Acromioplasty (Subacromial Decompression for shoulder pain)
Prior approval required

Please refer to EBI Guidance Arthroscopic shoulder decompression for subacromial pain - EBI (aomrc.org.uk)

Pain in the absence of associated diagnosis is called 'impingement syndrome'. Pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as, rotator cuff tears, acromio-clavicular joint pain or calcific tendinopathy, and non-operative treatments such as physiotherapy and exercise programmes are effective and safe in many cases. .

The ICB **will not** routinely fund arthroscopic acromioplasty for:

- Diagnostic purposes
- Shoulder decompression where there is significant osteoarthritis of the glenohumeral joint
- Open Acromioplasty

The ICB **will only** fund arthroscopic acromioplasty for subacromial decompression where **all** of the following criteria are met (and are clearly documented):

- The patient has a BMI<35 and is a non-smoker
- The patient has had persistent or progressive symptoms, despite adequate non-operative treatment/symptoms, for at least 6 months, together with a trialled period of conservative management to include:
    - Use of Paracetamol/NSAIDs (where appropriate) and home exercises
    - Where home exercises and Paracetamol/NSAIDs (where appropriate) are ineffective, the patient has completed a course of physiotherapy

  AND
- Symptoms are intrusive and debilitating, pain and loss of function

  AND
- MRI/Ultrasound/Clinical examination confirms full thickness rotator cuff tear

  OR
- Adhesive capsulitis, non-traumatic instability, calcific tendonitis, or acromioclavicular arthritis/join pain

PLEASE NOTE:

- **Patients with a BMI >35**

  AND/OR
- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily that there are exceptional individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to One You Lincolnshire Home | One You Lincolnshire

The patient should commit to a documented weight loss and exercise programme (this can be gentle exercise which will contribute to weight loss) programme for 3 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain then the patient may be referred to an appropriate healthcare professional for consideration of surgery.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to One You Lincolnshire Home | One You Lincolnshire

EXCLUSIONS:
Red Flag (*are signs and symptoms in patient diagnostic tests that may suggest a serious pathology)*

- Trauma, pain and/or weakness – suspected acute cuff tear
- Evidence of mass or swelling – suspected tumour
- Red skin, fever or systemically unwell – suspect infection
- Trauma/epileptic fit/electric shock leading to loss of rotation and abnormal shape – suspect an unreduced dislocation

For more information, please refer to:

- Subacromial Shoulder Pain - Commissioning Guide Subacromial Shoulder Pain - Commissioning Guide — Royal College of Surgeons (rcseng.ac.uk)
- Shoulder pain: Management, Last revised in November 2022 Management | Shoulder pain | CKS | NICE
- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines

Bunion (Hallux Valgus)

Prior approval required

Hallux valgus (often referred to as a bunion) is the deviation of the big toe (the hallux) away from the mid-line towards the lesser toes.

The ICB **will only** fund surgery for bunions only when the following criteria are met:

- Non-surgical treatments have been undertaken for a minimum of 6 months and have been unsuccessful (conservative management must be evidenced by the GP in the onward referral to secondary care)

  AND

- The bunion is severe and causing significant, persistent pain and discomfort to the patient (not relieved by chronic standard analgesia), preventing activities of daily living

  AND

- Severe deformity greater than 25 degrees leading to significant functional impairment or inability to wear suitable shoes

  OR

- There are recurrent or chronic ulcers and/or infections at the site of the bunion

  OR

- There is significant pain under the ball of the foot

  AND

- The patient's quality of life is affected by the amount of pain

The ICB **will not** fund bunion surgery for:

- Asymptomatic hallux valgus, regardless of cosmetic appearance, or
- Prophylactic or cosmetic reasons, or
- Minimal invasive bunion surgery

EXCLUSIONS: URGENT REFERRALS:

- Diabetic patients should be referred urgently to the Diabetic Service. Untreated Hallux Valgus in patients with diabetes may lead to ulceration, deep infection or even amputation
- Peripheral limb ischaemia
- Non healing Skin ulcer on the toe

For more information, please refer to:

- Minimally invasive percutaneous surgical techniques with internal fixation for correcting hallux valgus, Interventional procedures guidance (IPG789) Published: 20 June 2024 Overview | Minimally invasive percutaneous surgical techniques with internal fixation for correcting hallux valgus | Guidance | NICE
- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines
- The Royal College of Surgeons of England Commissioning Guide: Painful Deformed Great Toe In Adults

Bursa Excision (Bursitis)

Prior Approval Required for CSS and Secondary Care

BURSA EXCISION PROCEDURES ARE DELIVERED UNDER THE CSS

Please note, Bursa >10cm are not treated in the CSS and require Prior Approval for treatment in Secondary care.

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Bursitis is when a joint becomes painful and swollen. It can usually be treated at home and should go away in a few weeks. Bursitis happens when the fluid-filled sacs (bursa) that cushion your joints become inflamed. Individuals might have bursitis if one of their joints is:

- Painful – usually a dull, achy pain
- Tender or warmer than surrounding skin
- Swollen
- More painful when you move it or press on it

The area may also be red. This can be harder to see on darker skin.

Bursitis can affect any joint, but it's most common in the shoulders, hips, elbows or knees.

The ICB **will only** fund Bursa excision when **all** the following criteria are met:

- Where there is obvious pain

  AND

- Swelling up to 10cm maximum

For more information:

- NHS Choices. Bursitis: Bursitis - NHS

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Carpal Tunnel Syndrome (CTS)

Prior Approval Required for Secondary Care

CARPAL TUNNEL SYNDROME PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI Guidance Carpal tunnel syndrome release - EBI (aomrc.org.uk)

Carpal tunnel syndrome (CTS) is pressure on a nerve in your wrist. It causes tingling, numbness and pain in your hand and fingers. Mild cases with intermittent symptoms which interfere with activities or sleep should first be treated with:

- Corticosteroid injection(s) (medication injected into the wrist: good evidence for short (8-12 weeks) term effectiveness)

  OR

- Night splints (a support which prevents the wrist from moving during the night: not as effective as steroid injections)

The ICB **will only** fund surgical treatment of CTS where **one** of the criteria are met:

- Nerve Conduction studies have been undertaken to confirm carpal tunnel **OR**
- The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks **OR**
- There is either:
  - A permanent (ever-present) reduction in sensation in the median nerve distribution

    OR

  - Muscle wasting or weakness of thenar abduction (moving the thumb away from the hand)

Nerve Conduction Studies, if available, are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

De Quervain's Tenosynovitis Injection/Surgery

Prior Approval Required for CSS and Secondary Care

DE QUERVAIN'S INJECTION OF TENDONITIS ARE DELIVERED UNDER THE CSS (injections do not require prior approval in CSS)

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

De Quervain's tenosynovitis (De Quervain's) is a condition affecting the tendons that run into the thumb. These tendons run through a tunnel or sheaths which are involved in the movement of the thumb. It is the inflammation of this tendon sheath that leads to increased pain, thus can become a nuisance and very painful at the base of the thumb and swelling which may travel into the lower arm. Movements of the thumb and activities such as pinching, and gripping can be especially painful.

The ICB **will only** fund treatment, for De Quervain's where the following criteria are met:

- Patients may be referred where there is persistent pain after:
  - Physiotherapy treatment has been undertaken

    OR
  - Regular exercises to move the tendons to strengthen the muscles in the wrist and thumb

    OR
  - Resting the wrist in a splint has not helped

For more information, please refer to:

- The British Society for Surgery of the Hand, De Quervain's syndrome: De Quervain's syndrome | The British Society for Surgery of the Hand (bssh.ac.uk)
- The Effectiveness of Corticosteroid Injection for De Quervain's Stenosing Tenosynovitis (DQST): A Systematic Review and Meta-Analysis: The Effectiveness of Corticosteroid Injection for De Quervain's Stenosing Tenosynovitis (DQST): A Systematic Review and Meta-Analysis - PMC

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Discectomy – Cervical Spine
Discectomy/Micro discectomy/Anterior cervical decompression with or without fusion, or un-instrumented posterior cervical decompression, including revision surgery

Prior approval required

The ICB **will only** fund spinal surgical treatment where **all** the following criteria are met:

- Symptoms of pain persist despite non-operative treatments or fail to settle after 6 months of conservative management (3 months in exception). Conservative management, such as:
  - Medication with the correct usage of optimal tolerated doses of analgesia (Paracetamol/NSAIDs or Opioid analgesics)
  - Physical therapy

  OR

- There is evidence of abnormal or progressive neurological symptoms

  AND

- The patient's BMI is <35.0 and is a non-smoker

  AND

- The patient is 18 years or older

  AND

- The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms

  AND

- The patient has a corresponding neurologic deficit

  OR

- The patient has significant weakness in their hand or arm consistent with the level of spinal involvement, arm pain worse than neck pain

  OR

- There is evidence of nerve root irritation with a positive nerve root tension

PLEASE NOTE:

- **Patients with a BMI >35**

  AND/OR

- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily that there are exceptional individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to One You Lincolnshire Home | One You Lincolnshire

The patient should commit to a documented weight loss and exercise programme (this can be gentle exercise which will contribute to weight loss) programme for 3 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain then the patient may be referred to an appropriate healthcare professional for consideration of surgery.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to One You Lincolnshire Home | One You Lincolnshire Where stop smoking status is achieved, the patient may be referred to an appropriate healthcare professional for consideration of surgery.

EXCLUSION:
Patient with severe symptoms requiring emergency admission and those patients with recent neurological deficit.

For more information, please refer to:

- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines

Discectomy - Lumbar
Discectomy/micro discectomy for lumbar disc prolapse, Posterior Lumber Decompression/ Discectomy, including Revision Surgery

Prior approval required

Please refer to EBI Guidance Lumbar discectomy - EBI (aomrc.org.uk) This guidance applies to adults aged 19 years and over.

A discectomy is the surgical removal of intervertebral disc material to treat the symptoms resulting from compression of one or more spinal nerve roots.

This loose material, which is part of the natural degeneration of the disc with age, is often described as bulging, prolapsed, herniated, or slipped, resulting in pressure on the nerve root/s.

The symptoms it causes are called radiculopathy or sciatica and can include pain, tingling, pins and needles, numbness, weakness, and rarely bowel and bladder problems. As often, the symptoms will settle naturally, non-operative treatment is the preferred initial option.

The ICB will **not fund** spinal surgery for patients with lower back pain.

Patients presenting with radiculopathy who show objective evidence of clinical improvement within six weeks (e.g., VAS pain scores) are more likely than not to continue improving with non-operative treatment, such as:

- Reassurance and advice on continuation of activity with modification
- Weight-loss
- Analgesia
- Manual therapy

As well as screening those patients who are high risk of developing chronic pain.

The ICB **will fund** Lumbar Discectomy where **all** the following criteria are met:

- The patient has a BMI<35 and is a non-smoker

  AND

- In the presence of concordant MRI changes, Lumbar Discectomy may be offered to patients with:
  - Prolapsed disc or sciatica with nerve root compression with symptoms lasting for 3 months or more, despite best efforts with non-operative management (except in severe cases)

    OR

  - Severe central spinal stenosis with claudication symptoms of both legs

PLEASE NOTE:

- **Patients with a BMI >35**

  AND/OR

- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily the patient's individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to Home | One You Lincolnshire

The patient should commit to a documented weight loss and/or exercise programme (this can be gentle exercise which will contribute to weight loss) for 3 months.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to Home | One You Lincolnshire
Where a non-smoking status is achieved, the patient may be referred to an appropriate healthcare professional for consideration of surgery.

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

For more information, please refer to:

- Nice Guideline (2016) Low back pain and sciatica in over 16s: assessment and management (NG59) Overview | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE
- NHS England, Trauma programme of care (2017) National Low Back and Radicular Pain Pathway NHS England » The National Back Pain Pathway
- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines

Dupuytren's Contracture

Prior Approval Required for CSS and Secondary Care

DUPUYTREN'S CONTRACTURE INTERVENTIONS ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI Guidance Dupuytren's contracture release in adults - EBI (aomrc.org.uk)

Dupuytren's contracture is when one or more fingers bend in towards the palm and mainly affects the ring and little fingers. It can be present in both hands at the same time. It tends to get slowly worse over many months or years. Treatment cannot usually help in the early stages.

In line with EBI Guidance, intervention/treatment **is not indicated** in cases where:

- There is no contracture
- The contracture is mild (less than 20º contracture)
- The contracture is not progressing and does not impair function

The ICB **will only** fund intervention (needle fasciotomy, fasciectomy and dermo-fasciectomy) where the following criteria are met:

- Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint with significant interference with function **OR**
- Severe thumb contractures with significant interference with function

There is inadequate evidence to recommend the use of radiation therapy in the management of Dupuytren's disease. It should only be used with special arrangement for clinical governance, audit or research.

For more information, please refer to:

- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines
- Dupuytren's contracture decision tool NHS_Dupuytren's_contracture_decision_tool (england.nhs.uk)
- CKS Dupuytren's disease August 2022 Dupuytren's disease | Health topics A to Z | CKS | NICE
- The British Society for Surgery of the Hand Dupuytrens disease

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Ganglion Excision

Prior Approval Required for CSS and Secondary Care

GANGLION TREATMENTS ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please note, Ganglia >5cm are not treated in the CSS and require Prior Approval for treatment in Secondary care.

Please refer to EBI Guidance Ganglion excision - EBI (aomrc.org.uk)

Ganglia are cystic swellings containing jelly-like fluid which form around the wrists or in the hand.

In most cases, wrist ganglia cause only mild symptoms which do not restrict function, and many resolve without treatment within a year.

Wrist ganglion rarely press on a nerve or other structure, causing pain and reduced hand function. Ganglia in the palm of the hand (seed ganglia) can cause pain when carrying objects. Ganglia which form just below the nail (mucous cysts) can deform the nail bed and discharge fluid, but occasionally become infected and can result in septic arthritis of the distal finger joint.

Not all ganglions require surgery. Referral may be made where conservative treatment has failed, e.g., aspiration **and** there is pain or tingling/numbness or concerns (is cancer).

The ICB **will only** fund surgical excision where the following EBI recommendations have been undertaken:

Wrist/volar/foot/knee ganglia

- No treatment unless causing pain or tingling/numbness or concern (ie. malignant)
- Aspiration if causing pain, tingling/numbness, or concern
- Surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function

Seed ganglia that are painful

- Puncture/aspirate the ganglion using a hypodermic needle
- Surgical excision only considered if ganglion persists or recurs after puncture/aspiration

Mucous cysts

- No surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity

For more information, please refer to:

- NICE Trauma and Orthopaedic Guidelines NICE Trauma and Orthopaedic Guidelines
- The British Society for Surgery of the Hand, Ganglion cysts Ganglion cysts | The British Society for Surgery of the Hand (bssh.ac.uk)
-

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Hip Arthroscopy

Prior Approval Required

The ICB **will only** fund Hip Arthroscopy for the following groups of patients with the following criteria:

- **Sepsis of the hip joint**

  Hip arthroscopy is supported in the washout of an infected native hip joint (i.e., patients who have not had a hip replacement) in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed.

- **Loose bodies**

  Hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.

- **Excision of radiologically proven labral tears in the absence of osteoarthritis or femur-acetabular impingement syndrome**

  Hip arthroscopy is supported for the excision of radiologically proven labral tears associated with an acute traumatic episode in the absence of osteoarthritis or femoral-acetabular impingement syndrome.

Hip arthroscopy **is not routinely commissioned** for the treatment of hip impingement syndrome, or any other indication, pathology or for diagnostic purposes.

For more information, please refer to:

- Commissioning Guide: Pain Arising from the Hip In Adults
- Arthroscopic femoro–acetabular surgery for hip impingement syndrome, Interventional procedures guidance (IPG408) Published: 28 September 2011 Overview | Arthroscopic femoro–acetabular surgery for hip impingement syndrome | Guidance | NICE
- Commissioning Policy (EMSCGP047V1), Policy: Arthroscopy of the Hip EMSCG P047V1 Hip Arthroscopy Policy (ICB)

Hip replacement (primary)
Prior approval not required but must be delivered in line with criteria (See Exceptions)

NICE Guidelines for Osteoarthritis: care and management, NG226: Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE suggest the initial non-surgical management of hip pain, due to Osteoarthritis, should provide a conservative package of care, which may include:

- Weight reduction
- Activity modification
- Patient specific exercise programme
- Adequate doses of Paracetamol/NSAIDs (where appropriate) and analgesics, joint injections
- Walking aids and other forms of physical therapies

Referrals should only be considered when other pre-existing medical conditions have been optimised and conservative management has been undertaken prior to the patient being referred to secondary care.

The ICB will fund prostheses which meet the guidelines set out in NICE Technology Appraisal Guidance 304 Overview | Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip | Guidance | NICE The ICB would anticipate cemented hip replacement being used in preference to non-cemented, if clinically appropriate.

The ICB **will only** fund referral for consideration of primary hip replacement where **all** the following criteria are met:

- The patient has a BMI<35 and are a non-smoker

  AND

All the below conservative management measures have been undertaken:

- Medication – the patient should be taking optimal tolerated doses of analgesia and understand the correct uses (Paracetamol/NSAIDs or Opioid analgesics)

  AND

- Physiotherapy attendance – NICE ‘core’ treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy – (Physiotherapy is ineffective in bone-on-bone osteoarthritis)

  AND

- Received education regarding lifestyle, the need to maintain or lose weight, encouragement to stop smoking with providing support and a referral to One You Lincolnshire Home | One You Lincolnshire

  AND

- Where there is uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of maximal conservative treatment for the past 3 months. A diagnostic tool such as the Oxford Score with a score of <20 is a useful tool in assessing level of pain.

EXCEPTIONS:
PLEASE NOTE, PRIOR APPROVAL IS REQUIRED FOR:

- **Patients with a BMI >35**

  AND/OR

- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily the patient's individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to Home | One You Lincolnshire The patient should commit to a documented weight loss and exercise programme (this can be gentle exercise which will contribute to weight loss) programme for 3 months. Where weight loss is achieved and there is uncontrolled, intense persistent pain then the patient may be referred to an appropriate healthcare professional for consideration of surgery.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to Home | One You Lincolnshire
Where a non-smoking status is achieved, the patient may be referred to an appropriate healthcare professional for consideration of surgery.

Injections as a treatment for persistent pain
Prior approval not required but must be delivered in line with criteria
The ICB criteria is as following: • All patients should be referred to the Lincolnshire Community Pain Management Service and any treatment offered is as part of that service, if appropriate, and in line with the relevant NICE and Evidence-Based Guidance. • No referral should be made or accepted by other providers except where a patient is referred by the Lincolnshire Community Pain Management Service. • Injections are not recommended as a first-line treatment for persistent pain and should only be considered as one part of a multimodal pain management approach. This is in line with NICE and Evidence-based guidelines, which recommend a range of non-invasive treatments for people with persistent pain, these include education, advice and information, exercise and physical activity, psychological therapy and pharmacology following a biopsychosocial assessment of individual need. **FOR FURTHER INFORMATION, PLEASE REFER TO:** • NICE Guidelines for Osteoarthritis in over 16s: diagnosis and management: NG226: Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE • NICE Guidelines for Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain, NG193: Overview | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE • Low back pain and sciatica in over 16s: assessment and management, NG59: Overview | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE

Knee arthroscopy in conditions other than Osteoarthritis

Prior approval required

Please refer to EBI Guidance Arthroscopic surgery for meniscal tears - EBI (aomrc.org.uk)
This guidance applies to adults and children.

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

The ICB **will only** fund knee arthroscopy where **all** the criteria are met:

- There is clear evidence of internal joint derangement, as demonstrated by a competent clinical examination. Internal joint derangement may be because of one of the following:
    - A meniscal tear or an acute injury and MRI scan reveals a potentially reparable meniscus tear
    - Articular cartilage pathology (osteophytes)
    - 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 3 months conservative treatment has failed and not addressed the symptoms. Conservative treatments include, for example, adequate analgesia, Paracetamol/NSAIDs (where appropriate), physiotherapy/exercise programmes, and losing weight, if necessary

AND

- An MRI scan confirming the internal joint derangement

OR

- A locked knee and an urgent assessment, showed a bucket handle tear of the meniscus is present

Knee arthroscopy for diagnostic purposes **will not** routinely be funded by the ICB. The use of arthroscopy in patients with generic degenerative knee disease and/or no specific target pathology has not been found to be clinically beneficial.

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/signs suggestive of tumour/infection.
- Arthroscopy carried out in conjunction with open surgery

For further information, please refer to:

- NICE Guidelines for Osteoarthritis in over 16s: diagnosis and management: NG226
  Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE

Knee arthroscopy for patients with Osteoarthritis

Prior approval required

Please refer to EBI Guidance Knee arthroscopy for patients with osteoarthritis - EBI (aomrc.org.uk)

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

The ICB **will only** fund knee arthroscopy for patients with Osteoarthritis where the following criteria are met:

- 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.

  AND

- Conservative treatments have been undertaken such as, analgesia, Paracetamol/ NSAIDs (where appropriate), exercise programmes and losing weight, if necessary, with support and a referral to One You Lincolnshire Home | One You Lincolnshire

EXCLUSIONS:

This policy criteria 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

The following procedures **are not** recommended by NICE Guidance

- Knee replacement of meniscus with biodegradable scaffold
- Mosaicplasty
- Trochleoplasty for patella instability
- Removal of loose bodies where there are no derangement/mechanical symptoms

For further information, please see:

- NICE Guidelines for Osteoarthritis in over 16s: diagnosis and management: NG226 Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE
- Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE Guidance: NICE IPG230

Knee Autologous Chondrocyte Implantation

Prior approval not required but must be delivered in line with criteria

Autologous chondrocyte implantation (ACI) is a procedure to treat articular cartilage defects of the knee. This procedure is effective for treating small areas of cartilage damage that cause pain and swelling or restrict the range of motion. Autologous chondrocyte implantation is not indicated for those patients who have advanced arthritis of knee.

The ICB **will only** fund treatment where **all** the following criteria are met:

ACI is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if:

- The patient has not had previous surgery to repair articular cartilage defects

  AND

- There is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis)

  AND

- The defect is over 2 cm^2

  AND

- The procedure is done at a tertiary referral centre

  AND

- The patient's treatment is in line with NICE TA477 Guidance for Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee: Overview | Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee | Guidance | NICE

Knee – Patellofemoral Arthroplasty (PFA)
Prior approval not required but must be delivered in line with criteria

The ICB **will only** fund Patellofemoral Arthroplasty (PFA) where **all** the criteria are met:
• PFA will only be considered for patients with:
  • Severe knee pain not adequately controlled by six months of non-surgical management
  OR
  • Grade III and above arthritis confined to a single joint compartment
AND
• The proposed treatment to be undertaken is line with the Royal College of Surgeon of England Commissioning Guide Topics, Painful osteoarthritis of the knee (2017): Commissioning Guide Topics — Royal College of Surgeons (rcseng.ac.uk)

Knee replacement (primary) including partial knee replacement if appropriate

Prior approval not required but must be delivered in line with criteria (See Exceptions)

The ICB **will only** fund prostheses which are standard.

NICE Guidance for Osteoarthritis in over 16s: diagnosis and management, NG226 Overview | Osteoarthritis in over 16s: diagnosis and management | Guidance | NICE suggests the initial non-surgical management of knee pain due to osteoarthritis, should provide a package of care that may include weight reduction, activity modification, patient specific exercise programme, adequate doses of NSAIDs and analgesics, joint injection, walking aids and other forms of physical therapies. Referral should be considered when other pre-existing medical conditions have been optimised and there is evidence of weight reduction to an appropriate weight.

The GP should ensure that conservative management has been undertaken prior to the patient being referred to secondary care.

The ICB **will only** fund referral for consideration of primary knee replacement where **all** the following criteria are met:

- The patient has a BMI<35 and they are a non-smoker

  AND

All the below conservative management measures have been undertaken:

- Medication – the patient should be taking optimal tolerated doses of analgesia and understand the correct uses (Paracetamol/ NSAIDs or Opioid analgesics)

  AND

- Physiotherapy attendance – NICE 'core' treatments of either guided exercise and muscle strengthening programmes or of supervised physical therapy – (Physiotherapy is ineffective in bone-on-bone osteoarthritis)

  AND

- Received education regarding lifestyle, the need to maintain or lose weight, encouragement to stop smoking with providing support and a referral to One You Lincolnshire Home | One You Lincolnshire

  AND

- Where there is uncontrolled, intense, persistent pain resulting in substantial impact on quality of life and moderate functional limitations which have failed a reasonable period of maximal conservative treatment for the past 3 months. A diagnostic tool such as the Oxford Score with a score of <20 is a useful tool in assessing level of pain

EXCEPTIONS:
PLEASE NOTE, PRIOR APPROVAL IS REQUIRED FOR:

- **Patients with a BMI >35**

  AND/OR

- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily the patient's individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to Home | One You Lincolnshire The patient should commit to a documented weight loss and/or exercise programme (this can be gentle exercise which will contribute to weight loss) for 3 months.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to Home | One You Lincolnshire Where a non-smoking status is achieved, the patient may be referred to an appropriate healthcare professional for consideration of surgery.

Lumbar Radiofrequency Denervation

Prior approval required

Please refer to EBI guidance Lumbar radiofrequency facet joint denervation - EBI (aomrc.org.uk) This guidance applies to adults aged 19 and over.

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

Lumbar radiofrequency facet joint denervation should only be offered in accordance with NICE Guidelines for Low back pain and sciatica in over 16s: assessment and management NG59: Overview | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE which recommends it as an adjunct in the management of chronic low back pain only when non-operative treatment has failed, and the main source of pain is thought to arise from one or more degenerate facet joints.

Facet joints are pairs of joints that stabilise and guide motion in the lumbar spine. These joints are innervated by the medial branches of the dorsal rami. Suitable patients are first offered one or more diagnostic injections called a Medial Branch Block, to determine which facet joints are contributing to their symptoms, and should be offered only in accordance with the National Low Back and Radicular Pain Pathway, May 2017 National Low Back & Radicular Pain Pathway 2017 incl. NICE NG59

Lumbar Radiofrequency Denervation (RFD) for adults with chronic back pain **will only** be funded by the ICB, when **all** the following criteria are met:

- Non-surgical treatment has not been effective
- The main source of pain is thought to come from structures supplied by the medial branch nerve (for diagnostics, the Medial branch block should be administered with no steroid)
- There are moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral
- Patients who experience a positive response to a medial branch block (i.e., a significant but short-term improvement in pain symptoms) may be offered Radiofrequency Denervation to achieve longer-term pain relief

For more information, please refer to:

- Faculty of Pain Management (2015) Core Standards for Pain Management Services in the UK Core Standards | Faculty of Pain Medicine (fpm.ac.uk)

Morton's Neuroma

Prior Approval Required for CSS and Secondary Care

MORTON'S NEUROMA INJECTIONS ARE DELIVERED UNDER THE CSS (injections do not require prior approval in CSS)

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Morton's neuroma is where there's a thickening of tissue around a nerve in the foot that has been irritated or damaged. The symptoms can often be eased with non-operative treatments recommended by a GP. The main symptoms of Morton's neuroma include:

- A shooting, stabbing or burning pain
- Feeling like a pebble or lump is stuck under your foot
- Some people may also have tingling or numbness in their foot

In line with Clinical Knowledge Summaries (CKS) Guidance on the Management of Morton's Neuroma Scenario: Management | Management | Morton's neuroma | CKS | NICE, states:

Conservative measures should include:

- Avoidance of high heels and shoes with a constricting toe box or thin soles, to reduce pressure on the forefoot.
- To use a metatarsal pad
- To avoid (or reduce) impact activities, such as running and jumping
- Consider offering nonsteroidal anti-inflammatory drugs, if necessary. See the CKS topics on Analgesia - mild-to-moderate pain and Paracetamol/NSAIDs (where appropriate) - prescribing issues for prescribing information

If symptoms persist despite 3 months of footwear modifications and using metatarsal pads:

- Refer the person to an orthotist for a metatarsal dome orthotic

If symptoms persist despite a trial of an orthotic device (or referral to orthotics is not available):

- Refer to an orthopaedic surgeon with a special interest in the foot, a musculoskeletal clinic, or a podiatric surgeon for consideration of specialist treatments, such as corticosteroid injections, guided alcohol injections and surgery

The ICB **will only** fund treatment for Morton's Neuroma where **all** the following criteria are met:

- After recommended conservative management measures recommended have failed (in line with CKS)

  AND

- There is significant pain on walking with neurological signs

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

Prosthetic Limbs
Prior approval not required but must be delivered in line with criteria
The ICB **will only** fund any request for a limb that is a standard NHS issue. **For hip, knee and other joint prosthesis:** The ICB will fund revisions using standard prosthesis. **For Custom-made Orthopaedic prosthesis:** The ICB will be fund the actual cost of the prosthesis, in line with NHS England Service Specifications D01/s/d for Complex Disability Equipment – Prosthetic Specialised Services For People Of All Ages With Limb Loss: Service Specification and Clinical Commissioning Policy : Direct Skeletal Fixation for transfemoral limb loss (Adults) [2206]: NHS England » Clinical Commissioning Policy : Direct Skeletal Fixation for transfemoral limb loss (Adults) [2206] **For more information, please refer to:** Clinical Commissioning Policy: Microprocessor controlled prosthetic knees clin-comm-pol-16061P.pdf (england.nhs.uk)

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Spinal Cord Stimulation for Chronic Pain of neuropathic or ischaemic origin
Prior approval not required but must be delivered in line with criteria
The ICB criteria is as following: All patients should be referred to the Lincolnshire Community Pain Management Service and different treatments offered as part of that service, in line with NICE Guidance (TA159). NHS England commissions adult highly specialist pain management services delivered by Specialised Centres working alone or as part of a network with adjacent providers. Networks comprise the following Tiers of service: • Tier I: GP and primary care services and ICB commissioned community pain management services • Tier II: Specialist pain management services provided in secondary care • Tier III: Adult highly specialist pain management (tertiary) services (commissioned by NHS England) **For more information, please refer to:** • NICE Guidance TA159 Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin: Overview | Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin | Guidance | NICE

Spinal Fusion

Prior approval not required but must be delivered in line with criteria (See Exceptions)

Please see EBI Guidance Fusion surgery for mechanical axial low back pain - EBI This guidance applies to adults aged 19 years and over.

Spinal fusion is when two individual spinal vertebrae become joined together by bone formed as a result of surgery. This may involve the use of bone graft and/or surgical implants. The surgery aims to stop movement at segment(s) of the spine to stabilise the joint and remove pain. Spinal fusion is not recommended for patients with isolated back pain where there is no identified cause.

Spinal fusion surgery is not indicated for the treatment of isolated back pain i.e. pain which is localised to the back and not present in lower limbs, unless the following criteria are met:

- Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
- Scoliosis surgery
- Sacroiliac joint dysfunction
- Spinal fusion is appropriate during spinal decompression surgery for nerve compression, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.

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

Spinal fusion is when two individual spinal vertebrae become joined together by bone formed because of surgery. This may involve the use of bone graft and/or surgical implants. The aim of the surgery is to stop motion at that point to stabilise the joint.

The ICB **will only** fund spinal fusion where the following criteria are met:

Spinal Fusion is usually reserved for patients:

- With a symptomatic spinal deformity (e.g., scoliosis)

  OR

- Instability (e.g., spondylolisthesis; trauma)

  OR

- As an adjunct during spinal decompression surgery, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable

  AND

- Patients should have a BMI <35.0

  AND

- Conservative management has failed to reduce symptoms. Conservative management should include a combined physical and psychological treatment programme and

surgery will only be considered when there is **documented evidence** that the patient has engaged and has participated in the full programme

AND

- Patients must be non-smoking at time of surgery as the rate of potential fusion is significantly affected by smoking. Where the patient is a smoker, they should be referred to One You Lincolnshire Home | One You Lincolnshire and have stopped smoking for at least 6-8 weeks before surgery. This is in line with NG209 Overview | Tobacco: preventing uptake, promoting quitting and treating dependence | Guidance | NICE

EXCEPTIONS:

PLEASE NOTE, PRIOR APPROVAL IS REQUIRED FOR:

- **Patients with a BMI >35**

AND/OR

- **Patients who have been unable to obtain a non-smoking status after 3 months**

In these cases, the referring clinician will need to demonstrate satisfactorily the patient's individual clinical circumstances. The rationale is that these procedures are for conditions which are not life threatening and the procedure has a significant perioperative risk, which is greater in patients who have a BMI>35 or are smokers.

PATIENTS WITH A BMI >35:
The referring clinician should stress the importance of trying to lose weight prior to surgery and support a referral to Home | One You Lincolnshire The patient should commit to a documented weight loss and/or exercise programme (this can be gentle exercise which will contribute to weight loss) for 3 months.

PATIENTS WHO ARE CURRENT SMOKERS:
Patients should be informed that smoking increases complications following surgery and should offered support to stop smoking with a referral to Home | One You Lincolnshire Where a non-smoking status is achieved, the patient may be referred to an appropriate healthcare professional for consideration of surgery.

For more information, please refer to:

- National Low Back and Radicular Pain Pathway 2017: UKSSB | ISCP
- NICE Low back pain and sciatica in over 16s: assessment and management (November 2016 NG59): Overview | Low back pain and sciatica in over 16s: assessment and management | Guidance | NICE
- NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014): Overview | Neuropathic pain in adults: pharmacological management in non-specialist settings | Guidance | NICE
- Transaxial interbody lumbosacral fusion for severe chronic low back pain, Interventional procedures guidance [IPG620]Published: 25 July 2018 Overview | Transaxial interbody lumbosacral fusion for severe chronic low back pain | Guidance | NICE

Toenail – Wedge resection of ingrown toenail including Wedge resection

Prior Approval Required for CSS and Secondary Care

TOENAIL WEDGE RESECTION OF INGROWING TOENAIL TREATMENTS ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

An ingrown toenail develops when the sides of the toenail grow into the surrounding skin. The nail curls and pierces the skin, which becomes red, swollen and tender.

The big toe is often affected, either on one or both sides, possible symptoms include:

- Pain if pressure is placed on the toe
- Inflammation of the skin at the end of the toe
- A build-up of fluid in the area surrounding the toe
- An overgrowth of skin around the affected toe
- Bleeding or white/yellow pus coming from the affected area

Treating ingrown toenails
Without treatment, an ingrown toenail can become infected. Conservative measures should include:

- Keep feet clean by washing them regularly with soap and water
- Changes socks regularly
- Cut toenails straight across to stop them digging into the surrounding skin
- Gently push the skin away from the nail using a cotton bud (this may be easier after using a small amount of olive oil to soften the skin)
- Wear comfortable shoes that fit properly

The ICB **will only** fund toenail surgery where the following criteria are met:

- All conservative measures have been undertaken

  AND

- Recurrent infection (3 or more within a 12 month period) in cases of infection the whole nail should ideally be removed rather than performing a wedge resection

  AND

- Persistent symptomatic pain

For more information, please refer to:

- Royal College of Podiatry, Patient information - Ingrowing Toenail The Royal College of Podiatry

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Trigger Finger/Thumb

Prior Approval Required for CSS and Secondary Care

TRIGGER FINGER/THUMB TREATMENTS ARE DELIVERED UNDER THE CSS (Injections do not require prior approval in CSS)

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

Please refer to EBI guidance Trigger finger release in adults - EBI

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

Cases interfering with activities or causing pain should first be treated with:

- One or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics

  OR

- Splinting of the affected finger for 3-12 weeks (weak evidence)

The ICB **will only** consider surgery when **one** of the following criteria are met:

- Triggering persists or recurs after one of the above measures (particularly steroid injections)

  OR

- The finger is permanently locked in the palm

  OR

- The patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods

  OR

- The patient is diabetic

Surgery is usually effective and requires a small skin incision in the palm but can be done with a needle through a puncture wound (percutaneous release).

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

Ulnar Nerve Release (Cubital Tunnel Syndrome)

Prior Approval Required for Secondary Care

ULNAR NERVE RELEASE / INJECTIONS ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed above.

Cubital tunnel syndrome is a condition which affects Ulnar nerve, which is one of the main nerves of your hand. It causes pins and needles, numbness and sometimes pain along your ring and little fingers. You may also have weakness of the hand and in severe cases clawing, curling up, of the ring and little fingers.

The ICB **will only** fund injections and decompression where the following criteria are met:

- Patients may be referred where there are neurological signs of tingling and numbness in the little and ring finger

Surgical decompression behind the medial epicondylar groove is the only appropriate procedure for CSS.

Procedures on Guyon's canal are only appropriate for Secondary care.

For more information, please refer to:

- The British Society for Surgery of the hand: Cubital tunnel syndrome | The British Society for Surgery of the Hand (bssh.ac.uk)

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and detail how the criteria are met.

Vertebral augmentation

Prior approval not required but must be delivered in line with criteria

Please see EBI guidance Vertebral augmentation for painful osteoporotic vertebral fractures - EBI This guidance applies to adults aged 19 years and over.

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

The alternative to vertebral augmentation is conservative management. This consists of pain relief, bracing, and manual therapy, although the evidence for bracing and manual therapy has shown to be of no benefit. Bone healing can take place over 2-12 weeks. Hospitalisation, immobility and opioid pain medication often have significant side effects, particularly in older patients.

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

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

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

For more information, please refer to:

- NICE TA Guidance TA279, Percutaneous vertebroplasty and percutaneous balloon kyphoplasty for treating osteoporotic vertebral compression fractures: Overview | Percutaneous vertebroplasty and percutaneous balloon kyphoplasty for treating osteoporotic vertebral compression fractures | Guidance | NICE

19 Urology treatment policies criteria

Circumcision

Prior Approval Required

Please see EBI Guidance Penile circumcision - EBI

Penile circumcision is the surgical removal of the foreskin. It is performed as a day case procedure and requires general anaesthetic. While penile circumcision may be undertaken for religious, cultural, or medical reasons, the focus of this guideline is on the medical indications for penile circumcision.

Most foreskin conditions can be managed with simple advice and reassurance. There are a range of treatment options available for foreskin conditions and it's important that children and their parents are informed of these options prior to the decision to perform a penile circumcision, which cannot be reversed once performed.

While major morbidity and mortality following medical penile circumcision is very rare, these could be reduced and potentially avoided if surgical indications were more stringently applied.

Medical penile circumcision is rarely indicated as a primary treatment. Most children and young people presenting with penile problems require no intervention other than reassurance.

The ICB **will not fund** circumcision for religious or cultural reasons.

Children and young people under 16 years:

The ICB **will only** fund circumcision **for children and young people** where **one** of the following criteria are met:

- Prevention of urinary tract infection (UTI) in patients with recurrent UTIs or at high risk of UTI
- Pathological phimosis (balanitis xerotica obliterans /lichen sclerosus)
- For persistent phimosis in children approaching puberty, following an attempted a trial of non-operative interventions e.g. a six-week course of high-dose topical steroid. A prescription of this would not normally exceed three months and should have achieved maximal therapeutic benefit within this time. A topical steroid such as Betamethasone (0.025-0.1%) is commonly prescribed.
- Acquired trauma where reconstruction is not feasible, for example, following zipper trauma or dorsal slit for paraphimosis

All patients must have a formally documented discussion of the risks and benefits of foreskin preserving surgery versus penile circumcision using a shared decision making framework.

Adults –16 years and over:

Prior approval **is required** for patients over 16 years where the following criteria are met:

- Suspicion or evidence of malignancy
- Frenuloplasty when carried out because the frenulum tears or bleeds during intercourse
- Symptomatic Phimosis
- Phimosis leading to paraphimosis for difficulties in erection

- Recurrent, troublesome episodes of infection beneath the foreskin (balanitis (adults only) and balanoposthitis); this includes balanitis xerotica obliterans (BXO) that has not responded to conservative treatment

EXCLUSIONS:
This policy does not cover:

- Children and young people with congenital penile conditions such as hypospadias
- Suspected penile malignancy when referral should be made through the appropriate (2 week wait) route

For more information, please refer to:

- NHS Choices. Circumcision in adults: Circumcision in men - NHS
- Royal College of surgeons. 2016. *Foreskin Conditions – Commissioning Guide*
- British Association of Paediatric Urologists on behalf of the British Association of Paediatric Surgeons and the Association of Paediatric Anaesthetists. 2007. Management of foreskin conditions Management of Foreskin Conditions | British Association of Paediatric Surgeons
- NHS Somerset ICB Circumcision-CBA-Policy-2425.v2a-20240625.pdf
- NHS Choices. Circumcision in boys Circumcision in boys - NHS

Vasectomy

Prior Approval Required for Secondary Care

VASECTOMY PROCEDURES ARE DELIVERED UNDER THE CSS

CSS applies to individuals over the age of 16 and treatment to be carried out in line with the criteria detailed below.

A vasectomy (male sterilisation) is a surgical procedure to cut or seal the tubes that carry a man's sperm to permanently prevent pregnancy.

The ICB **will only** fund a vasectomy under local anaesthetic where **all** the following criteria are met:

- The patient understands that the sterilisation procedure is permanent and irreversible, and the reversal of sterilisation operation would not be routinely funded by the NHS

  AND

- The patient is certain that his family is complete

  AND

- The patient has sound mental capacity for making the decision as emotional instability or equivocal feelings about permanent sterilisation are contraindications to vasectomy

  AND

- The patient has received counselling about the availability of alternative, long-term and highly effective contraceptive methods and these are either contra-indicated or unacceptable to the patient

  AND

- The patient understands that sterilisation does not prevent or reduce the risk of sexually transmitted infections

Prior Approval will need to be sought by clinicians seeking to undertake a vasectomy under a general anaesthetic in secondary care, setting out why the patient's procedure cannot be undertaken under local anaesthetic clearly stating the clinical grounds for which they meet the criteria below.

Patients who require a vasectomy under general anaesthetic in Secondary care must meet one of the following criteria:

- Anatomic abnormalities, such as the inability to palpate and mobilise both vas deferens or large hydroceles or varicoceles
- Past trauma and scarring of the scrotum
- Acute local scrotal skin infections
- Electro-surgery is contraindicated in certain types of pacemakers

Please Note:
Patients should be advised that after a Vasectomy procedure they will need to use effective contraception until Azoospermia has been confirmed by two consecutive semen samples with no spermatozoa seen. This usually takes 8-12 weeks from the date of the operation.

Patients should also be aware that there is a risk of failure of this procedure. The early failure rate of vasectomy (i.e., the presence of motile sperm in the ejaculate at 3 to 6 months post-vasectomy) ranges from 0.3% to 9%

Patients who have undergone a vasectomy would not qualify for ICB funded fertility treatment in the future should they change their mind and wish to have a child, even if the procedure has been successfully reversed. This is in line with the information with the ICB's IVF policy.

Second Vasectomy:
The ICB policy **does not** routinely fund second vasectomy. Sterilisation is regarded as irreversible; therefore, reversal of sterilisation is not routinely funded by the ICB (see Section 20).

The fact that a patient has a new partner is not sufficient grounds to fund this treatment. NHS budgets are limited, any patient privately funding sterilisation would not be funded for a second vasectomy on the NHS.

Sterilisation of Patients with Gender Dysphoria:
Sterilisation of patients on the Gender Dysphoria pathway as part of their transition and genital reconstruction is solely commissioned by NHS England Specialised Services and the ICB cannot consider requests to fund sterilisation for patients on this pathway.

For more information please refer to:

- The Faculty of Sexual & Reproductive Healthcare: FSRH Service Standards for Vasectomy (April 2024) | FSRH
- Information about your procedure from The British Association of Urological Surgeons (BAUS): Vasectomy.pdf
- NHS Choices: Vasectomy - NHS
- NHS Herefordshire and West Essex ICB: Vasectomy Policy

Please refer to 7.1 CSS principles for more information on the CSS process.

Should an occasion arise where a patient's clinical need cannot be met by the CSS, the CSS provider will forward the original referral together with the completed CSS Rejection form to the EACH (Elective Activity Coordination Hub).

Please note: Should the GP receive a rejection from the CSS provider, or they feel the patient's condition isn't appropriate to be treated by the CSS provider, then they would need to seek prior approval before onward referral to secondary care. This referral should clearly advise the clinical rationale for a referral to secondary care and also detail how the criteria are met.

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19 Cosmetic surgery & non-surgical treatments not routinely commissioned

Cosmetic surgery & non-surgical treatments not routinely commissioned
Prior Approval Required

The Royal College of Surgeons of England What is cosmetic surgery advises: '*Cosmetic surgery, also known as aesthetic surgery, is where a person chooses to have an operation, or invasive medical procedure, to change their physical appearance for aesthetic reasons.'*

The ICB has identified the procedures listed below that are widely considered to be primarily cosmetic with relatively small health benefits compared to other competing priorities for limited NHS resources. These procedures are **not** routinely commissioned, and those which are only commissioned when certain criteria are met to ensure that ICB fund treatment only for clinically effective interventions. Any other cosmetic procedure that is not mentioned within Section 19 and Section 20 is not routinely commissioned by the ICB.

The procedures detailed below all require prior approval when one of the following criteria are met:

- The treatment is post-trauma; **or**
- Part of reconstruction following surgery (e.g., for cancer); **or**
- Part of the management of a congenital abnormality which results in a serious health function deficit, **or**
- For an iatrogenic* condition arising from treatment previously delivered within the NHS
  **The term 'iatrogenic condition' refers to a condition that was directly attributable to previous medical treatment. In this context, 'iatrogenic condition' specifically excludes known side effects of a treatment or possible complications which the patient would normally be notified about when they were informed of the benefits and risks when consenting to the original treatment."*

Please note:
Psychological Impact: The ICB does not commission cosmetic surgery & non-surgical treatments on the grounds of psychological impact. Accounting for psychological factors in arriving at a decision about eligibility for NHS funding is hard to do in a clear and fair way. These considerations are not included in the above criteria as psychological distress unfortunately does not constitute clinical exceptional circumstance. NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery, (CG31) November 2005 Overview | Obsessive-compulsive disorder and body dysmorphic disorder: treatment | Guidance | NICE

For more information, please refer to:

- Royal College of Surgeons of England: What is cosmetic surgery? — Royal College of Surgeons
- East Midlands Commissioning Policy, 2014: EAST MIDLANDS COMMISSIONING POLICY
- BAPRAS, Commissioning information: information-for-commissioners-of-plastic-surgery-services.pdf
- NHS Derby & Derbyshire ICB, Cosmetic policies link: Cosmetic
- NHS Choices: Cosmetic Surgery Cosmetic surgery - NHS

Procedures:
Benign Skin Lesions – Cosmetic purposes Are not commissioned for purely cosmetic purposes in any setting (primary care, community care and Secondary care)
Breast Augmentation for developmental failure
Breast Implant Removal/Reinsertion
Breast Reduction for Asymmetric Breasts
Breast Reduction
Breast Surgery – Other, including prosthesis
Botulinum Toxin For the following indications: wrinkles, frown lines, ageing neck
Botulinum Toxin Treatment for Hyperhidrosis
Chin implant (genioplasty, mentoplasty)/Cheek implants Except in post-trauma cases and/or as part of planned reconstruction following surgery (e.g., for cancer)
Collagen implant Except in post-trauma cases and/or as part of planned reconstruction following surgery (e.g., for cancer)
Correction of nipple inversion
Divarication of recti Is relatively common and asymptomatic **and** does not carry the risks associated with actual hernias and repairs are primarily cosmetic and does not lead to any complications that require intervention
Earlobe repair Unless there is a complete tear of the lobe because of unexpected trauma (not partially split lobes or elongated holes in lobes)
Electrolysis treatment For any condition
Excision of excessive skin From thigh, leg, hip, buttock, arm, forearm, or other areas
Hair depilation (removal) For excessive hair growth (hirsutism)
Labiaplasty, vaginoplasty and hymen reconstruction, phalloplasty
Laser treatment for facial hyperpigmentation
Lipomodelling (surgical fat transfer) Exception in post-trauma cases and/or as part of planned reconstruction surgery (e.g., for cancer)
Liposuction (suction assisted lipectomy) Except as part of planned reconstruction surgery (e.g., for cancer or a congenital syndrome)
Mastectomy Except where medically indicated, i.e., Cancer **or** related to gender reassignment not included in the original package of care
Mastopexy (breast uplift) • Except where the criteria are met in Breast Reduction, Breast Reduction fo**r** Asymmetric Breasts or Breast Surgery for Developmental Failure
Resurfacing by laser for skin conditions causing scarring • Including post-acne and post-traumatic scarring
Rhinoplasty Rhinoplasty is cosmetic surgical reshaping of the nose
Rhytidectomy (facelift) Unless part of the treatment of facial nerve palsy/congenital facial abnormalities/ treatment of specific facial skin conditions (e.g., cutis laxa, pseudoxanthoma elasticum)
Scar Reduction/Revision

20 Other Treatments not routinely commissioned

This list of procedures are not routinely commissioned and require an IFR for exceptionality. However, this list is not exhaustive and if a procedure is not listed it should not be assumed that this is funded where there is no policy or NICE TA.

Autologous Blood & Platelet-Rich Plasma Injection in Tendinopathy
Are used to treat damaged tendons, where a patient's blood is taken and re-injected into the affected area. For more information please see NICE IPG438 Autologous blood injection for tendinopathy

Cognitive Behavioural Therapy (CBT) for inpatient with Chronic Fatigue Syndrome
CBT for inpatient treatment of chronic fatigue syndrome is not routinely funded.

Complementary therapies for pain management
The ICB will not routinely fund, as complementary medicine/alternative therapies are not generally funded by the NHS (except where it is approved by a NICE Technology Appraisal); this includes, Complementary and Alternative Medicines including: Acupuncture - for any medical condition, including migraine and tension/cluster headaches, Alexander technique, Applied kinesiology, Aromatherapy, Autogenic training, Ayurveda, Chinese medicine, Chiropractic therapy, Complementary healing therapy, Environmental medicine, Herbal medicine/healing, Homeopathy, Hydrotherapy, Hypnosis, Massage, Meditation, MSK/Rheumatic pain, Naturopathy, Nutritional therapy, Osteopathy, Reflexology, Reiki, Shiatsu, Therapeutic community method for borderline personality, Any other complementary and alternative medicine/therapies not on the list above. This is in line with NICE Guidance NG193 Overview | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE.

It is important to be aware the scope of NG193 is chronic primary pain. This is defined as 'Pain which has no clear underlying condition, or the pain (or its impact) appears to be out of proportion to any observable injury or disease. ICD-11 gives examples of chronic primary pain, including fibromyalgia, complex regional pain syndrome, chronic primary headache and orofacial pain, chronic primary visceral pain and chronic primary musculoskeletal pain'. The guideline committee largely excluded research relating to secondary pain - caused by an underlying condition for example osteoarthritis or rheumatoid arthritis. The guideline development committee refers to separate NICE guidelines relating to Low back pain and sciatica, rheumatoid arthritis, Osteoarthritis ,spondyloarthritis People with chronic primary pain are a subset of people with persistent pain. The prevalence of chronic primary pain is unknown but is estimated to be between 1% and 6% in England. NG193 summarises that acupuncture reduced pain and improved quality of life in the short term (up to 3 months) compared with 'usual care' or sham acupuncture. There was insufficient evidence to determine longer term benefits. Once individuals have had their one-off course of acupuncture, should their symptoms improve in the short term and recur a further course is not recommended by the guidelines.

Referral criteria to the Lincolnshire Community Pain Management Service includes a requirement for patients to have trialled first line approaches to pain management, this includes treatment such as simple analgesia and physiotherapy. The service has been commissioned and designed to support patients living with persistent pain to live full and meaningful life despite their pain, not to provide interventions for short term relief in symptoms (such as acupuncture) for chronic primary pain. Following discussion between the Lincolnshire Community Pain Management Service, the ICB and Primary Care Clinical leadership group it was agreed that delivery of acupuncture as recommended by NG193 should be delivered as a first line treatment for those with chronic primary pain and **not be included** within the scope of the persistent pain service.

Coloured filtered/tinted lenses (including Irlen) for visual distress/reading difficulties
Provision of coloured filters/tinted lenses (including Irlen) are not routinely commissioned in the management of visual stress or patients with reading difficulties.

Cosmetic procedures not specifically listed
Any procedure not specifically listed elsewhere in this document that are, by consensus, viewed as cosmetic in nature requires an IFR e.g., the removal of non-diseased tissue.

Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children
This guidance applied to children 2 years and under. Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children - EBI There is clear evidence and expert consensus that a helmet does not affect the natural course of skull growth and should not be used. Helmets may be associated with significant risks such as pain, pressure sores and may adversely affect the bond between baby and parents. NHS Choices. Plagiocephaly brachycephaly: Plagiocephaly and brachycephaly (flat head syndrome) - NHS

Diagnostic Arthroscopy
The ICB will not commission arthroscopy for diagnostic purposes for ankles, elbows, knees, hips, shoulders, or wrists.

Extracorporeal Shock Wave Therapy (ESWT - lithotripsy)
The ICB does not routinely commission this therapy for these conditions:

- Plantar fasciitis
- Refractory Achilles tendinopathy
- Refractory tennis elbow
- Calcific tendonitis (tendinopathy) of the shoulder

For more information please see NICE Guidance Extracorporeal shockwave therapy for refractory plantar fasciitis

Functional Electrical Stimulation (FES) – Lower limb

Gynaecomastia
Surgery for Gynaecomastia to improve appearance alone is not routinely commissioned. This is because surgery for reduction of male breast tissue is deemed to be cosmetic. We do not routinely fund for idiopathic gynaecomastia in men. Where gynaecomastia is caused by medical treatment such as prostate cancer, an IFR may be considered where BMI is <27.0 and there is evidence of functional issues. Suspicious breast lumps should be referred via the 2 week wait process. An IFR may be submitted for consideration of exceptionality.

Infrared A Induced whole body hyperthermia treatment
The assertion is that by using the hyperthermia infrared A bed, the core temperature of the body can be raised and this could aid in the management of variety of conditions. The intervention is experimental and there is no robust evidence base for the treatment and is not normally funded for any indication.

Laser Treatment of Myopia (Short Sightedness)
Correction of short sightedness using lasers and is not available on the NHS.

Liposuction for Lipoedema
Lipoedema is a long-term (chronic) condition typically involving an abnormal build-up of fat cells in the legs, thighs and buttocks and is not available on the NHS.

Lignocaine (Lidocaine) for management of Chronic Pain
Treatment of Lignocaine (Lidocaine) for management of Chronic Pain is only provided through the Lincolnshire Community Pain Management Service, if clinically appropriate.

Lower Back Pain Imaging without Sciatica

Lycra Dynamic Splinting for Children with Neurological Impairment
There are currently no NICE guidelines on the use of Lycra dynamic splinting. Very few studies have been published to assess the effectiveness and no studies have investigated the benefit of continuation in the long term. It is not very clear as to what extra benefit it provides to the patient as compared to the other treatment options. Also, it has not been fully evaluated, nor is it clear whether there are patient groups or specific disabilities that may significantly benefit more than others.

Pain management programmes using Cognitive Behavioural Therapy (CBT)
CBT pain management programmes are only provided through the Lincolnshire Community Pain Management service, if clinically appropriate.

Patella Resurfacing
Patella resurfacing is not routinely commissioned as a stand-alone treatment.

Pinnaplasty

Residential pain management programmes
The ICB will not routinely fund residential pain management programmes.

Reversal Sterilisation – male and female
Sterilisation is regarded as irreversible. The fact that the patient has a new partner is not considered sufficient grounds to fund this treatment.

Sacral Nerve Stimulation (SNS) for Faecal/Urinary Retention This procedure is not routinely commissioned by the ICB and an IFR form is required for exceptionality.
Snoring symptoms Snoring (Uvulopalatopharyngoplasty, Laser Assisted Uvuloplasty & Radiofrequency ablation of palate). Treatment of simple snoring (i.e., in the absence of sleep apnoea) is not usually harmful to health and is regarding as being primarily for social rather than medical benefit. There is limited clinical evidence of effectiveness but there are significant risks to patients, and several alternatives to improve snoring: weight loss, stop smoking, reduce alcohol intake, medical treatment for nasal congestion, purchasing a mouth splint. Snoring surgery (in the absence of obstructive sleep apnoea) - EBI
Spinal injections as a treatment for Chronic lower back pain
Surgery for Benign Prostatic Hyperplasia (BPH)
Surrogacy Surrogacy is not available on the NHS. The ICB does not support or fund treatments for surrogacy.
Third Medical Opinion The ICB will not commission a third specialist opinion for the same problem; an opinion is considered valid if the clinician has appropriate expertise to advise and manage the presenting problem.
Tonsillectomy for treatment of Tonsilloliths Tonsillectomy for treatment of Tonsilloliths is not supported by the ICB.
Topical Negative Pressure (TNP) for wound closure (vacuum assisted closure – VAC) TNP for wound closure (VAC) is not supported by the ICB. Submission of an IFR would be required if considered exceptional.
Toric Intraocular lenses For corneal astigmatism correction is not routinely funded by the ICB.

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Equality and Diversity Statement

NHS Lincolnshire ICB aims to design and implement services, policies and measures that are fair and equitable. As part of its development, this policy and its impact on staff, patients and the public have been reviewed in line with NHS Lincolnshire ICB's legal equality duties.

In carrying out its functions, NHS Lincolnshire ICB is committed to having due regard to Section 149 of the Equality Act 2010 (the Public Sector Equality Duty). This applies to all the activities for which NHS Lincolnshire ICB is responsible, whether internal or on behalf of customers, including policy development, implementation, review and evaluation.

The Health and Social Care Act 2012 places specific legal duties on ICBs to have regard for the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way.

This document has been designed to ensure that, in any development or review of NHS Lincolnshire ICB policies, equality aspects are considered so that no-one is adversely affected by the new or reviewed policy.

Interaction with Other Policies

The following policies/guidance should be read in conjunction alongside this policy:

- NHS Lincolnshire ICB Individual Funding Requests (IFR) Policy, current version in use
- Who Pays? sets out the framework for establishing which NHS commissioner will be responsible for commissioning and paying for an individual's NHS care, July 2022: NHS England » Who Pays?

References

The following key references have been used in the creation of this policy:

- The Evidence-based Interventions programme (EBI), which is an initiative led by the Academy of Medical Royal Colleges to improve the quality of care: aomrcebi – Evidence-based interventions
- NHS England, Population Health, the RightCare programme: Population Health - Getting It Right First Time - GIRFT
- The National Institute for Health and Care Excellence (NICE), which are evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders: Find guidance | NICE
- One You Lincolnshire, which provides health and wellbeing programmes to Lincolnshire residents: Home | One You Lincolnshire

Equality Impact Assessment form – Project details

Project name	Prior Approval policy, Version 3.12, May 2025
EIA author	Samantha Jones
Team	Quality & Nursing
Date completed	01 April 2025 (Reviewed May 2025, no changes)
Version	3.0

What is the aim of the project/proposal?
The prior approval policy document has been updated and criteria's reviewed and appropriate changes made to reflect: amendments in EBI, to ensure links are up to date and references applied (as appropriate) and criteria's amended/moved to different Sections of the policy to reflect the ICB current position, which requires an EIA. The policy sets out to make explicit the position of the ICB about which treatments will or will not be commissioned, together with the criteria and thresholds to be applied. As the statutory body responsible for NHS spend and performance within the Lincolnshire system, it is imperative that the ICB seeks to maximise value for money and the number of patients treated within a sustainable financial envelope, meaning only evidence-based, clinically effective services will be commissioned.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.
The prior approval policy applies to all staff members, including Governing Body Members and practice representatives, involved in the ICB's policy-making processes, whether permanent, temporary or contracted-in (either as an individual or through a third-party supplier). The prior approval policy is for the attention of: • All employees undertaking commissioning and related financial decision making. • All staff members involved in the ICB's policy-making processes. • For reference, for all employees not directly involved in any of the above activities.

Stage 1: Scoping point

Is a full Equality Impact Assessment (EIA) required for this project?

You should consider whether a full EIA is required, referring to the relevant guidance for information and guidance on making this decision.

It is important this decision is made with an open mind and correctly, advice should be sought from the EIHR team if you are unsure.

Yes	☑	Proceed to the full EIA form	**No**	o	Explain why full EIA is not required

If no, explain below why further EIA is not required.
E.g. 'This report is for information only' or 'The decision has not been made by the ICB' or 'The decision will not have any impact on patients or staff'. Very few decisions affect all groups equally and this is not a rationale for not completing an EIA.

If, at an initial stage, further information is needed to complete a section, this should be recorded and updated in subsequent versions of the EIA. An EIA is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

Equality Impact Assessment

1. Evidence used
To demonstrate that the decision made has been informed you should include examples of the information used to determine the impact and complete the EIA. Examples are likely to include:

- ***Population data*** *e.g. demographic profile (census).*
- ***Service activity data*** *e.g., profile of patients using a service.*
- ***Consultation and involvement findings*** *e.g., any engagement with service users, local community, specific groups.*
- ***Research*** *e.g., good practice guidelines, service evaluations, literature reviews, reports.*
- ***Participant knowledge*** *e.g., experiences of working with different population groups, experiences of service users in other service areas/localities.*

The policy sets out commissioning position of procedures of limited clinical value (PLCV), Evidence Based Interventions (EBIs), and other treatment policy criteria's, and is a proactive response to the legal environment within which the NHS operates.

The document makes explicit the position of the NHS in Lincolnshire with regard to which treatments will, or will not be, commissioned by providers and the criteria and thresholds to be applied. The policy is a tool to enable the ICB to support providers in achieving QIPP targets and should be read in conjunction with the "Commissioning Policy for the Management of Individual Funding Requests".

The policy applies to the whole population being served which has the following demographic profile:

Lincolnshire is a largely rural county with an ageing population with 23% of residents over the age of 65. The diversity of the population has increased in recent years as a result of new and emerging communities, which is primarily made up of Eastern European communities. Levels of deprivation vary across the county, which has an influence on health and wellbeing needs. The general pattern is that the urban centres and coastal strip show higher levels of deprivation than other parts of the county.

The completion of a Quality Impact Assessment (QIA) is also required for the process of updating this policy. Completion of the QIA Initial Screening Tool ensured there was consideration of the impact of the policy on patient safety, patient experience, patient choice and access to services, be it positive, neutral, or adverse.

The ICB aims to design and implement services, policies and measures that are fair and equitable. As part of its development, this policy and its impact on staff, patients and the public have been reviewed in line with NHS Lincolnshire ICB's legal equality duties. Equality aspects have been considered so that no-one is adversely affected by the policy.

In carrying out its functions, the ICB is committed to having due regard to Section 149 of the Equality Act 2010 (the Public Sector Equality Duty). This applies to all the activities for which NHS Lincolnshire ICB is responsible, whether internal or on behalf of customers, including policy development, implementation, review and evaluation. There will be the ability to monitor the demographics of the patients referred to the prior approval process, and the outcome of their referral. This will ensure that there are no inequalities of access to procedures that sit within the prior approval process.

2. Potential impact of decision

In the following boxes, for each protected characteristic, detail the findings and impact identified (positive or negative) within the research detailed above. This should include any identified health inequalities which exist in relation to this work.

As part of these considerations, you should include how the ICB will be meeting the requirements of the public sector equality duty (PSED):

"In exercising their functions, public authorities must have due regard to the need to:

- *Eliminate unlawful discrimination, harassment and victimisation.*
- *Advance equality of opportunity between people sharing a protected characteristic and others.*
- *Foster good relations between people sharing a protected characteristic and others."*

Before completing this section, you should ensure you can suitably answer the following:

What is the equality profile of the population i.e. service users/patients and/or workforce that is intended to benefit from the activity/project?

(By collecting and analysing demographic data of protected characteristics relating to patients/service users and/or workforce, within the geographical area concerned, the ICB will be able to identify the groups that may be adversely affected at a greater proportion to others).

2.1 Age

Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure all patients are treated in a fair and equitable manner and to ensure consistency in decision making. The policy will work to ensure that no age-related adverse impact is experienced.

2.2 Disability

Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health, learning disabilities and cognitive impairments.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so that it has not adverse impact on disabled people.

Consideration may need to be given around providing information to support understanding of the process to specific individuals who may have accessibility requirement – implementation of the Accessible Information Standard will be considered in these circumstances supporting those who may require information in different formats in relation to their with sensory and neurodiversity requirements.

2.3 Gender reassignment (including transgender)
Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making so it does not impact adversely on people who may have gone through or going through transition.

2.4 Marriage and civil partnership
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part-time working and caring responsibilities.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so it does not impact adversely in terms of Marriage and civil partnership.

2.5 Pregnancy and maternity
Describe any impact and evidence in relation to pregnancy and maternity. This can include working arrangements, part-time working and caring responsibilities.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so it does not impact adversely in terms of pregnancy and maternity.

2.6 Race
Describe race-related impact and evidence. This can include information about different ethnic groups, Roma, Gypsies, Irish travellers, nationalities, cultures and language barriers.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so that it does not impact adversely on Race. Consideration may need to be given around providing information to support understanding of the process to specific individuals who have little or no English.

2.7 Religion or belief
Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end-of-life issues.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so it does not impact adversely in terms of Religion or belief. Consideration may need to be given around providing information to support understanding of the process to specific individuals who have little or no English.

2.8 Sex
Describe any impact and evidence in relation to men and women. This could include access to services and employment.

The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, so it does not impact adversely on whether a person is male or female or has gone through or is going through transition as in point 2.3 above.

2.9 Sexual orientation *Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*
The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making so it does not have an adverse impact on sexual orientation.
2.10 Carers *Describe any impact and evidence in relation to part-time working, shift patterns and general caring responsibilities (not a legal requirement, but an ICB priority and best practice).*
The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner including providing relevant information to carers of those patients so that they are fully aware of the process.
2.11 Other disadvantaged groups *Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (e.g. migrants and asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse and victims of drug/alcohol abuse. This list is not finite. This supports the ICB in meeting its legal duties to identify and reduce health inequalities.*
The prior approval policy has been designed to ensure that equality aspects are considered so that no-one is adversely affected by the reviewed policy. The purpose of the policy is to ensure that all patients are treated in a fair and equitable manner and to ensure consistency in decision making, irrespective of age, disability, race, religion and belief, gender, sexual orientation, or other disadvantaged groups. The decision-making processes set out in the prior approval policy are not impacted by socio-economic status. No patients would be disadvantaged by this policy by their socio-economic status, as the policy ensures that only evidence-based, clinically effective services will be commissioned regardless of socio-economic status.

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☐	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so, what actions are needed? *Please explain below.*				

4. Health inequalities

The Health and Social Care Act 2012 established the first specific legal duties on ICBs to have regard to the need to reduce inequalities between patients in **access** to, and **outcomes** from, healthcare services and in securing that services are provided in an integrated way. These duties had legal effect from 1 April 2013. The duties require that ICBs properly and seriously take into account inequalities when making decisions or exercising functions, and has evidence of compliance with the duties, whilst also assessing how well commissioned providers have discharged their legal duties on health inequalities.

4.1 What evidence have you considered to determine what health inequalities exist in relation to your work?

This can include local and national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other equality analyses. If there are gaps in evidence, state what you will do to mitigate them.

This may be different or similar to that which has informed the EIA.

In addition to the health inequality risks related to people with protected characteristics, health inequalities specific to Lincolnshire's demography were considered in the development of this policy. The QIA process reviewed the policy against quality criteria that are subject to local health inequalities. For example, patient & staff experience, clinical effectiveness and patient safety quality domains were rated as having neutral, positive or adverse impacts.

4.2 What is the potential impact of your work on health inequalities?

Can you demonstrate through evidenced-based considerations how the health outcomes, experience and access to healthcare services differ across the population group and in different geographical locations that your work applies to?

If you feel that the project will not impact / be relevant to health inequalities, please give a rationale.

The prior approval policy ensures that only evidence-based, clinically effective services will be commissioned. The prior approval policy document sets out to make explicit the position of the ICB about which treatments will or will not be commissioned from providers and the criteria and thresholds to be applied. The guidance in the policy applies irrespective of population groups and geographical locations (within Lincolnshire). Health outcomes, patient experience and access to services will not be impacted on by this policy.

4.3 How can you make sure that your work has the best chance of reducing health inequalities?

The ICB aims to design and implement services, policies and measures that are fair and equitable. As part of its development, this policy and its impact on staff, patients and the public have been reviewed in line with NHS Lincolnshire ICB's legal equality duties.

In carrying out its functions, the ICB is committed to having due regard to Section 149 of the Equality Act 2010 (the Public Sector Equality Duty). This applies to all the activities for which the ICB is responsible, whether internal or on behalf of customers, including policy development, implementation, and review.

The Health and Social Care Act 2012 places specific legal duties on ICBs to have regard for the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way.

5. Engagement/consultation
What engagement is planned or has already been done to support this project?

It is expected that the ICB will have carried out a level of engagement with those affected, whether formal or informal. This should be focused on the groups most affected and as per the guidance document published by NHSE: Working in partnership with people and communities: statutory guidance

Engagement activity	With whom? *e.g. protected characteristic/group/community*	Date

Please summarise below the key findings/feedback from your engagement activity and how this will shape the policy/service decisions e.g. "patient told us, so we will…" (If a supporting document is available, please provide it or a link to the document).

The prior approval policy is not a new process/initiative and this is a policy update, in line with the policy renewal timescale, in which the policy has been updated and criteria's reviewed and appropriate changes made to reflect: amendments in EBI, to ensure links are up to date and references applied (as appropriate) and criteria's amended/moved to different Sections of the policy to reflect the ICB current position.

6. Mitigations and changes
If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over-the-counter medication. In this case, it was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore, an exception is provided for this group, which has resolved the issue.

Are these vital to the project continuing?

None identified

7. Is further work required to complete this EIA?
Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)

Work needed	Section	When	Date completed

8. Development of the Equality Impact Assessment
If the EIA has been updated from a previous version, please summarise the changes made and the rationale for the change. E.g. Additional information may have been received – examples can include consultation feedback or service activity data.

Version	Change and rationale	Version date
E.g. version 0.1	*The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group.*	*26 September 2017*

8. Development of the Equality Impact Assessment *If the EIA has been updated from a previous version, please summarise the changes made and the rationale for the change. E.g. Additional information may have been received – examples can include consultation feedback or service activity data.*		
Version	**Change and rationale**	**Version date**
Version 1.0	Policy updated to reflect the organisational change to the Lincolnshire Integrated Care Board (ICB)	29 December 2022
Version 2.0	Policy updated to reflect the criteria change to the Lipoma treatment criteria and clarifying the Tiers for Weight Management and specific Tier 2 options available and the referral via the EACH	31 October 2024
Version 3.0	Policy updated and criteria's reviewed and appropriate changes made to reflect: amendments in EBI, to ensure links are up to date and references applied (as appropriate) and criteria's amended/moved to different Sections of the policy to reflect the ICB current position.	01 April 2025

9. Final sign off Completed EIA forms must be signed off by the completing manager. They will be reviewed as part of the decision-making process. Service lines should maintain an up-to-date log of all EIAs.		
Version approved:	3.12	
	Name	**Date**
Signature of responsible officer	Samantha Jones	19 May 2025
Which committee will be considering the findings and sign off the EIA?	Clinical Policies Sub-group committee	22 May 2025
Minute number *(to be inserted following presentation to committee)*		

Stage One - Quality Impact Assessment Initial Screening Tool

The QIA Initial Screening Tool is required for all projects to identify the project's impact on quality, be it positive, neutral, or adverse.

Five quality domains are thereby defined in the Initial Screening Tool, against which risks must be assessed and scored (see Appendix B for instructions on scoring).

For each quality domain in the Initial Screening Tool, highlight the proposal's impact on quality as either positive (P), neutral (N) or adverse (A). For **neutral** and **adverse** impacts, add a score for consequence (C) and likelihood (L) (Appendix B). Multiply the consequence and likelihood scores and record that number as the total score (T), then enter yes or no regarding need for a Stage 2 QIA for any domains with scores of 8 or greater. Calculate and record the total score of all domains. Complete an Equality Impact Assessment (EIA) and the EIA section on the QIA screening tool.

Quality Impact Assessment - Initial Screening Tool		Instructions: • Answer Positive, Neutral or Adverse (P, N or A) against each quality domain • If Neutral or Adverse, insert a Consequence (C) and Likelihood (L) score, multiply the scores, and insert the total score in the Total (T) column • Add a brief description of the potential impact and mitigating actions • Insert Y (yes) indicating need for a Stage 2 QIA for any domains with scores of 8 or greater • Record the total score of all domains • Complete an Equality Impact Assessment (EIA) and the EIA section on the QIA screening tool						
Quality Domain	**Impact Question** Could the proposal impact on any of the following?	**P/ N/ A**	**C**	**L**	**T**	**Brief description of potential impact**	**Mitigation strategy and monitoring arrangements**	**Stage 2 QIA? Y/N**
Duty of Quality	• The duty to safeguard children and vulnerable adults • The duty to promote equality – see https://bit.ly/3v85CNs • The functions of other services within the organisation • The clinical effectiveness of services • Patients' and public experiences of services • Compliance with NHS constitution's core principles - see https://bit.ly/37vzY4k	A	2	3	6	Some patients will experience dissatisfaction as they may not receive NHS funded treatment procedures they perceive to be required. Formal complaints from patients who do not receive their requested procedure.	The prior approval policy sets out the treatment procedures which are not commissioned. There is a process set out in the policy for requests for procedures to be funded which ensures decisions for each prior approval funding request are considered in line with the policy. The prior approval policy has been developed to ensure that only evidence-based, clinically effective services will be commissioned.	N

	Any other factors related to the duty to uphold and improve quality							
Patient Safety	• Avoidable harm; clinical/environmental/other • Infection prevention and control practices, systems, statutory expectations and acceptable standards • Referral to treatment times • Safeguarding Adults, Young People & Children – see https://bit.ly/3jeY3ih • Workforce levels and competencies Any other risk indicators relevant to patient safety	N	1	3	3	Patients may experience emotional distress or have a personal financial impact as a result of not receiving perceived required treatment procedures. They may seek to access the procedures through independently funded streams which may be from providers who are not regulated resulting in them potentially sourcing unsafe treatments.	The prior approval policy has been developed to ensure that only evidence-based, clinically effective services will be commissioned. Patients in Lincolnshire will not have their access to essential care and treatment limited by this policy. There is no impact on patient safety as a result of not funding treatments that have poor or unproven clinical or cost effectiveness or where there is the availability of more appropriate treatment alternatives.	N
Patient/ Staff Experience	• Informed choice, autonomy, and involvement • Access to services • Dignity, respect, compassion, and consent • Patients' satisfaction with services • Complaints and redress Any other risk indicators relevant to patient experience:	N	1	3	3	Patients may perceive that they do not have access to services they require. They may not be able to make some decisions about their care if the procedure they are requesting is not routinely commissioned and needs prior approval	The ICB aims to design and implement services, policies and measures that are fair and equitable. As part of its development, the prior approval policy and its impact on staff, patients and the public have been reviewed in line with the ICB's legal equality duties. The policy has been designed to ensure equality aspects are considered so that no-one is adversely affected by the policy. Staff are	N

							supported with making decisions about procedures through the processes described in the policy which provide appropriate guidance to staff. Patients would have the right to complain about decision outcomes in line with the ICB complaints policy.	
Clinical effective-ness	• Evidence based practice & standards • Clinical outcomes • Clinical leadership and engagement Any other risk indicators relevant to clinical effectiveness:	P	N/A	N/A	N/A	Positive impact as the policy highlights the need for additional consideration and prior approval where procedures are not evidenced to be clinically effective. The policy clearly outlines the need for procedures to have an evidence base of clinical and cost effectiveness prior to approval.	N/A	N
Non-clinical/ operational impact	• Impact on cost effectiveness • Impact on infrastructure • Impact on staff satisfaction and welfare • Impact on the public perception of the organisation • Social value impact • Relationships with partner organisations	P	N/A	N/A	N/A	Positive impact as the policy highlights the need for additional consideration and prior approval where procedures are not evidenced to be cost effective. The policy clearly outlines the need for procedures to have an evidence base of clinical and cost effectiveness prior to approval. The policy has a positive impact on the system infrastructure through best use of resources and reducing numbers of	N/A	N

						unnecessary treatments and therefore admissions; this positively impacts on patient flow through the system by prioritising resources for those in most clinical need. This has a positive impact on the public perception of the organisation, through demonstration of equity of access.		
		Total overall score =				**12**		
EQUALITY		**An Equality Impact Assessment must also be undertaken**						
Name of person completing the Equality Impact Assessment:		**Samantha Jones**				**Date:19/05/2025**	**Signature: S Jones**	
Position:		**Deputy Director of Nursing & Quality**						