NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Commissioning Policy

Excluded and Restricted Procedures

Version 3.1

Policy Folder & Policy Number	Commissioning
Version:	3.1
Ratified by:	Integrated Care Board
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CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
Clinical Leads (1 per CCG)	Internal	2021/22

RATIFICATION SCHEDULE

Name of Committee approving Policy	Date
South West Membership Meeting in common	08 June 2022
South East Membership Meeting in common	21 June 2022
Governing Bodies Meeting in common, Staffordshire and Stoke-on-Trent CCGs	30 June 2022
Integrated Care Board	01 July 2022
Quality and Safety Committee amendment – V3.1	16 November 2023

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
1.0	Combination of existing policies from six CCGs	May 2022	Gina Gill Jackie Newman
2.0	Adapted for ICB	22.06.2022	Gina Gill
3.0	Criteria added/amended following approval of recommendations within the Clinical Policy Alignment (formerly Difficult Decisions) Programme.	23.02.2023	Gina Gill
3.1	Criteria amended for NIV following clinical engagement with Respiratory Physicians at UHNM and ICB Clinical Leads.	11.10.2023	Jackie Newman

Impact Assessments – available on request

	Stage	Complete	Comments
Equality Impact Assessment	1	21.06.2022	
Quality Impact Assessment	1	14.06.2022	
Privacy Impact Assessment	N/A		
Quality Impact Assessment – V3.1	1	13/11/2023	

Version Number	Date	Outline of Amendments
1.0	May 2022	Amalgamation of the following excluded and restricted procedures policies: North Staffordshire CCG and Stoke on Trent CCGs Excluded and Restricted Procedures Policy April 2018 (v 5.1) South Staffordshire Excluded and Restricted Procedures Policy 2017 (v 5) East Staffordshire Procedures of Low Clinical Value Commissioning Policy 2017 (v 6) Addition of excluded procedures for all six CCGs based upon clinical evidence for the following: • Specialist Cognitive Behaviour Therapy (CBT) for Management of Aggressive Behaviour in People with Learning Disabilities • Cognitive Behaviour Therapy (CBT) for Stuttering • Themed Bi-manual Training for Cerebral Palsy • Specialist Integration Therapy for children with autism spectrum disorder and other diagnosed developmental disorders • Laser depilation as adjunct to surgery for pilonidal sinus • Endoscopic Thoracic Sympathectomy (ETS) for extreme facial blushing • Tonsillectomy for Tonsilloliths or tonsil stones • Targeted training to improve trunk (postural) control in children with cerebral palsy • Targeted training to improve trunk (postural) control in severely disabled children (Gross motor classification 1-5) • Ketogenic Diet for the treatment of Epilepsy in Adults • Seizure Detection Sensors/Systems for Management of Epilepsy • Transluminal balloon angioplasty • Dyadic Development Psychotherapy (DDP) • Sativex for multiple sclerosis (MS) • Sodium Oxybate the treatment of Narcolepsy and Cataplexy in adults Addition of excluded procedures based upon clinical evidence for the following interventions: *North Staffordshire and Stoke-on-Trent CCGs* • Cosmetic Excision of skin of head or neck – e.g. face lift, brow lift, rhinoplasty and blepharoplasty to treat the natural process of aging • Surgical Treatment of Meniere's Disease • Treatment of Salmonella Enteritis (non-severe) Faecal Transplant • ERCP Management of Pancreatitis • Endoscopic Drainage of Pancreatic Pseudocyst • Surgical Drainage of Pancreatic Pseudocyst • Insertion of Endobronchial Nitinol coils to improve Lung Function in Emphysema

		• Surgical Treatment of Synovitis and Tenosynovitis • Home monitoring of INR • Allograft reconstruction for glenoid bone loss in glenohumeral instability Addition of excluded procedures based upon clinical evidence for the following interventions: *South East Staffordshire and Seisdon Peninsular, Cannock Chase, East Staffordshire and Stafford and Surrounds Clinical Commissioning Group* • Sympathectomy for Raynaud's Disease • Surgical Treatment of Diverification of Recti (DRAM) • Excision of sweat gland bearing skin for hyperhidrosis Restricted criteria added/amended for all six CCGs based upon clinical evidence for the following; • Electrolysis treatment for any condition • Treatment of non-neonatal achalasia via pneumatic dilation or Heller myotomy and fundoplication (Heller Myotomy) Restricted criteria added/amended based upon clinical evidence for the following interventions: *North Staffordshire and Stoke-on-Trent CCGs* • Myringotomy with/without grommets for Otitis Media (Adults) • Open wound of ear drum Tympanoplasty • Cataract Surgery • Non-Invasive Ventilation • Trigger point injections for pain • Surgical Treatment of Obstructive Sleep Apnoea (OSA): Children *South East Staffordshire and Seisdon Peninsular, Cannock Chase, East Staffordshire and Stafford and Surrounds Clinical Commissioning Group* • Minor Skin Lesions • Laser treatment for birthmarks and scarring • Blepharoplasty • Operations on nose: septoplasty or septorhinoplasty • Surgical Treatment for Chronic Sinusitis • Umbilical and Para-umbilical hernia • Incisional Hernia • Rectal Bleeding • Cholecystectomy for Symptomatic Gallstones • Intra Uterine Contraceptive Devices (IUCDs) including Mirena Coils • Hysteroscopy • Planned Caesarean Section (when not to offer) • Surgery for protatism • Cough assist therapy

		• Surgery for hydrocele • Carotid Endarterectomy • Open and Upright MRI and MRI under General Anaesthetic (GA) in Adults • Continuous Blood Glucose Monitoring and integrated Insulin Pump Therapy – moved to separate commissioning policy • Low Intensity Ultrasound (Exogen) for the Healing of Fractures – moved to separate commissioning policy *East Staffordshire ONLY* • Alignment to Staffordshire and Stoke-on-Trent MSK policy. Alignment to NHS England evidence-based interventions criteria for all six CCGs for the following interventions; • Excision of lesion of the eyelid (including Chalazia) • Dilatation and curettage (D&C) in women for menorrhagia • Dupuytren's Disease – Palmar Fasciectomy • Trigger Finger – Surgical Treatment • Surgical removal of ganglion Signposting to NHS England Commissioned Services for the following interventions; • Ketogenic Diet for the treatment of Epilepsy in Children • Sacral Nerve Stimulation for Urinary or Faecal Incontinence • Penile implants • Sodium Oxybate the treatment of Narcolepsy and Cataplexy in children
2.0	June 2022	Adapted for ICB
3.0	Feb 2023	Criteria added/amended for the following interventions; • Female Sterilisation • Male Sterilisation • Breast Augmentation/Reconstruction • Abdominoplasty/Apronectomy • Body Contouring
3.1	Aug 2023	Criteria amended for NIV following clinical engagement

1.0 Purpose

1.1 The purpose of this Commissioning Policy (which replaces the current Policies on Procedures of Limited Clinical Value and Low Priority Treatments, or Exclusions and Restrictions) is to clarify the commissioning intentions of the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB).

2.0 Introduction

2.1 This Policy supports the decision-making process associated with the allocation of resources for commissioning. It will be used to support the development of effective, efficient and ethical Service Level Agreements with provider organisations, and the procurement of interventions on an exceptional basis.

2.2 The Policy establishes the framework within which the ICB can demonstrate that its decision-making processes are fair, equitable, ethical, and legally sound.

3.0 Background

3.1 NHS Commissioners receive funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations, and guidance. NHS Commissioners have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them.

3.2 NHS Commissioners are required to commission comprehensive, effective, accessible services which are free to users at the point of entry (except where there are defined charges) within a finite resource. It is, therefore, necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.

3.3 This Policy is designed to help the ICB to meet its obligation in providing equitable access to health care. It aims to achieve this by supporting a robust decision-making process that is reasonable and open to scrutiny.

4.0 Definition of "Low Priority Treatments"

4.1 The term "treatment" describes clinical care and programmers of care that include:

- Medicines
- Surgical procedures
- Therapeutic and other healthcare interventions

4.2 On systematic evaluation, some interventions have been identified as being either marginally effective or ineffective with limited clinical value in the vast majority of cases. Others have been shown to be an inefficient use of resource given their high cost per quality adjusted life year gained.

4.3

5.0 Operating Policy for the Development and Implementation of this Policy

5.1 Scope

5.1.1 A number of national organisations, such as NICE in England, Scottish Intercollegiate Guidelines Network (SIGN) in Scotland, and the Medical Colleges are committed to producing evidence-based commissioning policies. The emphasis is on high value care pathways. In addition, Public Health clinicians from across Staffordshire and the West Midlands have developed evidence-based advice to inform both the prioritisation process and commissioning decisions on low priority treatments. Throughout this Policy these treatments or procedures are categorised as Excluded or Restricted. Excluded treatments or procedures will not be funded by the NHS Commissioners. Restricted treatments or procedures will only be funded for those patients where an appropriate threshold for the intervention as stated in this Policy has been met.

5.2 Determining the Evidence Base

5.2.1 Evidence for treatment effectiveness and efficacy is available from many sources, including NICE, the Cochrane Institute, Royal Colleges, other professional guidelines, and sources such as peer reviewed journals or technical notes. Evidence varies in its robustness, ranging from meta-analyses of randomised control trials with large populations of participants, to traditional consensus about best practice. The NHS Commissioners in arriving at this Policy have taken advice from Public Health locally on the source, extent, and quality of the evidence in reaching their decisions and assessed the relative clinical value of many specific procedures through the local prioritisation process.

5.3 Populations

5.3.1 Unless stated otherwise the restrictions within this policy apply to both paediatrics and adults. A paediatric case is defined as a child between the ages of 0 and 18.

Unless stated otherwise the restrictions within this policy apply to all patients within the Staffordshire and Stoke-on-Trent Integrated Care System.

5.4 Ethical and Legal Policy for Decision Making

5.4.1 The NHS Commissioners have Prioritisation Frameworks which are reviewed on an ongoing basis. Utilisation of these prioritisation frameworks informs the review of this policy and the procedures and treatments that it covers.

5.5 Implementation

5.5.1 The schedule showing low priority treatments is set within this policy. This can be incorporated into contractual and service level agreements. NHS Commissioners will require primary and secondary care service providers and other organisations acting on behalf of NHS Commissioners to embrace and abide by the policy and to advise patients accordingly.

5.5.2 The Policy is implemented by GPs and Primary Care Health Professionals when advising and referring patients and by providers when considering the treatment options for patients. Those making referrals should refer to any provider for treatment or procedure covered by this policy. Providers should not suggest, recommend, or otherwise offer excluded treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend, or otherwise offer restricted treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend, or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure.

5.5.3 Providers should not suggest, recommend, or otherwise offer excluded treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend, or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure (see table on pg. 11).

5.5.4 Within the policy, and as stated against individual treatments or procedures listed in (see table on pg. 11), treatments and procedures are classified as Excluded or Restricted. Unless specifically stated all treatments and procedures are classified as Excluded or Restricted by all NHS Commissioners.

5.5.5 Excluded procedures and treatments are not commissioned by the NHS Commissioners.
Where individual patient circumstances require the escalation of their care and a procedure or treatment classified as excluded is being proposed then providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.

5.5.6 Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied. Where a patient satisfies the threshold statement or criteria the procedure or treatment is prior approved and can be undertaken. Where the threshold statement or criteria are not met then the procedure or treatment is excluded for that patient and paragraph 5.6.4 above applies.

5.5.7 This Policy is distributed to all providers, primary care contractors and ICB Localities.

5.6 Monitoring the Policy

5.6.1 NHS Commissioners will monitor the adherence to this policy through the contractual process, using contractual levers where breaches of the Policy are identified.

5.6.2 Referrals to secondary care that are outside of this Policy will be routinely monitored by the Commissioning Management and the Contracts Management Teams of the NHS Commissioners.

5.6.3 NHS Commissioners will provide periodic reports to their Boards reporting the number and nature of breaches of the Policy, by provider and by procedure.

5.6.4 Where there are defined thresholds, the compliance with the criteria will be subject to regular clinical audits carried out or organised by NHS Commissioners. The audit process will require providers to produce patient specific evidence that confirms the threshold criteria for procedures were satisfied at the time the decision to offer the procedure to the patient was taken. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the threshold criteria were met at the time the decision to perform the procedure was taken, then the default will be to consider the procedure was excluded and therefore it will not attract payment from the NHS Commissioners.

5.6.5 NHS Commissioners reserve the right to reduce the value of all payments for procedures with OPCS codes that match those for Excluded and Restricted procedures (as listed within this policy)

5.6.6 Any procedures marked as 'Requires Prior Approval' must be approved by ICB before the surgery is undertaken using the agreed form/mechanisms. Commissioners will not pay for any procedures undertaken without the required approval from the responsible commissioner. Prior Approval requests will be processed, and a decision made within 15 working days of receipt by the ICB (this may be delayed if insufficient information is provided and clarification sought by the ICB).

5.6.7 This policy is only applicable to elective/planned activity and non-elective activity is excluded from all the terms and conditions of this policy with no restrictions or exclusions applying. The policy also does not apply to patients who are on a 2ww/cancer pathway or where there is suspicion of malignancy and this activity will be excluded from any challenge or audit process.

6.0 Audit

6.1 BlueTeq prior approval system is the preferred prior approval mechanism to be used to pre-authorise procedures where restrictions apply. Colonoscopy for rectal bleeds, hysteroscopy and paediatric tonsillectomies shall be excluded from the Blueteq prior approval system however commissioners reserve the

right to undertake audits in line with GC15.

6.2 All monitoring will exclude any procedures where Commissioners have identified that the OPCS code is either not applicable or not relevant or a not directly linked to an OPCS code or where the OPCS code is not specified as the Trust is unable to 'track' this activity.

7.0 Maintaining an up-to-date Policy

7.1 NHS Commissioners will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the NHS Commissioners is to:

- Monitor the implementation of the Policy and the impact it has on clinical decision making;
- Inform referrers of the Policy;
- Inform all service providers with whom the NHS Commissioners have formal contractual arrangements of the Policy;
- Review the policy and the accompanying schedule on an ongoing basis and/or where an urgent consideration of new evidence is justified.

8.0 Managing Expectations

8.1 In their dealings with patients and the public, providers should, if necessary, make it clear that the decision by NHS Commissioners to consider treatments or procedures to be of low priority under this policy is a considered decision made against their responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them and that it is necessary for the NHS Commissioners to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the local population.

8.2 Where individual patient circumstances require the escalation of their care providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Request.

Behavioural/Psychological Therapy
Not routinely commissioned with the exception of children where assessment away from family may be vital to determine the root cause, fully exclude physical illness and allow protection and space for disclosure.

OPCS Codes	ICD 10 Codes	Procedures	Thresholds	Status
Not applicable	F60.3 F44.9	Psychotherapy for Borderline Personality Disorder and Dissociative disorders	Not routinely commissioned	Excluded
Not applicable	F95.0, F95.1, F95.2, F95.8, F95.9	Behaviour Therapy for Gilles de la Tourette syndrome and tic disorders	Not routinely commissioned	Excluded
X66.1, X66.2, X66.8, X66.9	G93.3	Inpatient cognitive behavioural therapy for Chronic fatigue syndrome	Not routinely commissioned	Excluded
X66.1, X66.2, X66.8, X66.9	F81.9	Specialist Cognitive Behavioural Therapy (CBT) for Management of Aggressive Behaviour in People with Learning Disabilities	Not routinely commissioned	Excluded
X66.1, X66.2, X66.8, X66.9	F98.5	Specialist Cognitive Behavioural Therapy (CBT) for stuttering	Not routinely commissioned	Excluded
Not applicable	Not applicable	Dyadic Development Psychotherapy (DDP)	Not routinely commissioned	Excluded

Cardiology

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
K16.5	Q21.1	Closure of Patent Foramen Ovale (PFO) for the prevention of stroke	Not routinely commissioned	Excluded
K16.5	G430, G431, G432, G433, G438, G439	Closure of Patent Foramen Ovale (PFO) for migraine headache	Not routinely commissioned	Excluded

Complementary Medicine/Therapies

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
X61.1, X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1, A70.6		Acupuncture	Acupuncture will only be commissioned as an adjunct to pain management and only through specialist pain clinics	Restricted
X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1.		Complementary Therapies/ Medicines	Including but not restricted to: • Alexander Technique • Applied Kinesiology • Aromatherapy • Autogenic Training • Ayurveda • Chelation Therapy • Chiropractic • Environmental Medicine • Gerson Therapy • Healing • Herbal Medicines • Homeopathy • Hypnosis • Massage • Meditation • Naturopathy • Nutritional Therapy • Osteopathy • Radiation Therapy • Reflexology • Reiki • Shiatsu	Excluded

Dermatology and Plastic Surgery

Unless stated as an exemption, all cases for patients aged 16 years and over will be referred from primary care to the ICBs Choice and Referral Centre for clinical triage into the local tier 3 community service or directly into local tier 3 community services for clinical triage where a Choice and Referral Centre is not available.

Any case with clinical 'red flags' or paediatrics should be referred directly to the acute service. The community service will be responsible for ensuring appropriate conservative and non-surgical treatment options are tried and have failed before referral for surgical opinion.

The assumption is that all cases referred for surgical opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

ONLY East Staffordshire PCN may directly refer to the Trust however there is an expectation all appropriate conservative and non-surgical treatment options are tried and have failed prior to referral.

Referrals should include imaging where appropriate.

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
N42.1, P13.7, S04.1, S04.2, S04.3	R610, R611, R619	Excision of sweat gland bearing skin for hyperhidrosis	Not routinely commissioned	Excluded
C10.1,D02.1, D02.2, D02.8, D02.9, E09.1, E09.2, E09.6, F02.1, F02.2, H48.1, H48.2, H48.3, H48.8, H48.9, H49.1,	L98.9,I78.1, L84.X,D22.0, D22.1,D22.2, D22.3,D22.4, D22.5,D22.6, D22.7,D22.9, D23.0,D23.1, D23.2,D23.3, D23.4,D23.5, D23.6,D23.7, D23.9,D17.0, D17.1,D17.2,	Treatment of Minor Skin Lesions including benign pigmented moles, comedones, corns/callous, lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, warts, xanthelasma and neurofibromata, epidermoid/Pilar (sebaceous) cysts	Will be routinely commissioned under the following circumstances: Significant functional impairment which is seen as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance, and which the clinical and patient agree is interfering with or compromising several activities of daily living **OR** 2 or more infections requiring prescribed antibiotic and/or pain with prescribed analgesia use over the	Restricted

H49.2, H49.3, H49.8, H49.9, N01.2, N27.1, N72.2, N72.3, P11.1, P11.2, P11.3, P11.4, P11.8, P11.9 S05.1, S05.2, S05.3, S05.4, S05.5, S05.8, S05.9, S06.1, S06.2, S06.3, S06.4, S06.5, S06.6, S06.7, S06.8, S06.9, S08.1, S08.2, S08.3, S08.8, S08.9, S09.1, S09.2, S09.3, S09.4, S09.5, S09.8, S09.9, S10.1, S10.2, S10.3, S10.4, S10.8, S10.9, S11.1, S11.2, S11.3, S11.4, S11.8, S11.9, S60.8,	D17.3, D17.4, D17.5, D17.6, D17.7, D17.9, B08.1D + H03.1A, B08.1,L82.X, L91.8,Q82.8, B07.X,A63.0, H02.6,D36.1, L72.0,L72.1, L72.9		past 12 months. Prior approval must be sought via BlueTeq as per current arrangement.	

C12.1, C12.2, C12.4, C12.5, C12.6, C12.8, C12.9 C19.1, C19.8	H02.3, H02.5, H02.7, H02.8 H02.9	Excision of lesion of the eyelid (including Chalazia)	Incision and curettage (or triamcinolone injection for suitable candidates) of lesions of eyelid including chalazia should only be undertaken if at least **ONE** of the following criteria have been met: • Has been present for more than 6 months and has been managed conservatively with warm compress, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a 6-month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected • E.g. Madarosis/recurrent/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions Cosmetic eyelid surgery to correct puffy, hooded, wrinkled tired looking eyes will not be commissioned	Restricted

S09.1, S09.2, S09.3, S09.8, S09.9	D18.0, Q82.5	Laser or surgical treatment for congenital vascular abnormalities (inc. Port Wine Stain, Paediatric Haemangiomas)	Will be routinely commissioned under the following circumstances: Paediatric haemangiomas can have surgical treatment offered for those which: • Threaten life or function, including compromising eyesight, respiratory, cardiac, or hepatic functions **OR** • Other internal lesions sited in an area liable to scar **OR** • Large facial hemangiomas that have failed to regress by school age **OR** • Show a tendency to bleed or to become infected **OR** • Kasabach-Merritt syndrome (coagulopathy)	Restricted
S02.1, S02.2, S02.8, S02.9	Z42.2, Z41.1	Abdominoplasty/Apronectomy/ Panniculectomy	Not routinely commissioned	Excluded
S03.1, S03.2, S03.3, (S03.8 or S03.9 with Z49.5 or Z50.1)	Z42.2, Z42.3, Z42.4, Z42.8, Z42.9	Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm. Buttock/Thigh/Arm lift or body Contouring	Not Routinely Commissioned	Excluded
D03.1, D03.2, D03.3, D03.8, D03.9, D06.2	Q17.5, H61.1,	Cosmetic operations on the external ear including Pinnaplasty, split earlobes, excision of lesion of external ear	Not routinely commissioned	Excluded

B29.5, B29.8, B29.9, B30.1, B30.8, B30.9, B31.2, B37.8, B37.9		Cosmetic Operations on Breast (female) Breast augmentation	Will be routinely funded for patients who meet the following criteria: • Reconstructive surgery following mastectomy for either suspected or proven malignancy **OR** • Following prophylactic bilateral mastectomy for cancer prevention in high risk cases.	Restricted
B31.3, B37.8, B37.9		Cosmetic Operations on Breast (female) Mastopexy	Not routinely commissioned	Excluded
B30.2, B30.3, B30.4, B31.4, B33.2, B33.3, B37.4, B29.5, B29.8, B29.9, B30.1, B30.8, B30.9, B31.2, B37.8, B37.9		Cosmetic Operations on Breast (female) Revision of breast augmentation	Breast implant revision surgery will **ONLY** be supported if one of the following applies: •Breast disease •Implants with capsule formation that interferes with mammography •Implants complicated by recurrent infection •Implants with Baker Class IV contracture associated with pain •Intra or extra capsular rupture of silicone gel filled implants *Breast implants will **ONLY** be replaced when the patient meets the acceptance criteria of the current breast augmentation policy. In all other patients faulty or problematic implants will be removed and not replaced.	Restricted

B31.1, B37.8, B37.9		Cosmetic operations on breast (female) Breast Reduction	Patients are **ONLY** eligible for surgery to reduce breast size if the following criteria are met: • The patient is suffering from functional problems: neck ache, backache and/or intertrigo, where any possible causes of these conditions have been considered and excluded **AND** • Symptoms are not relieved by physiotherapy and a professionally fitted brassiere has not relieved symptoms **AND** • The patient has a body mass index (BMI) within the range 18kg/m2 and 25kg/m2 **AND** • Have a cup size of F+ **AND** • Be 21 years of age or over Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or following, this assessment there should be access to a trained bra fitter where it is available. **AND** • There is an expected need to remove at least 500g of tissue from each breast	Restricted
B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9		Surgery for inverted nipples	Not routinely commissioned	Excluded

B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9	Q83.3	Removal of Supernumerary Nipples (Polymastia)	Not routinely commissioned	Excluded
S60.4	L90.5, L90.6	Refashioning of scars/keloids including stretch marks.	Not routinely commissioned	Excluded
B31.1, B31.4, B31.8, B31.9	N62.X	Gynaecomastia	Not routinely commissioned however if malignancy (either breast or testicular) is suspected, then normal cancer pathways should be followed. Chronic liver disease, thyroid disease, and renal disease should also be excluded.	Excluded
Not applicable		Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring and Keloids.	Not routinely commissioned	Excluded
S01.1, S01.2, S01.3, S01.4, S01.5, S01.6, S01.8, S01.9	G51.0	Cosmetic excision of skin of head or neck – e.g. face lift, brow lifts, rhinoplasty, and blepharoplasty to treat the natural process of aging.	Not routinely commissioned	Excluded
S62.1, S62.2	Z42.2, Z42.3, Z42.4, Z42.8, Z42.9	Liposuction of subcutaneous Tissue.	Not routinely commissioned	Excluded
C13.1, C13.2, C13.3, C13.4, C13.5,	H02.0, H02.1, H02.4, H02.5, H02.7, H02.8	Blepharoplasty	Blepharoplasty will be routinely commissioned only for upper lids in the presence of: • **visual field impairment** (reducing visual field to 120° laterally and 40°	Restricted

C13.8, C13.9, C14.8, C14.9, C15.1, C15.2, C15.4, C15.5, C15.8, C15.9, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.8, C18.9	H02.9		vertically) • **Severe congenital ptosis** This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin. Note: Excessive skin in the lower lid may cause "eyebags" but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons. The following procedures will not be funded: • Surgery for cosmetic reasons • Surgery for cyst of moll • Surgery for cyst of zeis • Removal of eyelid papillomas or skin tags • Surgery for pingueculum • Excision of other lid lumps	
Not applicable	L90.9	Facial Atrophy – new fill Procedures.	Not routinely commissioned	Excluded
P05.5, P05.6, P05.7, P05.8, P05.9	N90.6, N90.8, Z42.8, Z41.1, Z42.9	Cosmetic Surgery to Genitals	Female genital procedures for cosmetic purposes are not routinely commissioned. Labial surgery should **ONLY** be offered to patients who fulfil **ONE** of the following criteria: • Labiaplasty is required secondary to other medical conditions such as cancer • Where repair of the labia is required after trauma.	Restricted

S60.6, S60.7	L68.0, L68.1, L68.2, L68.3, L68.8, L68.9,	Permanent hair removal or reduction techniques for conditions including but not limited to: excess body hair, facial hirsutism, hypertrichosis and as adjunct to surgery for pilonidal sinus	Not routinely commissioned with the exception of electrolysis in the following circumstances; To manage misdirected lashes causing ocular irritation and corneal injury which would prevent need for further intervention/surgery. **OR** Where patients have undergone skin transplants using skin from a hair bearing area to a non-hair bearing area.	Excluded
S21.1 S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9.	L64.0, L64.8, L64.9 L65.0, L65.1, L65.2, L65.8, L65.9	Correction of hair loss including male female pattern baldness and hair transplantation	Surgical and medical treatments are not routinely commissioned. See wig provision https://www.nhs.uk/using-the-nhs/help-with-health-costs/wigs-and-fabric-supports-on-the-nhs/	Excluded
S10.3, S11.3, S60.1, S60.2.	Q82.5, L90.5, L91.0	Laser Treatment for birthmarks and scarring	Laser Treatment for birthmarks and scarring will only be routinely commissioned for large (in excess of 5cm x 5cm) and will be routinely commissioned under the following circumstances: The area to be treated is on the face **AND** The patient has been through all other recognised treatments or it has been considered that the treatment would not be effective due to the size or condition of the area affected.	Restricted
S09.1, S09.2, S09.3, S09.8, S09.9	L71.8, L71.9	Laser or surgical treatment for rosacea	Not routinely commissioned. Severe cases of rhinophyma may be considered when there is evidence of severe nasal airway obstruction.	Prior Approval

S09.1, S09.2, S09.3, S09.8, S09.9	N/A	Skin Resurfacing techniques: Dermabrasion, Chemical Peels, Laser treatment and referrals for prescriptions for topical treatments etc.	Not routinely commissioned	Excluded
S53.2 with X85.1 (to identify Botulinum Toxin)	R61.0, R61.1, R61.9	Botox for excessive sweating	Not routinely commissioned.	Excluded
X85.1 with Z60.1, with or without X37.5	Z41.1	Botox for facial aging or excessive wrinkles.	Not routinely commissioned	Excluded
S09.1, S09.2, S10.8, S10.9	L81.8	Tattoo removal.	Not routinely commissioned	Excluded
Not applicable	Not applicable	Gender dysphoria	Not routinely commissioned by ICB. Gender Reassignment is now the responsibility of NHS England and commissioned through specialised commissioning. GPs can refer directly to their contracted services http://www.nhs.uk/livewell/transhealth/pages/local-gender-identity-clinics.aspx	Excluded
A75.2	R23.2	Endoscopic thoracic sympathectomy (ECT) for extreme facial blushing.	Not routinely commissioned	Excluded

OPCS codes	ICD 10 Codes	Procedures	Thresholds	Status
U211, Y97, Y98		Open and Upright MRI and MRI under General Anaesthetic (GA) in Adults	Urgent open/upright MRI or MRI under GA requests in cases with red flag symptoms or signs should be made urgently by the referring clinician directly to the commissioned provider and are excluded from this policy. Patients with the following are eligible for funding for open/ upright MRI: • Patients who are unable to tolerate conventional MRI due to claustrophobia despite conservative management of anxiety (including noise-cancelling headphones, visual aids, and scanning feet first) AND the use of sedation (where sedation is not contraindicated). **AND** • Investigation is clinically required and will directly inform diagnosis or treatment **OR** • Patients where there is no alternative option (for example, due to obesity, severe contractures, inability to lie flat) Patients with the following are eligible for funding for MRI under GA: • Sedated and Ventilated on Critical Care	Prior Approval

			OR • Confusion and pre-existing agitation **OR** • Adult with Learning Disability **OR** • Unable to lie flat and stationary due to medical reasons or physical impairment AND unable to use an open/upright scanner (assessed using clinical judgement) Prior approval to be sought in line with current process.	

Ear, Nose and Throat and Paediatric surgery (inclusive of NEL)

Any case with clinical 'red flags' or paediatrics should be referred directly to the acute service. The community service will be responsible for ensuring appropriate conservative and non-surgical treatment options are tried and have failed before referral for surgical opinion.

The assumption is that all cases referred for surgical opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

ONLY East Staffordshire PCN may directly refer to the Trust however there is an expectation all appropriate conservative and non-surgical treatment options are tried and have failed prior to referral.

Referrals should include imaging where appropriate.

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
E20.1, E20.8, E20.9 (Where primary procedure is in F34.1, F34.2,	N/A	Adenoidectomy	Adenoidectomy will only be funded if undertaken in conjunction with Tonsillectomy and/or Grommets (*Please refer to policies for Tonsillectomy and/or Grommets)*.	Prior Approval

F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9)			For adenoidectomy only, prior approval will need to be sought	
F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9	J03.0, J03.8, J03.9, J35.0	Tonsillectomy	To be undertaken in line with the SIGN 2010 guidance: - The following are recommended as indications for consideration of tonsillectomy for recurrent acute sore throat in both children and adults: • Seven or more **well documented**, clinically significant, adequately treated sore throats in the preceding year, • **OR** • Five or more such episodes in each of the preceding two years **OR** • Three or more such episodes in each of the preceding three years **AND** • Sore throats are due to acute tonsillitis **AND** • The episodes of sore throat are disabling and prevent normal	Restricted

			functioning NB A child is under the age of 16 for the purpose of tonsillectomy **<u>An eligible episode must have three of the following criteria:</u>** Tonsillar exudates /Tender anterior cervical lymph nodes/ History of fever/ Absence of cough When in doubt as to whether a tonsillectomy would be beneficial, a six-month period of watchful waiting is recommended.	
F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9	J36	Tonsillectomy for Peritonsillar Abscess (Quinsy)	Prior approval will need to be sought. Supporting clinic letters to accompany request.	Prior Approval
F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9	J35.8, J35.9	Tonsillectomy for tonsilloliths or tonsil stones	Not routinely commissioned	Excluded
E20.1, E20.8, E20.9 (Where	G47.3	Surgical Treatment for Obstructive Sleep Apnoea	To be undertaken in line with agreed OSA pathway.	Restricted

primary procedure is in F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9), F32.4, F32.5, F32.6 F32.8, F32.9 Y02.1, Y11.4		(OSA) children	In the absence of an agreed OSA pathway, these procedures will only be commissioning in the following circumstances; When diagnosis of SDB in children is confirmed based on history, physical examination, audio/video taping, pulse oximetry, and limited or full-night PSG. AHI>5 indicative diagnosis OSA	
E20.1, E20.8, E20.9 (Where primary procedure is in F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9), F32.4, F32.5, F32.6 F32.8, F32.9 Y02.1, Y11.4	G47.3	Surgical Treatment for Obstructive Sleep Apnoea (OSA): Adults	Will be routinely commissioned under the following circumstances: • Patients have Epworth Sleepiness Score 15-18 or: Patient sleepy in dangerous situations such as driving **AND** • Patient has significant sleep disordered breathing (as measured during sleep study, usually by the Apnoea/ Hypopnoea Index: 15- 30/hr. = moderate, >30/hr. = severe **AND** • Patient has already tried CPAP unsuccessfully for 6 months prior to being considered for surgery OR patient has major side effects to CPAP such as significant	Restricted

			nose bleeds **AND** • A clinical decision is that the patient will significantly benefit **AND** The patient is fully informed as to the limited effectiveness of procedures, the lack of long-term outcomes and likely adverse effects including pain following surgery	
F32.4, F32.5, F32.6, F32.8, F32.9, Y02.1, Y11.4	R06.5	Treatments for snoring Including, but not restricted to: Uvulopalatopharyngoplasty, Uvulopalatoplasty, Palate Implants and Radiofrequency Ablation of the Soft Palate	Not routinely commissioned	Excluded
D15.1, D20.2,	H65.9	Myringotomy with/without grommets for Otitis Media: Children	To be undertaken in line with NICE clinical guideline 60 – Surgical Treatment of Otitis Media with Effusion Children with persistent bilateral OME **documented over a period of 3 months** **AND** •A hearing level in the better ear of 25-30 dBHL **OR** •The worse ear averaged at 0.5, 1,2 and 4 kHz (or equivalent dBA where dNHL not available)	Restricted

			Alternative indications for Grommets. Children should only be considered for grommet insertion if: - • The child has experienced persistent hearing loss for more than a year with deficit estimated to be more than 25 decibels; **OR** • More than 6 episodes of **acute otitis media** in previous 12 months **OR** • The child has developmental impairment (e.g. speech/ language/ cognitive/ behavioural) likely to be due to, or exacerbated by, clinically suspected hearing loss. **OR** Poor progress at school directly attributable to this condition, the child has proven hearing loss, plus a second disability such as Down's Syndrome or cleft palate.	
D15.1, D20.2,	H65.9	Myringotomy with/without grommets for Otitis Media: Adults	Commissioned for patients where their consultant considers there is development of a retraction pocket and grommet would	Restricted

			help prevent cholesteatoma **OR** Patient is experiencing persistent hearing loss affecting work or socialization that has persisted for more than a year with deficit estimated to be more than 25 decibels.	
D15.1, D15.2, D15.8, D15.9, D20.2	H65.0, H65.1, H66.0	Surgical treatment of acute otitis media	Not routinely commissioned	Excluded
D264, D151, D262-8	H81.0	Surgical Treatment of Meniere's Disease	Not routinely commissioned	Excluded
D14.1, D14.2, D14.3, D14.4, D14.8, D14.9	S01.3, S09.2	Open wound of ear drum - Tympanoplasty	This procedure will **ONLY** be commissioned in the following circumstances: Chronic discharging ear, with deafness.	Prior Approval

E02.3, E02.4, E02.5, E02.6 E07.3, E02.1, E02.2, E02.6, E02.7, E02.8, E02.9	(J34.2), Z42.0, (M95.0) Z41.1, (Q35.1, Q35.2, Q35.3, Q35.5, Q35.7, Q35.9), Q36.0, Q36.1, Q36.9, Q37.0, Q37.1, Q37.2, Q37.3, Q37.4, Q37.5, Q37.8, Q37.9	Operations on nose: septoplasty or septorhinoplasty	Septoplasty or septorhinoplasty will be commissioned for the following clinical indications: 1. Continuous nasal airway Obstruction that results in mouth breathing reported by the patient and confirmed by the clinician **OR** 2. Post-traumatic nasal deformity associated with documented sustained interference of the airway; **OR** 3. As part of the treatment for congenital abnormalities e.g. cleft lip and palate.	Restricted
E14.2, E13.3	J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9	Surgical Treatment of Chronic Sinusitis	Shall only be commissioned in the following circumstances; Patients with sinusitis symptoms for more than 12 weeks **OR** Nasal polyps **AND** All conservative measures have failed.	Restricted

Endocrinology

OPCS codes	ICD 10 Codes	Procedures	Thresholds	Status
		Continuous Glucose Monitoring and Integrated Insulin Pump Therapy	Please see separate Commissioning Policy for continuous glucose monitoring/integrated insulin pump therapy.	Restricted

General Surgery

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
C10.1, D02.1, D02.2, D02.8, D02.9, E09.1, E09.2, E09.6, F02.1, F02.2, H48.1, H48.2, H48.3, H48.8, H48.9, H49.1, H49.2, H49.3, H49.8, H49.9, N01.2, N27.1, N72.2, N72.3, P11.1, P11.2, P11.3, P11.4, P11.8, P11.9 S05.1, S05.2, S05.3, S05.4, S05.5, S05.8, S05.9, S06.1, S06.2, S06.3,	L98.9, L78.1, L84.X, D22.0, D22.1, D22.2, D22.3, D22.4, D22.5, D22.6, D22.7, D22.9, D23.0, D23.1, D23.2, D23.3, D23.4, D23.5, D23.6, D23.7, D23.9, D17.0, D17.1, D17.2, D17.3, D17.4, D17.5, D17.6, D17.7, D17.9, B08.1D + H03.1A, B08.1, L82.X, L91.8, Q82.8,B07.X, A63.0, H02.6,	Treatment of Minor Skin Lesions including benign pigmented moles, comedones, corns/callous. lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, warts, xanthelasma and neurofibromata, epidermoid/Pilar (sebaceous) cysts	Will be routinely commissioned under the following circumstances: Significant functional impairment which is seen as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance, and which the clinical and patient agree is interfering with or compromising several activities of daily living **OR** 2 or more infections requiring prescribed antibiotic and/or pain with prescribed analgesia use over the past 12 months. Prior approval must be sought via BlueTeq as per current arrangement.	Restricted

S06.4, S06.5, S06.6, S06.7, S06.8, S06.9, S08.1, S08.2, S08.3, S08.8, S08.9, S09.1, S09.2, S09.3, S09.4, S09.5, S09.8, S09.9, S10.1, S10.2, S10.3, S10.4, S10.8, S10.9, S11.1, S11.2, S11.3, S11.4, S11.8, S11.9, S60.8,	D36.1, L72.0, L72.1, L72.9			
T19.1, T19.2, T19.3, T19.8, T19.9, T201, T202, T203, T204, T208, T209, T211, T212, T213, T214, T218, T219	(K40.0), (K40.1), (K40.4), K40.2, (K40.3), K40.9	Inguinal Hernia	Surgical repair will be commissioned when patients meet one of the following criteria: • Incarcerated hernia or not amenable to simple reduction **OR** • Symptomatic inguinal hernia **OR** • Strangulated hernia (emergency surgery) Patients with occult/asymptomatic/minimally	Restricted

			symptomatic primary or recurrent inguinal hernias **AND** who have significant co-morbidity (ASA 3 or 4) **AND** who do not want to have surgical repair (after appropriate information provided) **can be managed conservatively at primary care level.** • All children <18 years with inguinal hernia should be referred to a paediatric surgical provider • Any groin hernia in a woman should be referred urgently to a specialist • patients who are undergoing or plan to undergo peritoneal dialysis should be referred.	
T24.1, T24.2, T24.3, T24.4, T24.8, T24.9	(K42.0), (K42.1), K42.9	Umbilical and Para umbilical Hernia	Not routinely commissioned except: • Pain or discomfort sufficient to cause significant functional impairment, significant interference with activities of daily living with prescribed analgesia use **OR** • If the patient is considered at risk of incarceration or strangulation. However, patients who are undergoing or plan to undergo peritoneal dialysis	Restricted

			should be referred.	
T25.1, T25.2, T25.3, T25.8, T25.9	K43.0, K43.1, K43.2, K43.6, K43.7, K43.9	Incisional Hernia	Asymptomatic incisional hernias will not be funded except where peritoneal dialysis is planned. Symptomatic incisional hernias will not routinely be commissioned unless the following exceptions are met; • Incisional hernias with moderate to severe pain with prescribed analgesia will be repaired. **OR** • Risk of strangulation	Restricted
T19.1, T19.2, T19.3, T19.8, T19.9 T24.1, T24.2, T24.3, T24.8, T24.9 with addition of Y75.2	(K40.0, K40.1, K40.2)	Laparoscopic inguinal or femoral Hernia Repair	This commissioned **ONLY** for • Bilateral hernia repair (where the patient has bilateral hernias with external swelling on clinical examination) **OR** • Recurrent hernia after previous hernia surgery.	Restricted
H22.1, H22.8, H22.9, H25.1, H25.8, H25.9, H28,1, H28,8, H28,9	K62.5	Rectal bleeding	Investigation should be undertaken in line with RCS guidance. Colonoscopy will not be commissioned as a first line investigation.	Restricted

H51.1, H51.2, H51.3, H51.8, H51.9	(K64.2, K64.3), K64.0, K64.1, K64.5, K64.8, K64.9	Haemorrhoidectomy	Will be routinely commissioned under the following circumstances: • Patient has recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding **OR** • Irreducible and large external haemorrhoids.	Restricted
G44.8 + Y11.4 + O11.1	K21.0, K21.9	Endoscopic radiofrequency ablation for gastro oesophageal Reflux Disease (GORD).	Not routinely commissioned	Excluded
	K21.0, K21.9	Linx Reflux Management system for Gastro Oesophageal Reflux Disease (GORD).	Not routinely commissioned	Excluded
J18.1, J18.2, J18.3, J18.4, J18.5, J18.9	K80.0, K80.1, K80.2, K80.4, K80.8	Cholecystectomy	Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned. Cholecystectomy for Symptomatic Gallstones is commissioned in line with RCS and NICE Guidance.	Excluded Restricted

A75.1, A75.2, A75.3, A75.4, A75.5, A75.8, A75.9, A76.1, A76.2, A76.3, A76.4, A76.5, A76.8, A76.9	I73.0	Sympathectomy for Raynaud's disease	Not routinely commissioned	Excluded
A70.1 with Z27.2	K31.8	Gastroelectrical stimulation for gastroparesis.	Not routinely commissioned	Excluded
G54.3	E11	Implantation of a duodenal-Jejunal Bypass Liner (DJBL) for managing Type 2 Diabetes.	Not routinely commissioned	Excluded
T32.1, T32.2, T32.3, T32.4, T32.8, T32.9	M62.0, M62.8, M62.9	Surgical Treatment of Diverification of Recti (DRAM).	Not routinely commissioned	Excluded
Y37.8	A02.0, A02.2, A02.8, A02.9	Treatment of Salmonella Enteritis (non severe) - faecal transplant.	Not routinely commissioned	Excluded
K42.8, J43.9	K86.1	ERCP Management of Pancreatitis	Not routinely commissioned for chronic pancreatitis	Excluded

J42.4,	K86.2, K86.3	Endoscopic Drainage of Pancreatic Pseudocyst.	Not routinely commissioned	Excluded
J61.4, J61.8, J61.9	K86.2	Surgical Drainage of Pancreatic Pseudocyst.	Not routinely commissioned	Excluded
L41.1, L41.2, L41.3, L41,4, L41.5, L41.6, L41.8, L41.9, L43.5	I70.1	Treatment of Atherosclerosis of Renal Artery.	Transluminal balloon angioplasty with or without stent is not routinely commissioned	Excluded
G15.2, G15.3, G15.5 G18.2, G18.3, G18.5, G44.3, G44.6 G09.1, G09.2, G24.1, G24.3	K22.0	Treatment of non-neonatal achalasia via pneumatic dilation or Heller myotomy and fundoplication (Heller Myotomy)	Will be routinely commissioned for patient with dysphagia and a manometric/radiologic diagnosis of achalasia. Surgery is for those patients deemed fit for surgery OR Who choose surgery over dilation Pneumatic dilation for poor operative candidates or those who refuse surgery.	Restricted

Gynaecology

Unless stated as an exemption, all cases for patients aged 16 years and over will be referred from primary care to the ICBs Choice and Referral Centre for clinical triage into the local tier 3 community service or directly into local tier 3 community services for clinical triage where a Choice and Referral Centre is not available.

Any case with clinical 'red flags' or paediatrics should be referred directly to the acute service. The community service will be responsible for ensuring appropriate conservative and non-surgical treatment options are tried and have failed before referral for

surgical opinion.
The assumption is that all cases referred for surgical opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.
ONLY East Staffordshire PCN may directly refer to the Trust however there is an expectation all appropriate conservative and non-surgical treatment options are tried and have failed prior to referral.
Referrals should include imaging where appropriate.

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383	Not applicable	Infertility and Assisted Reproduction	Please see separate Commissioning Policy for Infertility and Assisted Reproduction	Restricted
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383	Not applicable	Subfertility services	Please see separate Commissioning Policy for Infertility and Assisted Reproduction	Restricted
Q12.1, Q12.2, Q12.3, Q12.4, Q12.8, Q12.9		Intra Uterine Contraceptive Devices (IUCDs) including Mirena coils	Insertion, removal and checks of IUCDs should only be undertaken within primary care. It is not commissioned as a stand-alone secondary care service. Patients requiring a fitting within secondary care for clinical reasons where a fitting in primary care is not possible. Removals of lost or displaced IUCDs will be commissioned within secondary care where circumstances dictate that this cannot be managed within primary care. IUCDs fitted as a secondary	Excluded Restricted Restricted Restricted

			procedure/OPCS code will be commissioned within secondary care.	
P26.2, P26.3	Not applicable	Vaginal Ring Pessaries	Insertion and removal of vaginal ring pessaries will only be commissioned within primary care. First fitting will be commissioned as part of a first outpatient appointment where clinically necessary and will be commissioned for follow up if complications arise.	Restricted
		Vaginal Space Occupying Pessaries	Insertion and removal of vaginal space occupying pessaries will be commissioned within secondary care but only within an outpatient setting. The original pessary plus subsequent replacements will be routinely commissioned.	Restricted
Q22.2, Q23.3, Q23.4, Q24.2, Q25.1, Q25.8, Q25.9, Q27.1, Q27.2, Q28.3, Q28.4, Q35.1, Q35.2, Q35.4, Q35.8, Q35.9, Q36.1, Q36.2, Q36.8, Q36.9		Female sterilisation	Female sterilisation for the purpose of contraception will be routinely funded in the following circumstances; • Documented evidence that the patient is unable to tolerate other forms of contraceptive. **OR** • There is an absolute clinical contraindication to pregnancy **AND**	Restricted

			• Patients are aged 18 years and over **AND** • The patient has given fully informed consent for the permanent sterilisation procedure and have been informed that reversal of sterilisation is **NOT** available on the NHS and reversal of sterilisation has poor success rates	
Q18.8, Q18.9	Not applicable	Hysteroscopy	This procedure will be routinely commissioned within an outpatient setting unless clinically indicated. Treatment carried out within an inpatient or day case setting is not routinely commissioned.	Restricted (BlueTeq not required)
Q10.1, Q10.3, Q10.8, Q10.9	N92.0, N92.1, N92.4, N92.5, N92.6	Dilatation and curettage (D&C) in women for menorrhagia.	Not routinely commissioned	Excluded
Q07.2, Q07.4, Q07.8, Q07.9, Q08.2, Q07.5,	N92.0, N92.1, N92.4, N92.5, N92.6	Hysterectomy for menorrhagia	Will be routinely commissioned under the following circumstances: • There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) and it has failed to relieve symptoms unless it is medically inappropriate, or contraindicated.	Restricted

			AND At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Experience (NICE) guidelines: • Non-steroidal anti-inflammatory agents • Tranexamic acid • Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) **AND** • Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated.	

Haematology

OPCS codes	ICD 10 Codes	Procedures	Thresholds	Status
Not applicable	R798, Z921	Home Monitoring of INR	Not routinely commissioned	Excluded

Neurology

OPCS codes	ICD 10 Codes	Procedures	Thresholds	Status
A09.8	G43.0, G43.1, G43.2, G43.3, G43.8, G43.9	Trans-magnetic stimulation (TMS) for Migraine.	Not routinely commissioned	Excluded

A70.7	M79.2	Percutaneous Electro Neuro Stimulation (PENS) for Neuropathic pain.	Not routinely commissioned	Excluded
Not applicable	G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9	Targeted training to improve trunk (postural) control in children with cerebral palsy.	Not routinely commissioned	Excluded
Not applicable	F82X	Targeted training to improve trunk (postural) control in severely disabled children (inclusive of all gross motor classifications).	Not routinely commissioned	Excluded
Not applicable	G40.0, G40.1, G40.2, G40.3, G40.4, G40.5, G40.6, G40.7, G40.8, G40.9	Ketogenic diet for the treatment of epilepsy in children	Not routinely commissioned by ICBs. This is the responsibility of NHS England and commissioned through specialised commissioning. https://www.england.nhs.uk/wp-content/uploads/2018/09/E09-S-b-Paediatric-Neurosciences-Neurology.pro_.2013.04.v2.pdf	Excluded
Not applicable	G40.0, G40.1, G40.2, G40.3, G40.4, G40.5, G40.6, G40.7, G40.8, G40.9	Ketogenic diet for the treatment of epilepsy in adults	Not routinely commissioned	Excluded
Y75.1	G40.0, G40.1, G40.2, G40.3, G40.4, G40.5,	Seizure Detection Sensors/Systems for the management of	Not routinely commissioned	Excluded

	G40.6, G40.7, G40.8, G40.9	Epilepsy		
Not available	G47.4	Sodium Oxybate for treatment of narcolepsy and cataplexy in adults.	Not routinely commissioned	Excluded
Not available	G47.4	Sodium Oxybate for treatment of narcolepsy and cataplexy in children	Not routinely commissioned by ICBs. This is the responsibility of NHS England and commissioned through specialised commissioning. https://www.england.nhs.uk/publication/sodium-oxybate-for-symptom-control-of-narcolepsy-with-cataplexy-children-and-adolescents-aged-7-until-19-years/	Excluded
Not available	G35.X	Sativex for multiple sclerosis (MS)	Not routinely commissioned	Excluded

Obstetrics

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
R42.1, R42.2		Routine Doppler ultrasound of umbilical and uterine artery in low-risk pregnancies.	Not routinely commissioned	Excluded

R17.1, R17.2, R17.8, R17.9		A planned Caesarean Section should **NOT** be routinely offered to women with:	• With a 'small for gestational age' baby. • On the grounds of HIV status to prevent mother-to- child transmission of HIV to: o women on highly active anti-retroviral therapy (HAART) with a viral load of less than 400 copies per ml or; • women on any anti-retroviral therapy with a viral load of less than 50 copies per ml. • with hepatitis B • with hepatitis C • with a recurrence of genital herpes simplex virus (HSV) at birth • with a body mass index (BMI) of over 50 alone as an indicator.	Excluded
R17.1, R17.2, R17.8, R17.9		A planned Caesarean Section should be offered to women with:	• With a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful • In twin pregnancies where the first twin is breach • A placenta that partly or completely covers the internal cervical os (minor or major placenta praevia) • A previous caesarean section where it is clinically indicated • With injury/tears to the vagina and/or perineum/rectum	Restricted

			• With orthopaedic anomalies impeding the patient's ability of having a vaginal delivery • In patients with HIV who: o are not receiving any anti-retroviral therapy or o are receiving any anti-retroviral therapy and have a viral load of 400 copies per ml or more. • With both hepatitis C virus and HIV • With primary genital herpes simplex virus (HSV) infection occurring in the third trimester of pregnancy Pregnant women who may require a planned caesarean section should have consultant involvement in the decision-making process.	

Ophthalmology

Unless stated as an exemption, all cases for patients aged 18 years and over will be referred from primary care to the ICBs Choice and Referral Centre for clinical triage into the local tier 3 community service or directly into local tier 3 community services for clinical triage where a Choice and Referral Centre is not available.

Any case with clinical 'red flags' or paediatrics should be referred directly to the acute service. The community service will be responsible for ensuring appropriate conservative and non-surgical treatment options are tried and have failed before referral for surgical opinion.

The assumption is that all cases referred for surgical opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

ONLY East Staffordshire PCN may directly refer to the Trust however there is an expectation all appropriate conservative and non-surgical treatment options are tried and have failed prior to referral.
Referrals should include imaging where appropriate.

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
C13.1, C13.2, C13.3, C13.4, C13.5, C13.8, C13.9, C14.8, C14.9, C15.1, C15.2, C15.4, C15.5, C15.8, C15.9, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.8, C18.9	H02.0, H02.1, H02.4, H02.5, H02.7, H02.8 H02.9	Blepharoplasty	Blepharoplasty shall be routinely commissioned only for upper lids in the presence of: • **visual field impairment** (reducing visual field to 120° laterally and 40° vertically) **OR** • **Severe congenital ptosis** This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin. Note: Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons. The following procedures will not be funded: • Surgery for cosmetic reasons • Surgery for cyst of moll • Surgery for cyst of zeis • Removal of eyelid papillomas or skin tags • Surgery for pingueculum • Excision of other lid lumps	Restricted

C12.1, C12.2, C12.4, C12.5, C12.6, C12.8, C12.9 C19.1, C19.8	H02.3, H02.5, H02.7, H02.8 H02.9	Excision of lesion of the eyelid (including Chalazia)	Incision and curettage (or triamcinolone injection for suitable candidates) of lesions of eyelid including chalazia should only be undertaken if at least **ONE** of the following criteria have been met: • Has been present for more than 6 months and has been managed conservatively with warm compress, lid cleaning and massage for 4 weeks • Interferes significantly with vision • Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy • Is a source of infection that has required medical attention twice or more within a 6-month time frame • Is a source of infection causing an abscess which requires drainage • If malignancy (cancer) is suspected • E.g. Madarosis/recurrent/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions Cosmetic eyelid surgery to correct puffy, hooded, wrinkled tired looking eyes will not be commissioned.	Restricted
C44.2, C44.4, C44.5, C46.1	H44.2, H521	Laser Treatment for myopia (short sightedness).	Not routinely commissioned	Excluded

Not applicable	H36.0	Screening for diabetic retinopathy by consultant ophthalmologists.	Not routinely commissioned	Excluded
Not applicable	H40.0	Screening for glaucoma by consultant ophthalmologists.	Not routinely commissioned	Excluded
C71.1, C71.2, C71.3, C71.8, C71.9, C72.1, C72.2, C72.3, C72.8, C72.9, C74.1, C74.2, C74.3, C74.8, C74.0, C75.1, C75.8, C75.9	H25.0, H25.1, H25.2, H25.8, H25.9, H260, H261, H262, H26.3, H26.4, H26.8, H26.9, H28.0, H28.1, H28.2, H28.8	Cataract Surgery	Commissioned when a patient meets the following criteria for each affected eye: Visual Acuity: • Metres 6/9 or worse • US 20/30 or worse • Decimal 0.66 or worse • LogMar 0.18 or worse • VAS 91 or worse **AND** • Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sports/cards etc. • Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground • Ability to work, give care or live independently is affected The Visual Acuity should clearly indicate which eye is refers to and which eye the cataract removal is being requested for. Other indications for cataract surgery include facilitating treatment for one or	Restricted

			more of the following; • Monitoring posterior segment disease e.g. diabetic retinopathy • Correcting anisometropia • Patient with Glaucoma who require cataracts surgery to counteract intraocular pressure Patients with Single Sight (Monocular Vision): The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur.	
Not applicable	H35.3	Implantable Intraocular Lens Systems for Age Related Macular Degeneration.	Not routinely commissioned	Excluded

Respiratory

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
Not applicable		Sinus X ray	Not routinely commissioned	Excluded
E48.8, Y36.2, Y53.4, Z24.6	J43	Insertion of Endobronchial Nitinol coils to Improve Lung Function in Emphysema	Not routinely commissioned	Excluded

E85.2	J96.0, J96.1, J96.9	Non-Invasive Ventilation	This intervention will ONLY be routinely commissioned in the following circumstances: • Patient has Type 2 respiratory failure **AND** • Shows improvement in blood gases, Oximetry or symptoms and demonstrates compliance with equipment at review after at least 6 weeks	Restricted
Not applicable		Cough assist Therapy	Mechanical insufflation-exsufflation (MI-E) therapy, or Cough Assist, for neuromuscular disorders and cervical spinal cord injury patients is commissioned in the following circumstances; 1. An established diagnosis as paralytic/restrictive disorder including but not exclusively: - spinal cord injuries (SCI) - neuromuscular diseases such as ALS - Guillain-Barre Syndrome - myasthenia gravis - muscular dystrophy - multiple sclerosis - post-polio - kypho-scoliosis - syringomyelia 2. Patient is unable to cough or clear secretions effectively with a - PCF (Peak Cough Flow) less than 160 L/min - VC (vital capacity) below 1.1L in general	Restricted

			respiratory muscle weakness, or voluntary	
Not applicable	R95X	Home monitoring to prevent sudden infant death syndrome (SIDS)	Not routinely commissioned	Excluded

Specialist Therapies

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
Not applicable	G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9	Themed Bimanual Training for Cerebral Palsy.	Not routinely commissioned	Excluded
Not Applicable	F80 – F89	Specialist Sensory Integration Therapy (SIT) for children with autism spectrum disorder and other diagnosed developmental disorders.	Not routinely commissioned	Excluded

Trauma and Orthopaedics

Unless stated as an exemption, all cases for patients aged 16 years and over will be referred from primary care to the ICBs Choice and Referral Centre for clinical triage into the local tier 3 community service or directly into local tier 3 community services for clinical triage where a Choice and Referral Centre is not available.

Any case with clinical 'red flags' or paediatrics should be referred directly to the acute service. The community service will be responsible for ensuring appropriate conservative and non-surgical treatment options are tried and have failed before referral for surgical opinion.

The assumption is that all cases referred for surgical opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.
ONLY East Staffordshire PCN may directly refer to the Trust however there is an expectation all appropriate conservative and non-surgical treatment options are tried and have failed prior to referral.
Referrals should include appropriate imaging.
For non-trauma musculoskeletal conditions please refer to Appendix 1

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
Not applicable		Bespoke Knee Prosthetic	Not routinely commissioned	Excluded
A65.1, A65.9	G56.0	Carpal Tunnel Syndrome (CTS)	**All patients referred into secondary care must have been through the MSK/MIS Service to optimise access to conservative treatment unless CTS is severe. Where MSKMIS service is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.** The ICB will fund carpal tunnel surgery where: • Patient has acute, severe symptoms that persist for more than three months after conservative therapy in MSK/AQP service, treated with either local corticosteroid injection and/or nocturnal splinting **OR** • There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction	Restricted

			AND • Severe symptoms significantly interfering with daily activities and sleep which have been assessed	
T59.1, T59.2, T 5 9 . 8 , T 5 9 . 9 , T59.8, T59.9, T60.1, T60.2, T60.8, T60.9	M67.4, M71.3	Surgical removal of ganglion (Including surgical removal of ganglion on wrist surgical removal of seed ganglia at base of digits, surgical removal of mucoid cysts at DIP joint)	Not routinely commissioned for the treatment of asymptomatic ganglia Surgical removal of ganglion on hands will **ONLY** be routinely commissioned where there is evidence of: • Aspiration failed to resolve pain or tingling/numbness **AND** • Restricted hand function Removal of seed ganglia at base digits Surgical treatment will ONLY be routinely commissioned in the following circumstances: • If ganglion persists or recurs after puncture/aspiration Surgical Removal of Mucoid cysts at DIP joint: Surgical treatment will **ONLY** be routinely commissioned in the following circumstances: • Recurrent spontaneous discharge of fluid **OR**	Restricted

			• Significant nail deformity	
T52.1, T52.2, T52.5, T52.6, T54.1	M72.0	Dupuytren's Disease – palmar fasciectomy	**All patients referred into secondary care must have been through the MSK/MIS Service. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.** Treatment is not indicated in cases where there is no contracture and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function. Surgical intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) will only be routinely commissioned in the following circumstance: • Finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20°at the proximal interphalangeal joint **OR** • Severe thumb contractures which interfere with function	Restricted

T69.1, T69.2, T69.8, T69.9, T70.1, T70.2, T71.8, T71.9, T72.3, T72.8, T72.9	M65.3	Trigger Finger - surgical treatment	Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously. Cases interfering with activities or causing pain should be treated with: • 1 or 2 steroid injections **OR** • Splinting of the affected finger for 3-12 weeks Surgical treatment will ONLY be routinely commissioned in the following circumstances: • The triggering persists or recurs after one of the above measures (particularly the steroid injections have not worked) **OR** • The finger is permanently locked into the palm **OR** • The patient has had two other trigger digits unsuccessfully treated with appropriate non-operative methods **OR** • Diabetics	Restricted

T71.1, W69.1, W69.2, W69.3, W69.5, W69.8, W69.9, W84.3, W84.6	M65.4, M65.8, M65.9, M67.8, M67.9	Surgical treatment of synovitis and tenosynovitis	Not routinely commissioned	Excluded
W90.3, W90.4		General Joint Injections for pain (peripheral joints)	Not commissioned in a sterile theatre unless x-ray screening or general anaesthesia is required and where they are performed with other procedures i.e. nerve blocks or manipulation. Not commissioned when a patient could be a candidate for joint replacement in the next 6-12 months except as a diagnostic tool prior to joint replacement in order to confirm the joint as the major source of pain/ symptoms and for patients who are currently unfit or unsuitable for surgery or who do not wish to proceed to surgery.	Restricted
W90.3, W90.4		Trigger Point Injections for Pain	Not commissioned in a sterile theatre unless x-ray screening or general anaesthesia is required and where they are performed with other procedures i.e. nerve blocks or manipulation. Trigger point injections of therapeutic substances into peripheral nerves for persistent non-specific neck/back pain are not routinely commissioned. It is important to note this policy does not cover pain due to malignancy, infection,	Excluded

			fracture, ankylosing spondylitis and other inflammatory conditions, radicular pain resulting from nerve root compression or cauda equine syndrome.	
W903 IN COMBINATION WITH Z846, Z94		Hyaluronic Acid Injections into the Knees	Not routinely commissioned	Excluded
Not applicable		Therapeutic ultrasound in Physiotherapy.	Not routinely commissioned	Excluded
X49.1, X49.2, X49.3		Lycra splinting for the prevention and correction of upper limb contractures for patients with neurological dysfunction.	Prior approval to be sought with follow up of outcomes and patient concordance	Prior Approval
W85.1 in combination with W31.1		Autologous Chondrocyte Implantation in the Ankle	Not routinely commissioned	Excluded
Y02.1	M17.9	Implantation of a Shock or Load Absorber for mild to moderate symptomatic Medial Knee Osteoarthritis.	Not routinely commissioned	Excluded
W58.8 or W58.9 with W32.2 and Z81.3	M85.9	Allograft reconstruction for glenoid bone loss in glenohumeral instability	Not routinely commissioned	Excluded

Not applicable – no OPCS available		Intramedullary Nail in Lower Limb Length Discrepancy	Not routinely commissioned	Excluded
Not Applicable	Q67.6, M95.4	Orthotic Treatment for Pectus Excavatum	Not routinely commissioned	Excluded
T02.2	Q67.6, M95.4	Surgical Treatment for Pectus Excavatum	Not routinely commissioned by ICBs – NHS England commissioning responsibility https://www.england.nhs.uk/wp-content/uploads/2019/02/1675-Policy_Surgery-for-pectus-deformity.pdf	Excluded
Not Available		Low Intensity Ultrasound (Exogen) for the Healing of Fractures	See separate commissioning policy	Restricted

Urology

OPCS Codes	ICD 10 codes	Procedures	Thresholds	Status
N30.3	N47X, N48.0, N48.1, N48.2, N48.6, N48.8, N48.9	Circumcision	All ages: Male Circumcision for cosmetic, social, cultural, and religious reasons is not routinely commissioned. Circumcision will be funded in the following medical circumstances for adults and children: - Pathological Phimosis **OR** - Three documented episodes of balanoposthitis Relative indications for circumcision or other	Restricted

			foreskin surgery include the following: - Prevention of urinary tract infection in patients with an abnormal urinary tract **OR** - Recurrent Paraphimosis **OR** - Balanitis Xerotica Obliterans **OR** - Congenital abnormalities	
Q29.1, Q29.2, Q29.8, Q29.9 Q30.3, Q30.8, Q30.9, Q37.1, Q37.8, Q37.9. N18.1, N18.2, N18.8, N18.9		Reversal of Sterilisation: reversal of vasectomy or reversal of tubal ligation (Male and Female)	Not routinely commissioned	Excluded
M67.1, M67.2, M67.3, M67.4, M67.8, M67.9		Surgery for protatism	Will be routinely commissioned where there is evidence of one of the below: • International prostate symptom score >7; • Dysuria; • Post voided residual vol >150ml; • Recurrent UTI; • Deranged renal function; • PSA > Age adjusted normal values • Retention of urine • Failed medical management	Restricted
M51.8, M51.9, M53.3, M53.4, M53.5, M53.8, M53.9, M57.1,	N39.3, N39.4, R32X	Stress incontinence surgery	The ICB will only agree to fund the first episode of primary surgical treatment of urinary incontinence as NHS England is now responsible for the commissioning of Stress	Restricted

M57.2, M57.3, M57.8, M57.9			Incontinence Surgery where previous surgery has failed. http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-recur-pro-urina-incon.pdf	
		Sacral Nerve Stimulation for Urinary or Faecal Incontinence	Not routinely commissioned – NHSE responsibility https://www.england.nhs.uk/wp-content/uploads/2013/08/a08-p-b.pdf	
A70.8, A70.9 with Z11.2	K59.0	Sacral Nerve Stimulation for Constipation	Not routinely commissioned	Excluded
N32.4	F52.2	Injection of therapeutic substance into penis for erectile dysfunction	Not routinely commissioned except as 3rd-line treatment in diabetes after lifestyle & phosphodiesterase inhibitors. Patients must have tried at least 2 oral PDE5 inhibitors prior to referral	Restricted
Not applicable	F52.2	Erectile dysfunction – medical management	Referrals to secondary care should not be made for the purposes of NHS prescribed medication. Medical management of erectile dysfunction should only be undertaken in accordance with current national restrictions reflected in GMS/PMS contract.	Excluded
N29.1, N29.2, N29.8, N29.9		Penile Implants	Not routinely commissioned by ICBs – NHSE Responsibility https://www.england.nhs.uk/publication/penile-prosthesis-surgery/	Excluded

N17.1, N29.8, N29.9		Vasectomy	Vasectomy is not routinely commissioned within secondary care. All referrals **MUST** be sent to a Community Provider. Following an assessment if it deemed clinically appropriate by the Community Surgeon a referral can be made into secondary care. (Consideration for referral into secondary care: cryptorchidism, evidence of allergy to local anaesthetic, inability to locate the vas deferens, previous scrotal surgery resulting in scarring that prevents the vas deferens been palpable, Large hydrocoele/Inguinoscrotal hernia, masses, cysts that prevents the vas deferens from being identified, significant bleeding that cannot be managed) – **Prior Approval must be sought.**	Restricted
N11.1, N11,2, N11.3, N11.4, N11.5, N11.6, N11.8, N11.9	N430, N431, N432, N433, N434, P835	Surgery for hydrocele	Patient is over 2 years of age. **AND** Discomfort and/or disfigurement have resulted in significant functional impairment, significant interference with activities of daily living, recurrent infections requiring prescribed antibiotic and/or pain with prescribed analgesia use.	Restricted

OPCS codes	ICD 10 codes	Procedure	Thresholds	Status
L832, L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888, L889	I83.0, I83.1, I83.2, I83.9, I80.3	Surgical Treatment of uncomplicated varicose veins and reticular veins or telangiectasia	Surgery (stripping of veins) is routinely commissioned when the patient meets one or more of the following criteria: • Varicose veins which have bled and are at risk of bleeding again **OR** • A history of varicose ulceration **OR** • Signs of prolonged venous hypertension (haemasiderin, pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes) **OR** • Superficial thrombophlebitis in association with varicose veins **OR** • Significant symptoms attributable to chronic venous insufficiency which are resulting in significant functional impairment.	Restricted

L29.4, L29.5		Carotid endarterectomy	Not routinely commissioned for asymptomatic or mild to moderate carotid stenosis.	Restricted
A70.8, A70.9 with Z12.1	I74.2, I74.3, I74.4, I74.8, I74.9	Geko device for reducing the risk of venous thromboembolism.	Not routinely commissioned	Excluded

Appendix 1

Commissioning Policy

Non-Trauma Musculoskeletal Conditions

01 July 2022

Circulated to the following individuals/groups for comments

Name	Designation
Mr. Richard Dias	Consultant Surgeon, T&O, Royal Wolverhampton Hospital Trust (RWT)
Mr. Shreeram Deshpande	Consultant Surgeon, T&O, Royal Wolverhampton Hospital Trust (RWT)
Mr. Justin Lim	Consultant Surgeon, T&O, University Hospital North Midlands (UHNM)
Mr. Damian Mcclelland	Consultant Surgeon, T&O, University Hospital North Midlands (UHNM)
Mr. Vinay Jasani	Consultant Surgeon, T&O, University Hospital North Midlands (UHNM)
Dr Julie Ashworth	Consultant in Pain Medicine IMPACT Community Pain Service, University Hospital North Midlands (UHNM) Honorary Senior Lecturer Keele University
Claire Powell	T&O Business Manager, University Hospital North Midlands (UHNM)
Mr. Babis Karagkevrekis	Consultant Surgeon, T&O, Consultant Surgeon, Burton Hospital (BHT)
Mr. Frank Bindi	Consultant Surgeon, T&O, Consultant Surgeon, Burton Hospital (BHT)
Dr Emma Salt	Consultant Physiotherapist Burton Hospitals NHS Foundation Trust
Joanne Bridgland	Clinical Specialist in Lower limb and Extended Scope Physiotherapist (A&E)
Fran Smith	T&O Business Manager, Burton Hospital (BHT)
Steven Peck	T&O Interim Business Manager, Burton Hospital (BHT)
Sarigiovannis Panos	Professional Lead for Physiotherapy Staffordshire & Stoke on Trent Partnership NHS Trust
Ashish Khiloshiya	Clinical Lead/Team Lead, Chronic Pain Management Service, South Division, Staffordshire and Stoke-On-Trent NHS Trust
Dr Kika Konstantinou	Spinal Physiotherapy Specialist / Senior Clinical Lecturer, Arthritis Research UK Primary Care Centre, Research Institute for Primary Care & Health Sciences, Keele University
Dr A Menon	Interim Clinical Director, Staffordshire & Stoke on Trent Partnership NHS Trust
Roger Whittaker	Professional Lead for Podiatry, Staffordshire & Stoke on Trent Partnership NHS Trust

Stephanie Gommersall	MICATS Team Leader, Staffordshire & Stoke on Trent Partnership NHS Trust
Kate Harper	IPOPS Team Lead, Staffordshire & Stoke on Trent Partnership NHS Trust
Helen Hodgkiss	ESP, IPOPS, Staffordshire & Stoke on Trent Partnership NHS Trust
Kay Stevenson	Consultant Physiotherapist, Senior Knowledge Mobilisation Fellow, Staffordshire & Stoke on Trent Partnership NHS Trust
Nicola Birch	Extended Scope Physiotherapist, MSK Physiotherapy Team Lead (East Staffs),Virgin Care – East Staffordshire
Charley Walker	Extended Scope Physiotherapist, (East Staffs),Virgin Care – East Staffordshire
Tandi Coetzee	Extended Scope Physiotherapist, Virgin Care – East Staffordshire
Karen Dawson	Service Manager- MICATS, Staffordshire & Stoke on Trent Partnership NHS Trust
Dr Gary Free	GP and Planned Care Clinical Lead, Cannock Chase CCG
Dr Marianne Holmes	GP and Planned Care Clinical Lead, Stafford & Surrounds CCG
Dr Vije Rajput	GP and Planned Care Clinical Lead, South Staffordshire and Seisdon Peninsula CCG
Dr Mona Arora	GP and Clinical Lead for North Staffs and Stoke on Trent CCGs
Dr John Harvey	Consultant in Public Health

Review and Amendment Log

Version Number	Type of change	Date	Description of change
V0.1	Initial policy	30/06/2017	Policy development
V0.2	Additions to procedures	21/07/2017	Additional procedures added to policy
V0.3	Final draft for circulation to MS, GF & MH	14/08/2017	
V0.4	MS amendments made	17/8/2017	
V0.5	Amendments from KK, NS & SoT, Spinal & MSK Work stream	19/09/ 2017	Sections :- spinal, hip and knee reviewed and amended
V1	Changes from upper and lower limb T&F groups	02/10/ 2017 03/10/ 2017	Final amendments made.
V1.1 -1.7	Changes from spinal, ortho and task and finish groups	04/10/2017-24/10/2017	Further amendments made in relation to certain procedures for spinal and shoulder surgery.
V1.8	J Ashworth suggested word changes	31/10/2017	• and feels the patient requires surgery) • rheumatologist or pain consultant is currently treating patient and suspects rotator cuff injury • Patients have received a biopsychosocial assessment within a specialist pain service (ideally multidisciplinary)
V1.9	CC, SAS and SES&SP GB	20/11/2017	MRI wording changed to MRI for Chronic lumbar back-pain (>6 weeks) with no clinical or serological indicators of infection or neoplasia or other red flags to be used in specialist care only where management will be altered.
V2	Change on Bristow Laterjet procedure (shoulder section)		Bristow Laterjet procedure changed from Excluded to Restricted following outcome of CPAG scoring.
V2.1	OPCS codes and minor wording changes	25/07/2018	Review and revision of OPCS codes to be used for contracting and monitoring. Minor amendments to wording to reflect comments back from UHNM review. Page 26 Arthroscopic Bankart Repair

			now included with open procedure with same restrictions updated CPAG review
V2.2	Spinal procedures added	07/09/2018	Minor amendments to wording to reflect comments back from UHNM review. Criteria added for Epidural injections and therapeutic spinal nerve blocks and Spinal decompression and discectomy (lumbar) for radicular pain/spinal claudication
V2.3	Policy remit	21/06/2022	East Staffordshire CCG included within policy remit.
V2.4	Policy remit	24/06/2022	Adapted for ICB

1 Policy statement:

Following a review of the evidence and consideration of the local circumstances the six Staffordshire Clinical Commissioning Groups will separately fund (in accordance with this policy):

1.1 Musculoskeletal conditions (MSK) requiring surgical intervention in accordance with defined clinical and process criteria (see page 7&8)

2 Scope of policy

2.1 This policy should be considered in line with all other Staffordshire Commissioning Policies. Copies of these Commissioning Policies are available on the ICB's website

2.2 This policy relates to surgical procedures and other interventions such as joint injections for the following: lower limb, upper limb* and spinal procedures in both an outpatient and inpatient setting

2.3 This policy should be used in conjunction with the end-to-end STP MSK pathways for both upper, lower limb and spinal (appendix 1)

2.4 Joint replacement and other interventions for trauma, avascular necrosis (AVN) cancer and red flags **are not** within the scope of this policy

2.5 If the patient is currently under the care of a Consultant Rheumatologist, has exhausted conservative options and requires surgical intervention, the patient can be referred directly to the centre of choice

***Please note that all other MSK related conditions and procedures are contained in the main ERP policy at present**

3 Background

This policy aims to improve consistency across the whole of Staffordshire and prevent variation in access to NHS Musculoskeletal Services and allows fair and equitable treatment for all the population we serve.

It also addresses the ICB's statutory responsibility to maintain financial balance and supports decision making in relation to how and where finite local resources are allocated.

The policy is designed to assist the ICB to meet its obligation in providing equitable, affordable access to healthcare and to ensure that patients receive the correct management of care with the best possible outcomes.

The National Service Framework for Musculoskeletal Conditions[1] (2006) identified the need for more robust primary care led medical intervention prior to Orthopaedic and/or Rheumatology

[1] http://webarchive.nationalarchives.gov.uk/20130124073659/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf

(non- inflammatory) referral. This led to the commissioning of Community MSK services which manage the non-surgical pathway.

There are well established services across Staffordshire which currently have an average onward referral rate of 21% to secondary care. Whilst referrals have been significantly reduced across the Staffordshire health economy there are still referrals which may not be suitable or benefit from surgery and are therefore deemed inappropriate.

This policy ensures that all non-surgical interventions have been explored and optimised in conjunction with informed shared decision making. The ICB understands that there will always be a small cohort of patients who need to see an Orthopaedic surgeon to decide whether to have surgery or not and if it is appropriate.

4 Relevant National Guidance and Research

4.1 Evidence

Musculoskeletal (MSK) conditions cover a wide spectrum of conditions across Rheumatology and Orthopaedics and represent a large proportion of both GP and hospital attendances.

The evidence for early intervention and appropriate management via primary care and community interface services is vast and represents a significant proportion of the ICB and local Health Economy (LHE) activity and spend. The need for emergency or urgent referral to an Orthopaedic or Spinal surgeon for Red Flags and certain presentations is also recognised.

The development of this musculoskeletal clinical commissioning policy is based on clinical evidence, clinical guidelines including NICE, research, best practice and expert clinical consensus. The following are the main contributors to the development of this policy, however a more comprehensive reference list can be found in the appendices:-

- National Service Framework for MSK (2006)[2]
- NICE Guidelines (see below) [3]
- British Orthopaedic Association Guidelines[4]
- British Orthopaedic Foot & Ankle Society[5]
- Royal College of Surgeons of England (RCSEng)[6]

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[2] Http://webarchive.nationalarchives.gov.uk/20130124073659/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf

[3] https://www.nice.org.uk/guidance/cg177; https://www.nice.org.uk/guidance/qs87; https://www.nice.org.uk/guidance/ipg230; https://www.nice.org.uk/guidance/ta304;https://www.nice.org.uk/guidance/ipg408

[4] http://www.boa.ac.uk/pro-practice/commissioning-guides/

[5] https://www.bofas.org.uk/

[6] https://www.rcseng.ac.uk/standards-and-research/nscc/commissioning-guides/topics/

All of the organizations have developed evidence-based advice to assist commissioning decisions on excluded and/or restricted procedures. In this policy procedures will **ONLY** be funded for patients where they meet specific criteria as stated within the access criteria and that patients have been assessed and received appropriate medical and non-medical interventions within the community Musculoskeletal (MSK) Intermediate Service (MIS) with the exception of Red flags, Cancer and Trauma. Where patients meet the criteria to undergo surgical intervention, they must only be referred to secondary care if:

- They have viewed and completed the relevant decision aid tool and agree to surgery
- Are fit for surgery
- They have considered the recuperation period, risk of infection, reduced function, increased pain, altered or loss of feeling, stiffness etc.

Any restricted procedures, as identified within the ICB's Policy on Excluded and Restricted Procedures (ERP) must be approved by the ICB before the surgery can be undertaken. The commissioners' preference is for prior approval to be sought through Blueteq, but alternatively prior approval can be sought by letter or email from the IFR team (see page 3). Commissioners will not pay for any procedures undertaken without the required approval.

5 Commissioning Policy

NHS Cannock Chase, North Staffordshire, South East Staffordshire & Seisdon Peninsula and Stafford & Surrounds and Stoke on Trent Clinical Commissioning Groups,(termed "the Commissioners") consider all lives of all patients whom it serves to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related to the patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.

5.1 Surgical Intervention for upper limb, lower limb and spinal conditions involving arthroplasty, arthrodesis and minor surgical procedures relating to Musculoskeletal Conditions

(This policy does not include acute trauma conditions, cancer or trauma)

Surgery will only be funded where **all** of the following **criteria** are met:

5.2 Clinical

- Patient age ≥ 16 years
- Patient has followed the medical pathway and exhausted appropriate non-surgical treatment options
- Have been through and **referred by** a Musculoskeletal Intermediate Service (MIS) or directly from a Rheumatology Consultant or a Pain Consultant who is currently treating the patient and feels the patient requires surgery)
- Patient is willing to undergo surgery and aware that a surgical option is the likely outcome of the referral
- Patient is considered medically fit to undergo surgery and/or opinion is sought in cases where medical fitness is unclear
- Patient meets the clinical criteria for the specific procedure

(See further within this document)

5.3 Process

- Patient is considered a suitable candidate for onward referral for surgery by primary/community health care professional having followed the medical pathway and all non-surgical options have been exhausted.
- Referral to a surgical provider is received from a Musculoskeletal Intermediate Service (MIS)
- Referrals from other routes are to be **rejected** excluding Red Flags and/or Differential Diagnosis (see pathways) or patient who has already had surgery in the same joint
- Adherence to the Local Health Economy MSK pathway
- Prior approval for surgery for restricted procedures in accordance with Prior approval arrangements (Blueteq)

This policy will be reviewed and updated on publication of new evidence in the form of relevant trial data, updated national guidance, and national or local audit outcomes.
General practitioners (GPs) and Musculoskeletal Intermediate Services should take account of this policy before considering onward referral. GPs must not refer cases directly to secondary care but refer to the Musculoskeletal Intermediate service (MIS) unless they have a:-

- **Red Flag***
- **Differential Diagnosis (***please refer to specific pathways found in the appendix 1)
- **Have had previous surgery in the affected joint**

Reporting requirements and funding arrangements are detailed on the website
Individual Funding Requests - Staffordshire and Stoke-on-Trent, Integrated Care Board (icb.nhs.uk)

ALL restricted procedures contained within this policy are subject to the ICB's requirement for prior approval. The preferred method of prior approval within the ICB is via Blueteq, which will result in a unique approval code being generated. Where providers who do not use Blueteq then requests must be emailed to the relevant ICB secure email address (on page 4) and will be processed by the IFR Team and a unique approval code will be issued.
Providers will **NOT** be paid if the unique approval code is not issued. Retrospective approval is prohibited.

6 Clinically Exceptional Circumstances

If there is demonstrable evidence of a patient's clinical exceptional circumstances, the referring practitioner should refer to the Commissioner's Operational Policy for Individual Funding Requests(IFR) document for further guidance on the process for consideration
And
Where the clinician proposing to undertake the procedure feels that there is a substantial clinical need and that the patient will significantly benefit more than the average patient of the same condition then the referring clinician must present a clear clinical case to the ICB and the IFR form should be used to capture this information. Individual Funding Requests can also be submitted online via Blueteq.

7 Lower Limb

7.1 Hip Pain (OA)

Around 450 patients per 100,000 of the national population will present to primary care with hip pain each year, of these, 25% will improve within three months and 35% at twelve months; this improvement is sustained.

Pain felt around and attributed to the hip can also be due to spinal or abdominal disorders which should be excluded. Hip pathology may cause pain felt only at the knee.

- Degenerative hip disease is the most common diagnosis in the adult and is the long-term consequence of predisposing conditions
- Inflammatory joint disease of the hip may develop at any age, alone or with other joint involvement and may be due to auto-immune disease
- Osteoarthritis (OA) of the hip describes a clinical syndrome of joint pain accompanied by varying degrees of functional limitation and reduced quality of life
- Osteoarthritis may not be progressive, and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures. Symptoms progress in 15% of patients within 3 years and 28% within 6 years
- Hip preserving operations to include impingement and osteotomy for malalignment, to prevent early osteoarthritis in young adults, should be undertaken in Centres performing high volumes of surgery in this cohort of patients (BOA et al. 2013). Whilst there is no definitive number that a surgeon should be doing it is recommended that the number for hip and knee replacements per surgeon, per annum is a minimum of 35 which demonstrates better outcomes. The Getting it Right First Time (GIRFT 2015) identified that the average number of procedures per surgeon per annum was 52 with 24% of surgeons undertaking 10 or less per annum
- Total Hip Replacement (THR) is cost effective, returning 90% of patients to their previous job, and enabling the elderly to keep independent. The National Tariff for THR is cheaper than long-term conservative treatment for osteoarthritis of the hip (Commissioning Guide 2013)

- Patients with a BMI of **35 or more** must be actively supported to engage with local weight management programmers to reduce their BMI

- Joint replacement and other interventions for trauma, avascular necrosis (AVN), cancer and Red Flags **are not** within the scope of this policy

NB: - GIRFT (2015) https://www.boa.ac.uk/wp-content/uploads/2015/03/GIRFT-National-Report-Mar15..pdf

7.1.1 Hip Procedures

OPCS Codes	Hip Condition/Procedure	Threshold	Status
W88.1, W88.8, W88.9 with Z90.2 or Z84.3	**Diagnostic Arthroscopy of Hip**	The ICB does not commission diagnostic arthroscopy	**Excluded**
W83.3, W83.6, W83.8, W84.1, W84.6, W84.7, W84.8 (W82.1, W82.2, W82.3, W82.8, W82.9, W83.1, W83.2, W83.4, W83.5, W83.7, W83.9, W84.2, W84.3, W84.4, W84.5, W84.9, W86.1, W86.8, W86.9, W89.1, W89.8, W89.9 with Z90.2 or Z84.3)	**Therapeutic Arthroscopy of the Hip**	This is not routinely commissioned, and patients must have:- • Been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. • Have exhausted **all** appropriate non-surgical interventions	**Restricted**
W37.1, W37.8, W37.9, W38.1, W38.8, W38.9, W39.1, W39.8 W39.9, W93.1, W93.9, W94.1, W94.9, W95.1, W95.9	**Primary Total Hip Replacement** Arthritic hip with severe acetabular bone loss, abnormal anatomy (such that non-standard implants may be	The ICB will consider referral for hip replacement if all the criteria below has been met:- **1.** • Been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not	**Restricted**

(W55.1, W56.2 with Z90.2 or Z84.3) (W58.1 with Z84.3)	necessary), prior fusion and cases secondary to infection should be undertaken in specialised centres such as University Hospital of North Midlands (UHNM) Royal Orthopaedic Hospital (ROH) Coventry & Warwickshire Hospital, Royal National Orthopaedic Hospital (RNOH), or in a DGH by a surgeon with expertise.	available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. • Has followed the STP agreed MSK OA Hip Pathway or has had previous surgery in same joint • Has exhausted all appropriate non-surgical interventions • Patient still has a painful irritable and stiff hip interfering with sleep, activities of daily living, work or leisure which has not been controlled with measures above • There is narrowing of the joint space on radiograph • Patients with a BMI of 35 or more must be actively supported to engage in lifestyle modifications including with weight management to reduce their BMI **2.** **OR** • Is a young adult (<40) with persistent hip pain which affects activities of daily living, work, or leisure **3.** **OR**	

		• Where joint destruction is rapid and where a delay in surgery may cause total loss of mobility and independence.	
Procedures above undertaken for the diagnosis of Hip Impingement	**Hip Impingement** – these operations should be undertaken by surgeons with a special interest and expertise in young adult hip problems	• Patients must have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) and onward referred. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. The ICB will fund open or arthroscopic hip surgery for the treatment of femoro-acetabular impingement (FAI) ONLY when patients fulfil all of the following criteria: • Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans. • An Orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist. • Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above. • Failure to respond to all available conservative treatment options including activity modification,	**Restricted**

		pharmacological intervention and specialist physiotherapy. • Compromised function, which requires treatment within a 6-8 months' time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date. • Treatment with more established surgical procedures is not clinically viable.	
(W08.5, W13.3, W68.1 with Z90.2, Z84.3 or Z76.8)	**Femoral/pelvic osteotomy** These operations should be undertaken in specialised centres such as University Hospital of North Midlands (UHNM), Royal Orthopaedic Hospital (ROH) Coventry & Warwickshire Hospital, Royal National Orthopaedic Hospital (RNOH), or in a DGH by a surgeon with expertise.	**May be considered in:** patients aged <50 years with persistent hip symptoms with abnormalities of femoral and/or acetabular anatomy • Patients must have been triaged or seen in a community Musculoskeletal Intermediate Service (MIS) and onwardly referred. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.	**Restricted**

7.2 Knee Pain (OA)

Osteoarthritis (OA) of the knee describes a clinical syndrome of joint damage resulting in pain accompanied by varying degrees of functional limitation and reduced quality of life. Close to 20% of adults aged 45 and above have sought treatment for Knee Osteoarthritis. The majority of patients present to primary care with symptoms of pain and stiffness, which reduces mobility and with associated reduction in quality of life.

- Osteoarthritis may not be progressive, and most patients will not need surgery, with their symptoms adequately controlled by non-surgical measures as outlined by NICE 2017

- When patient's symptoms are not controlled by up to three months of non-operative treatment, they become candidates for assessment for joint surgery based on imaging and evidence of severe OA. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support tools, of which there are numerous for e.g. https://www.england.nhs.uk/rightcare/shared-decision-making/, https://www.evidence.nhs.uk/Search?om=[{%22ety%22:[%22Patient%20Decision%20Aids%22]},{%22srn%22:[%22NHS%20RightCare%22]}]&ps=50

- Knee replacement is the commonest type of surgery used to treat osteoarthritis. The lifetime risk of requiring joint replacement is 10% and in 2011 approximately 70,000 were implanted in the UK

- Total knee replacement is highly effective in up to 85% of patients providing consistent lasting benefit with 95% 7–19-year joint survival. It is highly cost effective. However, 20% of patients have ongoing symptoms at twelve months following total knee replacement. Therefore, the discussion of benefits versus risks is crucial

- Patients with a BMI of 35 or more must be actively supported to engage with local weight management programmers to reduce their BMI

7.2.1 Knee Procedures

OPCS Codes	Knee Condition/Procedure	Threshold	Status
W87.1 W87.8 W87.9	**Diagnostic Arthroscopy of Knee**	The ICB will not commission diagnostic arthroscopy unless:- • For assessment of severe knee pain(based on a recognised pain scale score) following arthroplasty **AND** • Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy)	**Restricted**

W85.2, W85.3, W85.9, (W82.1, W82.2, W82.3, W82.8, W82.9, W83.2, W83.3, W83.4, W83.5, W83.6, W83.7, W83.8, W85.8, W89.1, W89.2 with Z78.7, Z84.4, Z84.5, Z84.6)	**Therapeutic Arthroscopy of OA knee**	**All patients must have** had assessment and appropriate intervention via a Musculoskeletal Intermediate Service (MIS) or been triaged and referred straight on. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. **Knee arthroscopy,** lavage and/or debridement for patients with non-mechanical symptoms is not commissioned **Knee arthroscopy**, lavage and/or debridement will not be routinely funded unless the person has knee osteoarthritis with a clear history of mechanical locking (as opposed to morning joint stiffness, 'giving way' or X-ray evidence of loose bodies) • Clear history of intermittent mechanical symptoms e.g. locking that have not responded to non-surgical treatment (**if the knee does not unlock then refer urgently to the appropriate clinic)**	**Restricted**
O18.1, O18.9, W40.1, W40.8, W40.9, W41.1, W41.8, W41.9, W42.1, W42.8, W42.9, (W58.1, W55.1, W56.2, with Z78.7, Z84.4, Z84.5, Z84.6)	**Primary Knee replacement**	The ICB will consider referral for knee replacement if all the criteria below has been met:- • Patients must have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) and onwardly referred. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been	**Restricted**

		undertaken including any relevant community physiotherapy and diagnostics. • Have exhausted all appropriate non-surgical options • Have moderate or severe knee pain not adequately controlled after commencement of treatment and appropriate non-surgical management following NICE guidance (NICE cg177) • Patients with a BMI of 35 or more will be actively supported to engage in lifestyle modifications including with weight management to reduce their BMI • All patients must have engaged in a shared decision-making process about alternatives, with a view to fully involve them in decisions and their care Patients who do not meet **all** of the criteria above may be considered in the following circumstances:- • Functional disability in the presence of end stage cartilage disease Progressive deformity of the knee (varus/valgus) with functional disability.	

(W52.1, W54.1, W53.1, W52.8, W52.9, W53.8, W54.8, W54.9, W58.1 with Z78.7, Z84.4, Z84.5, Z84.6)	**Partial Knee replacement –** This involves the replacement of only one compartment of the arthritic knee Partial knee replacement is less common, and it is more appropriately commissioned and delivered by specialised units, with experienced surgeons, performing around 10 such procedures within a unit per year (NJR 2017)	As well as the criteria for primary knee replacement patients should have: - • Symptomatic Osteoarthritis predominantly confined to a single joint compartment	**Restricted**
O18.0, O18.2, O18.3, W40.2, W40.3, W40.4, W41.2, W41.3, W41.4, W42.2, W42.3, W42.5, (W54.4, W58.2, W43.3, W44.3, W45.3, W52.0, W52.3, W53.3, W54.0, W54.2, W54.3, W55.2, W55.3, W56.3, W56.4, with Z78.7, Z84.4, Z84.5, Z84.6)	**Knee Revision Surgery**	Commissioners do not routinely fund Modular Rotating Hinge knees	**Excluded**

7.3 Foot and Ankle

More than 29,000 patients nationally are referred from primary care to foot and ankle specialists per year with ‘ankle pain’. In Rheumatoid Arthritis (RA), 17% have initial involvement of the hind foot and up to 71% have walking difficulty due to foot problems British Orthopaedic Foot and Ankle Society (BOFAS). The following conditions are covered within this policy: -

- **Hallux valgus** (HV) is common with a standardised prevalence of 28.4% in adults older than 40 years. 8% of General Practitioner consultations for musculoskeletal problems relate to the foot and ankle and of these 28% are for foot pain

- **Flat foot** - Flatfeet are a normal physiological variant affecting 20-30% of the population. However the majority of these will have no symptoms and will not be affected in work or recreational activity and do not require treatment. This policy pertains to those patients who have pre-existing flatfeet that are symptomatic and those with previously normal feet that develop symptomatic flatfeet

Hind foot -

- The majority of hind foot arthritis is post traumatic following fractures or severe sprains and this can affect patients of working age

- Other causes of hind foot arthritis include Rheumatoid Arthritis (RA), other inflammatory arthropathies, metabolic disorders such as haemachromatosis, bleeding disorders and conditions causing deformity including neurological disease

- **Refractory Plantar Fasciitis**
  Heel pain is a common presenting complaint in the foot and ankle. Plantar fasciitis is the most common cause of chronic pain beneath the heel in adults, making up 11–15% of the foot symptoms requiring professional care among adults. It is estimated that 1 in 10 people will develop plantar fasciitis during their lifetime. Plantar fasciitis is more common in middle-aged obese females and young male athletes and is most common in people aged 40-60 years and accounts for about 80% of cases of heel pain. Plantar Fasciitis has been described as painful heel syndrome, chronic plantar heel pain, heel spur syndrome, runner's heel, and calcaneal periostitis
  https://cks.nice.org.uk/plantar-fasciitis#!topicsummary
  http://www.nhs.uk/conditions/heel-pain/Pages/Introduction.aspx

- **Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis**
  Plantar fasciitis is a painful condition affecting the connective tissue that stretches between the heel and the middle of the foot. It is usually caused by overuse, injury or muscular abnormalities. In extracorporeal shockwave therapy, a machine is used to deliver sound waves to the painful area. It is not known exactly how it works, but it is thought that it might stimulate healing of the fascia. Current evidence on its efficacy is inconsistent.
  Not routinely funded, application by IFR only
  https://www.nice.org.uk/guidance/ipg311
- **Extracorporeal Shockwave Therapy for Refractory Achilles Tendinopathy**

About 6 in 100 inactive people develop Achilles tendinopathy at some point in their lifetime. However, the chance of it developing is higher in athletes or those who train regularly or do a lot of exercise. It can be a particular problem for some runners. https://patient.info/health/achilles-tendinopathy

- In adults aged 21–60 years, the incidence of mid-portion Achilles tendinopathy is around 2.35 per 1,000. The incidence is rising, mainly because more people participate in recreational and competitive sports. Risk factors for tendinopathy include strenuous physical activities such as running and jumping, ageing, diabetes mellitus, obesity, hypertension, dyslipidaemia, rheumatoid arthritis or other inflammatory joint diseases, the use of fluoroquinolone antibiotics, abnormal lower limb anatomy, sports training errors, or poor equipment.
- http://dtb.bmj.com/content/50/8/93.full?keytype=ref&siteid=bmjjournals&ijkey=Py8w8YeWh7NPk

- Achilles tendinopathy is characterised by chronic degeneration of the Achilles tendon and is usually caused by injury or overuse. Symptoms include pain, swelling, weakness and stiffness over the Achilles tendon and tenderness over the heel (insertional tendinopathy).

- Conservative treatments include rest, application of ice, non-steroidal anti-inflammatory drugs, orthotic devices, physiotherapy (including eccentric loading exercises).

- The evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy raises no current evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy is inconsistent and limited in quality and quantity. Not routinely funded, application by IFR only. https://www.nice.org.uk/guidance/ipg571

7.3.1 Foot and Ankle Procedures

OPCS Codes	Foot and Ankle Condition/Procedure	Threshold	Status
W15.1, W15.2, W15.3, W15.4, W15.5, W15.6, W15.8, W15.9, W56.1, W57.1, W59.1, W59.2, W59.3, W59.4, W59.5, W59.6, W59.8, W59.9, W79.1, W79.2, W79.8, W79.9	**Surgical Referral for symptomatic Hallux Valgus (Bunion)** Surgical correction for hallux valgus using minimal access techniques (IPG332) is not commissioned. Evidence on safety is inadequate therefore procedure should only be used within special arrangements for clinical governance, consent and audit or research.	Surgical referral has not been made for cosmetic purposes alone Referral for surgical consideration of hallux valgus shall only be considered where a patient meets **ALL** of the following: • Patients must have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) or MSK Podiatrist. Where MIS is not available (East	**Restricted**

(W43.1, W43.8, W43.9, W44.1, W44.8, W44.9, W45.1, W45.8, W45.9, W52.1, W52.8, W5.29, W53.1, W53.8, W53.9, W54.1, W54.8, W54.9, W55.1, W55.8, W55.9, W56.2, W56.8, W56.9, W57.8, W57.9, W58.1, W58.8, W58.9 with Z86.4 or Z90.6)	Hallux Valgus in patients with diabetes should be treated in line with the diabetes pathway and referred to podiatry for an urgent assessment	Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. • Patients have persistent symptoms despite at least 6 months of conservative management. Prior conservative management must include **ALL** of the following: - Reasonable modification of footwear – avoidance of high-heeled shoes, narrow fitting shoes. Wear wide fitting shoes which will naturally stretch and breathe - Non-surgical treatments - Simple analgesia • Significant persistent pain preventing patients from fulfilling vital activities of daily living **OR** • Severe deformity which prevents the patient from wearing suitable footwear.	
T59.4, T60.3, T60.4, W03.1, W03.2, W03.3, W03.4, W03.8, W06.4, W06.5, W15.1, W15.2, W15.3, W15.4, W15.5,	**Common Foot and Ankle Procedures**	Treatment of and not exclusive: ganglion excision, claw toe, hallux rigidus, hammer toe, in growing toenail, metatarsalgia, Morton's neuroma, plantar fasciitis, metatarsal damage, achilles tendon disorders, tibialis posterior dysfunction, arthritis are	**Restricted**

W15.6, W15.7, W15.8, W15.9, W59.1, W59.2, W59.3, W59.4, W59.5, W59.6, W59.8, W59.9, W79.3, W79.8, W79.9, X10.3, X11.1, X11.2, X11.8, X11.9, X25.1 (T72.8, T74.4, T74.8, T80.9, T81.9, U13.3, U21.1, T96.2, T96.8, W06.8, W06.9, W08.1, W08.2, W08.3, W08.4, W08.5, W08.8, W09.1, W09.3, W17.4, W20.9, W21.4, W31.8, W31.9, W60.1, W60.2, W62.1, W62.2, W62.8, W62.9, W63.1, W63.9, W64.2, W69.4, W71.2, W77.8, W78.4, W78.8, W78.9, W81.1, W81.2, W81.5, W81.6, W81.7, W81.8, W90.2, W90.3, W91.9, W92.3, W92.4, X38.2, X59.8, X59.9, Y53.2, Y53.5, Y82.2 with O13.1, Z12.4, Z12.5, Z50.5, Z50.6, Z58.2, Z58.3, Z58.4, Z58.6,		not routinely commissioned by the ICB except if the following criteria are met:- Patients must have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. • Have persistent symptoms despite at least 6 months of conservative management excluding in growing toenail • Significant persistent pain preventing patients from fulfilling vital activities of daily living **OR** • Have recurrent ulcers and infections Prior conservative management must include **ALL** of the following:- • Reasonable modification of footwear – avoidance of high-heeled shoes, narrow fitting shoes. Wear wide fitting shoes which will naturally stretch and breathe • Simple analgesia • Foot/ankle exercises	

Z58.8, Z59.8, Z59.9, Z62.1, Z77.2, Z77.3, Z77.5, Z77.8, Z77.9, Z78.4, Z78.5, Z78.6, Z78.9, Z79.1, Z79.2, Z79.3, Z79.4, Z79.8, Z79.9, Z80.1, Z80.2, Z80.3,, Z80.4, Z80.8, Z80.9, Z85.2, Z85.3, Z85.4, Z85.5, Z85.6, Z85.8, Z85.9, Z86.2, Z86.3, Z86.4, Z86.5, Z86.6, Z86.8, Z86.9, Z90.4, Z90.5, Z90.6, or Z90.7)			
W03.5, W12.2, W13.4, W14.1, W14.3, W14.4, W16.1, W16.3, W16.4, W28.2, W28.3 (T64.4 with Z59.9 or Z79.3) (W13.2, W28.1 with Z79.2) (W13.3, W28.1, W32.2 with Z79.5)	**Acquired Flat Foot** Stage I Disease – Debridement, this may be supplemented with the use of an arthrodesis screw Stage II Disease - a Flexor Digitorum Longus transfer, Calcaneal Osteotomy and Spring ligament Reefing. Adjunctive procedures include gastrocnemius recession, midfoot fusion or osteotomy and subtalar arthrodesis. Stage III Disease - Triple arthrodesis of the subtalar, calcaneocuboid and talonavicular joints.	Referral for surgical consideration of flat foot shall only be considered where a patient meets ALL of the following: • MUST have been triaged or seen in a Musculoskeletal Intermediate Service (MIS) or MSK podiatric Service for assessment and orthotic provision. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. • If the patient is unresponsive to conservative treatment or there is significant persistent pain or loss of function impacting on daily living	**Restricted**

	Stage IV Disease - Pantalar fusion or a triple fusion and ankle replacement.	• Surgery will be considered for patients with flatfeet (who have pre-existing or recent onset of symptomatic flat feet) in the following circumstances: • If the deformity is recent onset or deteriorating this should be made a priority. • If the patient is unable to go up onto tip-toe unaided and standing only on the affected foot or if the foot is not correctable when assessed on the couch.	
W03.6, W04.1, W04.2, W04.3, (T74.4, T74.8, T96.3, T96.8, W90.3, W92.3, W92.4, X38.2 with Z80.8, Z80.9, Z85.6 or Z90.5)	**Hind foot –** Treatment for arthritis • Image guided/targeted injections can be used as a diagnostic and also therapeutic tool. • Hind foot fusions of one, two or three of the hind foot joints is a surgical procedure to relieve severe pain from arthritis or correct painful deformity. • Double and triple fusion (involving the talonavicular and calcaneocuboid joints)	Patients must have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) **AND** • Exhausted appropriate non operative interventions as specified in the OA pathway • Appropriate analgesia	**Restricted**

(T96.3, T96.8, W06.8, W06.9, W08.2, W08.3, W08.4, W08.5, W13.4, W14.1, W14.3, W14.4, W16.1, W16.3, W16.4, W20.9 W21.4, W28.1, W28.2, W28.3, W60.1, W60.2, W62.1, W62.2, W62.8, W62.9, W63.1, W64.2, W77.8, W81.1, W81.2, W81.5, W81.7, W90.3, X38.2 with Z85.6) OPCS codes not available for Phonophoresis Prolotherapy Cryotherapy Viscosupplementation	**Symptomatic ankle arthritis:** Refer to a Consultant Orthopaedic Foot & Ankle Surgeon for consideration of surgery:	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. **AND** • Be unresponsive to conservative treatment **AND** • Have symptomatic Osteoarthritis Phonophoresis (The use of ultrasound to enhance the delivery of topically applied drugs Prolotherapy (Injection of e.g. dextrose into tissues to try to promote healing), Platelet Rich Plasma Cryotherapy (use of cooling to promote healing) Viscosupplementation (this has gone through clinical priority advisory group (CPAG) and scored as low evidence.	**Restricted** **Excluded** **Excluded** **Excluded** **Excluded**
(T96.3, W36.6, W80.1, W80.2, W80.8, W80.9, W82.1, W82.2, W82.3, W82.8, W82.9, W83.2, W83.3, W83.4, W83.5,	**Arthroscopy & Debridement (ankle)**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have	**Restricted**

W83.6, W83.7, W83.8, W89.1 with Z85.6)		been undertaken including any relevant community physiotherapy and diagnostics. **AND either/or** • Unresponsive to conservative treatment • Clinical examination or MRI scan has demonstrated clear evidence that there is an internal joint derangement e.g. removal of ankle/subtalar loose bodies, debridement of osteochondral defects and resection of scar tissue	
	Ankle Replacement – Arthroplasty is the responsibility of NHS England https://www.england.nhs.uk/wp-content/uploads/2013/06/d10-spec-orthopaedics.pdf	Commissioned by NHS England	**Excluded**
Please see separate policy for FES	**Functional Electrical Stimulation (FES) for Foot Drop**	FES using skin surface electrodes will be commissioned for patients who meet the following criteria. **This is exempt from the requirement for Musculoskeletal Intermediate Service referral as the problem is neurological in origin.** **ALL** patients must have had a successful trial of FES and demonstrate improved gait. • The patient has foot drop caused by upper-level nerve damage	**Restricted**

		• The patient has been assessed by a specialist in foot drop of neurological origin and all treatment options have been considered • There is evidence that foot drop has caused trips or falls, or gait issues • The patient can walk a minimum of 10 metres independently (+/- aids) • The patient can physically manage a FES (+/- minimal assistance) • The patient's cognitive ability is such that they can manage a FES independently • The patient does not have co morbidities which would affect their capacity to benefit from FES • The patient does not have any of the known clinical contraindications to FES • Clear FES treatment goals and expectations of benefit are outlined, this is in relation to the effectiveness, and these are assessed annually. outlined	
	Other types of FES (implanted or wireless) are not commissioned.	Not routinely commissioned	**Excluded**

8 Upper Limb

Shoulder pain is the third most common reason for musculoskeletal consultations in general practice, after back and neck pain. Shoulder pain accounts for 5% of all GP encounters, with a lifetime risk of 30% in the general population. In a study of adults consulting for shoulder pain in a UK primary care setting, a prevalence of 2.36% and incidence of 1.47% were reported, peaking at 50 years and showing a linear increase with age.[7]

Shoulder symptoms can cause significant distress to patients, resulting in severe socio-economic loss to society with an increased burden on the health-care budget. However medical intervention should not be undertaken in the first instance unless otherwise indicated.

8.1.1 Shoulder Procedures

OPCS Codes	Shoulder Condition/Procedure	Threshold	Status
W78.1 (W78.4, W76.7, W91.9, with Y76.7 and Z81.4)	**Arthroscopic Capsular Release (ARC) for Adhesive Capsulitis (Frozen Shoulder)**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. Consideration will be given for those patients who have not responded to a maximum of 3 months of conservative management as listed below:- • Appropriate medicines management • Physiotherapy (Minimum of 6 weeks, continue for a further 6 weeks if patients function and symptoms have improved) May include advice, exercises, manual therapy, thermotherapy, electrotherapy and steroid injection • Have relevant patient information leaflets/support	**Restricted**

[7] **Linsell L, et al. Prevalence and incidence of adults consulting for shoulder conditions in UK primary care: patterns of diagnosis and referral. Rheumatology (Oxford) 2006;45(2):215–21.**

		• Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep **AND** • Have failed to respond to a steroid injection in conjunction with physiotherapy.	
(W92.2 with Y53.5 and Z81.4)	**Hydrodilatation for Adhesive Capsulitis (frozen shoulder).**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. Consideration will be given for those patients who have not responded to maximum of 3 months of conservative management as listed below:- • Appropriate medicines management • Have relevant patient information leaflets/support • Physiotherapy • Patients must have significant persistent pain > 3months preventing them from fulfilling vital activities of daily living • Disturbance of sleep Due consideration to be given MUA & injection as valid alternative to Hydrodilation	**Restricted**
(U13.2, U21.6, U21.1 with Z81.2, Z81.3 or Z81.4)	**Ultrasound and/or MRI for soft tissue shoulder (if rotator cuff injury is suspected)**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) or be under the care of a Rheumatologist, Pain Management	**Restricted**

		Consultant. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. Consideration will be given for those patients who have not responded to 6 weeks of conservative management as listed below:- • Appropriate medicines management • Have relevant patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep	
(W88.1, W88.8, W88.9 with Z81.4)	**Diagnostic Arthroscopy**	The ICB does not support the use of arthroscopy for diagnostic purposes. Alternatives should be used such as X-ray, MRI, Ultrasound.	**Excluded**
(W81.7 with Y76.7 and Z81.4)	**Therapeutic Shoulder Arthroscopy**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. Consideration will be given for those patients who have not responded to conservative management between 3-6 months as listed below:- • Activity modification • Physiotherapy Programme • Appropriate analgesia	**Restricted**

		• Steroid injections where clinically appropriate **AND** • Full thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging **OR** • Significant superior labrum anterior posterior (SLAP) tear as demonstrated by clinical symptoms and radiological imaging **OR** • Partial thickness rotator cuff tear as demonstrated by clinical symptoms and radiological imaging which has not responded to 3 months of conservative management **OR** • Adhesive capsulitis demonstrated by clinical symptoms which has not responded to 6 months of conservative management **OR** • Adhesive capsulitis demonstrated by clinical symptoms and in the view of the treating consultant is having an extraordinarily severe impact on quality of life, and which has not responded to conservative management including corticosteroid injection where clinically appropriate **OR** • Subcromial shoulder pain demonstrated by clinical symptoms which has not responded to 6 months of conservative management **OR** • Non-traumatic shoulder joint instability that has not	

		responded to 6 months of conservative management **OR** • Traumatic shoulder joint instability alongside relevant conservative management as clinically appropriate.	
(W84.7 with Z81.3 or Z81.4)	Therapeutic Arthroscopy for Minor (type I*) SLAP tear repair	The ICB does not routinely fund this procedure	**Excluded**
O27.2, O27.3 with Y76.7) (O27.1, O27.4, O27.8, O27.9, W77.1 with Z81.4 and Y76.7)	**Management of recurrent anterior dislocation of the shoulder. Open and arthroscopic Bankart repair.** (exclude young recurrent anterior dislocation)	Patients **MUST** have been triaged or seen in Musculoskeletal Intermediate Service (MIS) if not already under a secondary care consultant. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. The following criteria apply:- • Young anterior dislocation (less than 25) whether first time or recurrent, should be assessed in secondary care for consideration of early stabilisation surgery (BESS guidelines). • 25-45 years can be treated by physiotherapy following initial instability, but recurrent dislocation should be seen and assessed in secondary care. • According to BESS guidelines, first time dislocation in patients over the age of 45 should be seen and assessed in secondary care to pick up cases of associated acute cuff tear. • Recurrent atraumatic structural instability in the	**Restricted**

		absence of muscle patterning deemed suitable for surgical intervention https://www.rnoh.nhs.uk/sites/default/files/rehabilitation-guidelines-for-post-operative-shoulder-instability-repair-updated20june08_0.pdf	
(O27.2, O27.3 with Y76.7) (O27.1, O27.4, O27.8, O27.9, W77.1 with Y76.7 and Z81.3 or Z81.4)	**Bristow Latarjet Procedure** The Bristow-Laterjet must not be used for multi-directional instability or psychogenic habitual dislocations. The Bristow-Laterjet Repair for shoulder instability must only be performed by an experienced Orthopaedic surgeon with advanced arthroscopic skills and familiarity with anatomy encountered during the open Bristow-Laterjet Procedure	The ICB does not routinely fund this procedure Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) and received 12 weeks of conservative treatment. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. **And** • have an Instability Severity Index Score (ISIS) of greater than 3 **And** • Have a severe glenoid bone defect (>20% of the glenoid surface as measured on a pre-operative CT scan)	**Restricted**
O06.1, O06.8, O06.9, O07.1, O07.8, O07.9, O08.1, O08.8, O08.9, W49.1, W49.8, W49.9, W50.1, W50.4, W50.8, W50.9, W51.1, W51.5,	**Shoulder Replacement Surgery** Elderly patients with intact but poorly functional cuff can be considered for reverse total shoulder replacement in line with the criteria for reverse	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.	**Restricted**

W51.8, W51.9, W96.8, W96.9, W97.8, W97.9, W98.8, W98.9 (W43.1, W43.8, W43.9, W44.1, W44.8, W44.9, W45.1, W45.8, W45.9, W52.1, W52.8, W52.9, W53.1, W53.8, W53.9, W54.1, W54.8, W54.9, W55.1, W55.8, W55.9, W56.2, W56.8, W56.9, W58.1, W96.1, W96.5, W97.1, W97.5, W98.1, W98.6 with Z81.3 or Z81.4)	shoulder surgery with rotator cuff pathology.	Consideration will be given for those patients who have not responded to conservative management as listed below:- • Activity modification • Appropriate analgesia • Severe pain and functional disability that significantly interferes with activities of daily living from injury e.g. osteoarthritis, post traumatic arthritis of shoulder for at least 6 months duration **AND** • has severe limited range of motion of the glenohumeral joint on physical examination **AND** • Radiographic evidence of destructive degenerative joint disease (as evidence by 2 or more of the following: irregular joint surfaces, glenoid sclerosis, osteophyte changes, flattened glenoid, cystic changes in the humeral head, or joint space narrowing of the shoulder joint)	
(T79.3, T79.5, W78.1, W84.7 with Z81.4)	**Reverse shoulder surgery with rotator cuff pathology**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.	**Restricted**

		• Appropriate analgesia • Steroid injection if clinically appropriate (injection should be no less than 3 months before referral) • Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living • Disturbance of sleep • Physiotherapy programme • Lifestyle modification Surgical intervention may be considered if patient has failed to benefit from **ALL** conservative treatments and patient remains in significant pain and activities of daily living are greatly affected **AND** a total shoulder replacement has been considered **AND** there is evidence of rotator cuff dysfunction. **FOR ANY OTHER INDICATION CLINICIANS MUST APPLY FOR FUNDING VIA THE IFR DEPARTMENT.**	
O29.1 (W57.2 with Z81.2)	**Subcromial Decompression for shoulder pain**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken	**Restricted**

(W08.5 or W08.9 with Z68.1)		including any relevant community physiotherapy and diagnostics. Patient's must have undergone 6-8 weeks of conservative management: - • Appropriate analgesia • Steroid injection if clinically appropriate • Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living. • Disturbance of sleep. • Physiotherapy programme • Lifestyle modification • Referral supported by appropriate imaging Surgical intervention may be considered if patient has failed to respond to **ALL** conservative treatment and patient remains in significant pain and activities of daily living are greatly affected.	
(T79.1, T79.3, T79.4, T79.5, T79.8, T79.9 with Z81.4)	**Rotator Cuff Disorders**	Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available i.e. East Staffordshire PCN, all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics. AND have received: - • Appropriate analgesia • Steroid injection if clinically appropriate	**Restricted**

		• Patient information leaflets/support • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living. Abduction of shoulder between 60 and 120 degrees. • Disturbance of sleep. • Physiotherapy programme • Lifestyle modification Surgical intervention may be considered if patient has failed: • Evidenced base conservative treatment and patient remains in significant pain and activities of daily living are greatly affected	
(W90.3, W90.4, X30.9 with Z81.2, Z81.3, Z81.4, Z68.4 or Z68.5)	**Supra-scapula nerve block –** May offer temporary benefit in reducing symptoms and facilitating engagement with physiotherapy/exercise programme. Policy is not applicable to ; • Visceral pain • Cancer pain • Hemiplegic shoulder pain • Peri or post-operative pain • Continuous nerve block via indwelling catheter	<u>Inclusion criteria:</u> • Adults with shoulder pain secondary to musculoskeletal (MSK) disorders commonly treated in MSK practice. • Osteoarthritis (GHJ or ACJ) • Adhesive capsulitis / frozen shoulder • Rotator cuff arthropathy • Single or 'one off' suprascapular nerve blocks • Either guided using radiology, or via bony landmarks Patients **MUST** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS). Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.	**Restricted**

		AND have the following: - • Persistent shoulder pain, i.e. chronic shoulder pain (more than three month's duration) which has failed to, or only partially responded to more traditional therapies (other shoulder injections/ physio etc.) • The shoulder pain is being generated by more than one site in the shoulder e.g. AC OA with GH OA with supraspinatus cuff pathology • Nerve block should be offered conjunction with a prescribed/personalised exercise programme.	

9 Spinal

9.1 Low Back pain

Low Back Pain (LBP) is extremely common and is the largest single cause of loss of disability adjusted life years, and the largest single cause of years lived with disability in England (Global Burden of Disease, 2013). In terms of disability adjusted life years lost per 100,000, LBP is responsible for 2,313. By contrast the remainder of musculoskeletal complaints counts for 911, depression 704 and diabetes 337. It should be borne in mind that this is principally occurring in people of working age, or with families.

UK specific data shows that LBP was the top cause of years lived with disability in both 1990 and 2010 – with a 12% increase over this time. 3% of the population's life is being lost to LBP.
LBP accounts for 11% of the entire disability burden from all diseases in the UK; furthermore the burden is increasing both absolutely (3.7% increase) and proportionally (7% to 8.5%).

In CG88 NICE estimated that the cost of LBP to the NHS in 2008 was £2.1 billion. The same analysis estimated that the societal cost of informal care and production loss was £10.7 billion in 1998. Overall, LBP is one of the most costly conditions for which an economic analysis

has been carried out in the UK
The national pathfinder pathway project focused on low back pain and radicular in the over 16's which has led to the National Back Pain and Radicular Pain pathway published in May 2017 (3rd edition) including NICE guidance NG59. This section of the commissioning policy follows the recommendations in these.

9.1.1 Low back pain and radicular back pain procedures/treatments

OPCS Codes	Spinal Condition/Procedure	Threshold	Status
Low Back Pain	**Spinal injections**		
U05.5, U13.3, U13.4, U13.5, U21.1	**X-rays and MRI of the lumbar spine for non-specific pain**	MRI for Chronic lumbar back-pain (>6 weeks) with no clinical or serological indicators of infection or neoplasia or other red flags to be used in specialist care only where management will be altered.	**Restricted**
(V54.4, W90.3, X30.9, X38.2 with Z06.3 or Z84.1)	**Spinal injections –** These include: • Intraarticular Facet joint injections • Intradiscal therapy • Prolotherapy • Trigger point injections	Not routinely funded for the treatment of non-specific low back pain.	**Excluded**
A70.5, A70.6, A70.7, X61.1, X61.4, X61.8, X61.9	**Alternative therapy such as acupuncture and Tens**	Are not funded within the NHS	**Excluded**
V54.4, Z67.5, Z67.6	**Medial nerve branch blocks as a diagnostic prior to the Radiofrequency denervation (rhizolysis)**	Patients **must** have been triaged or seen in the Musculoskeletal Intermediate Service (MIS) or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.	**Restricted**

		• Patients have received a biopsychosocial assessment within a specialist pain service (ideally multidisciplinary) • Back pain severity on a scale of ≥6/10 which has been assessed using a validated pain score questionnaire such as VAS (https://www.physio-pedia.com/Visual_Analogue_Scale) • Patients must be actively involved in shared decision making in respect of their treatment and demonstrated commitment to their long-term treatment plan • Patients must have a commitment in taking responsibility for managing their condition by demonstrating lifestyle changes which may include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, and improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate • Back pain has persisted for at least 12 months and all clinically appropriate conservative management options, including medication, physiotherapy, and exercise, have already been tried without success • Back pain causes significant impact on daily functioning which has been assessed using the MSK	

V48.1, V48.3, V48.5, V48.6, V48.7, V48.8, V48.9,	**Radiofrequency denervation (rhizolysis)**	HQ tool (https://www.keele.ac.uk/pchs/implementingourresearch/makinganimpact/musculoskeletalpain/msk-hqhealthquestionnaire/) Radiofrequency denervation for chronic non-specific low back pain will only be funded in accordance with the criteria below: • Moderate or severe localised back pain (rated as 6 or more on a visual analogue scale or equivalent). **AND** • The main source of pain is thought to come from structures supplied by the medial branch nerve as evidenced by a previous positive response to **one** or **two** diagnostic medial branch blocks **AND** • Patient is being treated in the context of a specialist (ideally multidisciplinary) Chronic Pain Management Service https://www.nice.org.uk/guidance/ng59 (See Page 55)	**Restricted**
V33.3, V38.2, V38.3, V38.4, V38.5, V38.6, V38.8, V38.9, V39.3, V39.4, V39.5, V39.6, V39.7, V39.8, V39.9, V40.4	**Spinal fusion**	Spinal fusion is only commissioned for back pain in the presence of **ONE or more** of the following • Spondylolisthesis or spondylolysis • Spinal deformity • Post discectomy or decompression • Neurological compression with associated neural compression symptoms	**Restricted**
V36.3	**Disc replacement**	Disc replacement will not routinely be funded for patients with non-specific low back pain.	**Excluded**

Lumbar Radicular Pain			
A73.5	**Diagnostic nerve root block**	Diagnostic nerve root blocks are only funded after surgical review when decompressive surgery is being considered for nerve root compression. Repeated diagnostic nerve root blocks are not routinely funded for the same level of injection for the same nerve root	**Restricted**
A57.7, A73.5, A52.1, A52.2, V48.1, V48.3, V48.5, V48.6, V48.7, V48.8, V48.9, X30.6, X30.8, X30.9, (A52.8, A52.9 with Z06.3, Z07.3, Z10.9, Z66.5, Z67.5, Z67.6, Z76.9 or Z84.1 (W54.4, W90.3, X30.9, X38.2 with Z06.3 or Z84.1)	**Epidural injections and therapeutic spinal nerve blocks**	**Epidural injections and therapeutic nerve blocks**: Not routinely funded for the treatment of low back pain without root compression. There should be evidence that a patient with low back pain and/or sciatica has been assessed in line with NICE guidance NG59 1. Patients should have been triaged or seen by a Musculoskeletal Intermediate Service (MIS - Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.) and have been referred on with evidence available for: • MRI (or similar diagnostic test) which shows radicular compression with documented clinical correlation (MRI scans should be relevant to the presenting symptoms and be at least within 6-12 months of the current episode) AND Symptoms persisting despite non-operative treatment for	**Restricted**

		at least 6 weeks (conservative management including exercise, medication and education) 2. Referral for injection for acute back pain (less than 6 weeks after onset) is only funded for patients with root compression symptoms (leg pain) that are severe and debilitating and patient is immobile (despite a documented trial of a full analgesic ladder and physiotherapy without success). 3. Patients may receive one further injection after a documented improvement for a period of 6 months after the first injection. A maximum of 2 injections will be funded for that episode of care. Further injections will require prior approval from the ICB. 4. All requests for repeated **therapeutic nerve** injections for chronic radicular pain, on the grounds of **clinical need**, need to be made via the ICB Prior Approval Process. 5. The ICB would only consider repeated spinal injections for patients with **chronic radicular pain** (duration >12 weeks) after prior approval has been sought in cases where there is documented clinical improvement from previous injections. 6. **Lumbar facet joint injections** will not be routinely commissioned.	

V22.1, V23.1, V24.1, V25.1, V25.2, V25.3, V25.4, V25.5, V25.6, V25.8, V25.9, V26.1, V26.3, V264, V26.5, V26.6, V26.9, V28.1, V33.1, V33.2, V33.3, V33.6, V33.7, V33.8, V33.9, V34.7, V34.8, V36.3, V37.1, V37.2, V37.3, V37.4, V37.8, V37.9, V38.1, V38.2, V38.3, V38.4, V38.9, V39.1, V39.2, V39.4, V60.3, V67.1, V67.2, V68.1	**Spinal decompression and discectomy (lumbar) for radicular pain/spinal claudication**	Spinal decompression (laminectomy / laminotomy / foraminotomy) and discectomy will only be funded for patients with sciatica (radicular pain) or stenotic symptoms (neurogenic claudication) in accordance with the following criteria: Patients should have been triaged or seen by a Musculoskeletal Intermediate Service (MIS - Where MIS is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community physiotherapy and diagnostics.) and referred on with evidence of: • MRI (or similar diagnostic test) showing radicular compression with documented clinical correlation (MRI scans should be relevant to the presenting symptoms and be at least within 6-12 months of the current episode) • Symptoms persisting despite non-operative treatment for at least 6 weeks (conservative management including exercise, medication and education) • Patient consents for surgical treatment This policy restriction does not apply to patients with red flag symptoms or signs.	**Restricted**

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