Commissioning Policy

Excluded and Restricted Procedures

Version 2.3

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Name of originator/authors:	Head of Planned Care, Cancer & Diagnostics/ IFR Improvement Manager
Name of responsible committee/individual:	Finance and Performance Committee
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Target audience:	NHS and partnering agencies, all health providers that provide care to Staffordshire and Stoke-on-Trent patients, Primary and Community Care including GPs either via a contract or NCA arrangements, and care professionals; general public within Staffordshire and Stoke-on-Trent Integrated Care Board

CONSULTATION SCHEDULE

Name and Title of Individual	Groups consulted	Date Consulted
ICB Portfolio & Clinical Leads	Internal	2024/2025 2025/2026

GOVERNANCE SCHEDULE

Name of Committee	Role	Date
Clinical Prioritising Advisory Group (CPAG)	Support	November 2024
Quality and Safety Committee	Support	February 2025
Portfolio Boards:	Support	December 2024 and January 2025
Finance and Performance Committee	Endorsement	N/A
Health & Care Senate	Approval	13.02.2026
ICB Board	Ratification	30.04.2026

VERSION CONTROL

Version	Version/Description of amendments	Date	Author/amended by
1.0	ERP approved at ICB Board	11/10/2023	Jackie Newman
2.0	Reviewed and updated as per review schedule.	02/10/2024	Vanessa Weaver & Jackie Newman
2.1	Addition of weight management drugs, bariatric surgery for patients over 18 years, simple ear wax, aquatic therapy for children & young people, aquatic therapy for inflammatory arthritis, sequential oral sensory (SOS) therapy. Additional narrative for orthotic provision	April-July 2025	Mel Mahon, Vanessa Weaver, Catherine Lewin, Graeme OMalley & Jackie Newman
2.2	Minor amendment to the Infertility and Assisted Reproduction intervention. Prior approval must be sought and the preferred approval process is via Blueteq.	11/11/2025	Nicola Bucknall

2.3	Minor amendments:– Vaginal ring pessaries, overarching Trauma & Orthopaedic wording. Additions:- Revision of previous cosmetic surgical procedures, Health optimisation statement, Mental Health Assessments, CF/ME Residential treatment programmes, surgical removal of kidney stones, cystoscopy for men with uncomplicated lower urinary tract symptoms, venous angioplasty for the treatment of multiple sclerosis, surgical treatment of uncomplicated varicose veins and reticular veins or telangiectasia, MRI scan of the hip for diagnosis of OA, Knee MRI when symptoms are suggestive of OA, Knee MRI in the investigation of suspected meniscal tears, appendicetomy without confirmation of appendicitis, PSA test, Endoscopic laser foraminoplasty	April 2026	Jackie Newman & Vanessa Weaver

IMPACT ASSESSMENTS – available on request

	Date	Stage	Comments
Privacy Impact Assessment	N/A	N/A	N/A
Quality Impact Assessment Impact assessments V2	17/3/2026	Gateway 1	QIA24-042 - *This QIA sets out clear criteria for health professionals and patients to ensure equity of application.*
EHIA – Amendment	29/01/2026	Stage 1	Amendment to the ERP alignment) *No changes to original EHIA in 2022 – Satisfied that due regard has been demonstrated)*

1.0 Purpose

1.1 The purpose of this policy is to ensure that Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Board, which will be referred to as 'the ICB' throughout this policy only fund treatments that are clinically effective and only offer interventions on the NHS that are evidence-based and appropriate.

The policy details the treatments deemed to have sufficient clinical evidence to justify funding from the ICB's allocated fixed budget. The aim is to improve the quality of care being provided to patients by reducing unnecessary interventions and preventing avoidable harm. This will enable the ICB to reallocate this finite resource and ensures any money saved is spent on other more effective treatments.

This policy provides a collated list of all procedures and services that the ICB have restricted NHS funding for. Patients should only be referred for the interventions listed if they meet the eligibility criteria. The onus is on the treating clinician, and the Provider Organisation, to seek the necessary authorisation from the ICB prior to commencing treatment or procedure. It is the clinician's responsibility to provide relevant, accurate evidence of how the patient meets the criteria.

If a provider undertakes either an excluded or a restricted procedure within this policy without gaining prior approval the ICB will not pay for the procedure, this is in conjunction with the Provider signed contract.

If a provider undertakes one of the listed procedures which is listed as 'excluded' then the ICB will withhold payment. The only route which funding may be considered is on grounds of clinical exceptionality. Please refer to IFR link https://staffsstoke.icb.nhs.uk/contact-us/individual-funding-requests/

2.0 Introduction

2.1 Across the country most, if not all ICBs have a set of policies and procedures for limiting the number of low clinical value treatments and interventions. This Policy supports the decision-making process associated with the allocation of resources for commissioning. The ICB has a prioritisation process which is overseen by the Clinical Advisory Prioritisation Group (CPAG) https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/governance-handbook/all-policies/commissioning/icb-policy-on-the-prioritisation-of-healthcare-resourcesmaster/?layout=default

2.2 CPAG use an approved standardised scoring system, which has been supported by the ICB Board, to evaluate clinical evidence that is available for a particular therapeutic treatment, intervention or a diagnostic test.

2.3 In addition, the Evidence Based Intervention (EBI) programme, which was launched in 2018 is a clinical initiative led by the Academy of Medical Colleges in partnership with NHS England, NHS Clinical Commissioners, National Institute for Health and Care Excellence (NICE), Getting it Right First Time (GiRFT), providers and the public. The aim of the EBI programme is to improve the quality of care and is designed to reduce the number of medical or surgical interventions as well as some tests and treatments where the evidence shows that it is inappropriate for some patients in some circumstances.

Another focus of the CPAG portfolio, in conjunction with the EBI programme, is to free up valuable resources so they can be put to better use elsewhere in the NHS.

2.4 The Policy establishes the framework within which the ICB can demonstrate that its decision-making processes are fair, equitable, ethical, and legally sound. The risk of not having an ERP Policy means that each decision is left solely to the clinician to manage each patients' individual problems without guidance and context of the health needs of the wider population.

2.5 This Policy is designed to help the ICB to meet its statutory 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.

2.6 Where patients fall outside of this policy, then the only route which funding may be considered is on grounds of clinical exceptionality. Please refer to IFR link https://staffsstoke.icb.nhs.uk/contact-us/individual-funding-requests/

3.0 Background (Rationale for Policy)

3.1 The ICB is required to commission comprehensive, effective, accessible and equitable 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.

3.2 This policy supports clinicians in making decisions on when to refer, where the primary reason for the referral is surgical intervention. The policy is also a statement about what the ICB will routinely pay for.

3.3 Each year the NHS is subjected to greater pressures. Ensuring that treatment and care is focused where it can make the biggest difference is a vital part of making the best use of finite resource. The ICB receives funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations, and guidance. This is a significant challenge for all NHS organisations and is a key focus for the ICB. The ICB has a responsibility to seek the greatest health advantage possible for local populations using the finite resources allocated to them. This policy will help clinicians identify interventions with limited clinical benefit which enables potential reinvestment, where benefits are greater for the population of Staffordshire and Stoke-on-Trent.

3.4 This policy covers interventions where there is significant risk that patients undergoing them will gain little health benefit. The procedures have low rather than no clinical value. Some may be effective but may have low value because other treatments could be tried first. Other effective procedures may provide large benefits for some cohorts but less to those with few symptoms, where risks and benefits are closely balanced. There are some interventions which are effective in some but give no clinical value in others. There are those interventions that whilst effective are undertaken for primarily cosmetic reasons which commissioners often consider as providing low clinical value.

4.0 Definition of "Low Priority Treatments"

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

- Medicines – both prescribed and non-prescribed.
- 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.

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 National Institute for Heath & Care (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 ICB. 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.

The term 'female' and 'male' for the purpose of this policy relates to the biological sex of the patient. The ICB is including those born with internal and external genitalia, chromosomes and/or hormones that relate to that sex and not their gender.

5.1.2 This policy should be used in conjunction with patient symptomatic clinical referral pathways.

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 ICB 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, see section 2.

5.3 Populations

5.3.1 Unless stated otherwise the restrictions within this policy apply to patients of all ages. If the restriction is a paediatric case, then this is defined as a child between the ages of 0 and 18.

Unless stated otherwise the restrictions within this policy apply to all patients registered with a GP Practice in Staffordshire and Stoke-on-Trent Integrated Care System.

5.4 Ethical and Legal Policy for Decision Making

5.4.1 The ICB has 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 and Compliance

5.5.1 This policy will be reviewed and approved by the Health & Care Senate and will be made publicly available via https://staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/governance-handbook/all-policies/commissioning/icb-excluded-and-restricted-procedures-policy-v3-1/?layout=default

Queries relating to the content of this policy or has difficulty understanding this policy should in the first instance contact the IFR Team IFRTeam@staffsstoke.icb.nhs.uk

5.5.2 The schedule showing low priority treatments is set within this policy. This will be formally incorporated into the contracts and service level agreements and will be subject to routine monitoring for compliance. The ICB will require primary, tertiary and secondary care service providers and other organisations acting on behalf of the ICB to embrace and abide by the policy and to advise patients accordingly.

5.5.3 This Policy must be implemented by GPs and all 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 in this policy. In the first instance where there is a Tier 3 service provider pathway in place the Primary Care referrer **MUST** refer to the Tier 3 service prior to offering Patient Choice. Patient Choice will be offered if the patient requires onward referral from the Tier 3 service or the referral relates to a suspicion of cancer or is an emergency. Providers should not suggest, recommend, or otherwise offer excluded treatments or procedures covered in 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.

5.5.4 **ALL** restricted procedures contained in this policy are subject to the ICB's requirement for prior approval. The preferred method of prior approval within the ICB is via an automated web-based software system however where providers do not use this facility then formal requests must be emailed to the ICBs secure email address IFRTeam@staffsstoke.icb.nhs.uk and will be processed by the IFR Team and a unique approval code will be issued. Providers will **NOT** be paid if a unique approval code is not issued. Retrospective approval is prohibited.

5.5.5 If treatment has been privately financed, it is assumed that the patient has sufficient funds to cover the whole package of care; it would not be reasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency or the patient has exceptional circumstances, please see https://staffsstoke.icb.nhs.uk/contact-us/individual-funding-requests/

5.5.6 The ICB acknowledges that if an individual patient has commenced private treatment that is routinely commissioned by the ICB the patient has a right to transfer back to NHS care with the caveat that the patient is reassessed by an NHS clinician in line with current policy to ensure compliance with the current policy that is in situ. Where the patient meets criteria, the patient will be subject to standard NHS clinical pathways. Any devices that are privately funded the NHS will not pick up the costs of consumables or maintenance unless they meet NHS criteria.

The continuation of loan device trials will not be routinely funded. Where treatments have been initiated by providers this is done so at the providers' own risk. The provider must manage the patients' expectations and have a clear exit strategy for the trial and/or continuing care.

5.5.7 Within this policy, and as stated against individual treatments or procedures listed appendix 1 treatments and procedures are classified as Excluded or Restricted by the ICB.

The Individual Funding Request (IFR) process is to be used in circumstances when an individual patient does not meet the clinical criteria for a procedure as listed in this policy but can demonstrate exceptionality in accordance with the IFR Policy https://staffsstoke.icb.nhs.uk/contact-us/individual-funding-requests/

5.5.8 Restricted procedures and treatments are not commissioned by the ICB except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment that have been recommended by the Clinical Prioritisation Advisory Group (CPAG) and approved by the ICB Board. 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 met. 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 5.5.7 above applies.

5.5.9 This Policy is distributed to all provider organisations, primary care contractors, Primary Care Networks and will be published on the ICB website.

5.6 Monitoring the Policy

5.6.1 The ICB 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 Portfolio Management and the Contracts Management Teams of the ICB.

5.6.3 The ICB 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 the ICB. 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 ICB.

5.6.5 The ICB reserves 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 the ICB before the procedure is undertaken using the agreed form/mechanisms. The ICB will not pay for any procedures undertaken without the required approval. It is the responsibility of the requester to provide the ICB with the necessary clinical evidence to demonstrate that the patient meets the criteria. Where a clinical opinion is required, a decision will be made within 30 working days of receipt by the ICB (this may be delayed if insufficient information is provided, and further clarification is required). Please refer to the clinical opinion standard operating procedure staffsstoke.icb.nhs.uk/your-nhs-integrated-care-board/our-publications/governance-handbook/all-policies/commissioning/sop-clinical-opinions-ifr-final20240604/?layout=default

5.6.7 Prior approval is not required if a patient is being referred to secondary care for consultant management other than a procedure listed in this policy (for example diagnostic tests, investigations or treatment options).

5.6.8 If a procedure is not listed in this policy but the Office of Population Censuses & Surveys (OPCS) codes have appeared in the Secondary Uses Services (SUS) data within the last two financial years of the request, this would indicate that both provider and the ICB would classify the activity as commissioned and therefore is chargeable by prior approval. If a procedure has not appeared in the SUS data and is also not covered in this policy this would indicate that both the provider and the ICB acknowledge that this procedure is unlikely to have been actively commissioned and on that basis the provider must seek clarification and appropriate approval before carrying out the procedure. Failure to do so will result in the procedure not been funded.

5.6.9 This policy is only applicable to elective/planned activity; 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.

5.6.10 Prior approval for NHS funding is not the same as a guarantee of treatment. The final decision around appropriateness and clinical safety will be a clinical one which will be discussed with the patient.

6.0 Audit

6.1 The preferred method of prior approval within the ICB is via an automated web-based software system to be used to pre-authorise procedures where restrictions apply. Due to the time scales obtaining prior approval may not always be feasible; therefore ad hoc audits will be requested by the ICB to ensure that the restricted diagnostics meet the threshold criteria. However where providers do not use this facility then formal requests must be emailed to the ICBs secure email address IFRTeam@staffsstoke.icb.nhs.uk and will be processed by the IFR Team and a unique approval code will be issued. Providers will NOT be paid if a unique approval code is not issued. Retrospective approval is prohibited.

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 The ICB will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the ICB 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 ICB 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 When Clinicians are assessing their patient's, providers should, if necessary, make it clear that the decision by the ICB to consider treatments or procedures to be of low priority under this policy is considered a 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 ICB 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.

9.0 Health Optimisation

9.1 Maintaining a healthy weight is the basis of a healthy lifestyle, accomplished through a combination of a balanced diet, regular physical activity, prioritising sleep and mental wellbeing and other healthy habits like moderate alcohol consumption and not smoking, vaping, or taking recreational drugs. A healthy lifestyle has numerous benefits, for example, reducing risk the risk of chronic diseases like heart disease, stroke, type 2 diabetes, some cancers, a stronger immune system, it can lead to better bone and joint health and improved mental and emotional well-being.

Any surgical intervention carries a risk, however small, to the patient. These risks are increased in those who are overweight/living with obesity or smoking. When surgery is planned this is an ideal opportunity to encourage patients to stop smoking and reduce their weight as this can significantly improve outcomes following surgical procedures by reducing risks and complications, enhancing recovery and shorter hospital stays and are less likely to need re-admission and other health care costs.

Appendix 1

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.

Procedures	Thresholds	Status
Psychotherapy for Borderline Personality Disorder and Dissociative disorders	Not routinely commissioned	**Excluded**
Behaviour Therapy for Gilles de la Tourette syndrome and tic disorders	Not routinely commissioned	**Excluded**
Inpatient cognitive behavioural therapy for Chronic fatigue syndrome	Not routinely commissioned	**Excluded**
Specialist Cognitive Behavioural Therapy (CBT) for Management of Aggressive Behaviour in People with Learning Disabilities	Not routinely commissioned.	**Excluded**
Specialist Cognitive Behavioural Therapy (CBT) for stuttering	Not routinely commissioned	**Excluded**
Dyadic Development Psychotherapy (DDP)	Not routinely commissioned	**Excluded**

Cardiology

Procedures	Thresholds	Status
Closure of Patent Foramen Ovale (PFO) for the prevention of stroke	Not routinely commissioned	**Excluded**
Closure of Patent Foramen Ovale (PFO) for migraine headache	Not routinely commissioned	**Excluded**
Angioplasty for Percutaneous Coronary Intervention (PCI) in Stable Angina	PCI is not routinely commissioned for patients with stable angina unless at least ONE indication in criteria 1 is met or at least ONE indication in criteria 2 and lifestyle interventions have been adhered to: Weight management, smoking cessation, cardioprotective Regular physical activity. **Criteria 1** • There is ongoing anginal symptoms despite optimal anti-anginal medication* **OR** • There is ongoing angina symptoms with intolerance of anti-anginal medications* **Criteria 2** If agreed at an appropriately constituted myocardial revascularisation cardiac multidisciplinary meeting (MDM), PCI may also be performed in patients with stable angina in the following cases: • In patients with impaired left ventricular systolic function **OR** • In patients with left main stem disease **OR** • In patients with significant ischemic burden **OR** • Where PCI is otherwise considered appropriate by the MDM. **AND** All patients being considered for elective revascularisation should have documented evidence that a formal shared decision-making process has taken place with informed patient choice. * Optimal risk medical management should be offered and needs to be stated on the Blueteq.	**Restricted**

Complementary Medicine/Therapies

Procedures	Thresholds	Status
Acupuncture	Acupuncture will only be commissioned as an adjunct to pain management and only through specialist pain clinics	**Restricted**
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**

Procedures	Thresholds	Status
Aquatic Therapy for Children & Young People	Not routinely commissioned	**Excluded**
Aquatic Therapy for Inflammatory Arthritis	Not routinely commissioned	**Excluded**
Animal Therapy	Not routinely commissioned	**Excluded**
Sequential Oral Sensory (SOS) Therapy	Not routinely commissioned	**Excluded**

Dermatology and Plastic Surgery

Unless stated as an exemption, all cases for patients aged 18 years and over will be referred from primary care to the Tier 3 Community Dermatology provider for clinical triage. Following clinical triage patients will be assessed and treated within the local tier 3 community or if there are any patients who have clinical 'red flags' then they 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. It is the responsibility of the receiving Provider to seek approval for all restricted procedures that they undertake in-line with their contracts with the ICB. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

When a direct referral has been made directly to the Trust there is an expectation that all appropriate conservative and non-surgical treatment options have been tried and have failed prior to referral. Referrals should include appropriate imaging.

Procedures	Thresholds	Status
Excision of sweat gland bearing skin for hyperhidrosis	Not routinely commissioned	**Excluded**
Treatment of Minor Skin Lesions including but not limited to: benign pigmented moles,	Will be routinely commissioned under the following circumstances: Significant functional impairment which is seen as the inability to perform normal working	**Restricted**

Procedures	Thresholds	Status
comedones, corns/callous, lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, warts, xanthelasma and neurofibromata, epidermoid/Pilar (sebaceous) cysts	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, restriction of joint movement, lesion causing regular pain requiring long-term medication, the lesion bleeds (more than twice weekly for at least four weeks) in the course of normal everyday activities, the lesion causes pressure symptoms which are unavoidable and cannot be managed conservatively and cause atrophy. Verruca on the feet do not normally meet this criterion as they can be pared back to avoid pressure symptoms. **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 the agreed prior approval route as agreed detailed in the contract. Where the lesion prevents the individual from being able to wear mandatory personal protective equipment (PPE) https://www.hse.gov.uk/ppe/ppe-regulations-2022.htmsafety following an occupational health assessment. The OcH assessment will need to evidence that all reasonable adjustments have been explored and are not suitable. The funding request together with the OcH report will need to be forwarded to the IFRTeam@staffsstoke.icb.nhs.uk for manual prior approval following a clinical decision.	
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	**Restricted**

Procedures	Thresholds	Status
	• 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	
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**
Abdominoplasty/Apronectomy/ Panniculectomy	Not routinely commissioned	**Excluded**
Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm. Buttock/Thigh/Arm lift or body contouring	Not Routinely Commissioned	**Excluded**

Procedures	Thresholds	Status
Revision of previous cosmetic surgeries	Not routinely commissioned (Revision of ANY previous cosmetic procedures (irrespective of whether this was previously NHS funded) as patients MUST meet the criteria of the current policy at the time of request)	Excluded
Cosmetic operations on the external ear including Pinnaplasty, split earlobes, excision of lesion of external ear	Not routinely commissioned	**Excluded**
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**
Cosmetic Operations on Breast (female) Mastopexy	Not routinely commissioned	**Excluded**

Procedures	Thresholds	Status
Cosmetic Operations on Breast (female) Revision of breast augmentation +/- Breast Implant Removal	Breast implant revision surgery will **ONLY** be supported if one of the following applies: • Implants with capsule formation that interferes with mammography • Implants complicated by recurrent infection • Implants with Baker Class IV contracture associated with pain (to be confirmed by a specialist opinion) • Intra or extra capsular rupture of silicone gel filled implants • Patient develops Breast Associated Anaplastic Large Lymphoma (BIA-ALCL) **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. Only implant removal should be performed, and no other subsequent cosmetic procedure e.g. mastopexy.** *The removal of breast implants due to symptoms termed as Breast Implant Illness (BII) or Autoimmune Syndrome Induced by Adjuvants (ASIA) on social media, or due to the risk of developing Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is not currently recommended. This criterion does not cover the following: - Gender reassignment surgery - Implants inserted following surgery for breast cancer or breast cancer prevention performed under the NHS.	**Restricted**
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**	**Restricted**

Procedures	Thresholds	Status
	• 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	
Surgery for inverted nipples	Not routinely commissioned	**Excluded**
Removal of Supernumerary Nipples (Polymastia)	Not routinely commissioned	**Excluded**
Refashioning of scars/keloids including stretch marks.	Not routinely commissioned	**Excluded**
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**
Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring and Keloids.	Not routinely commissioned	**Excluded**
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**
Liposuction of subcutaneous Tissue.	Not routinely commissioned	**Excluded**

Procedures	Thresholds	Status
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° 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	**Restricted**
Facial Atrophy – new fill Procedures.	Not routinely commissioned	**Excluded**

Procedures	Thresholds	Status
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 **OR** • Where repair of the labia is required after trauma.	**Restricted**
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**
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**
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**
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**

Procedures	Thresholds	Status
Skin Resurfacing techniques: Dermabrasion, Chemical Peels, Laser treatment and referrals for prescriptions for topical treatments etc.	Not routinely commissioned	**Excluded**
Botox for excessive sweating	Not routinely commissioned	**Excluded**
Botox for facial aging or excessive wrinkles.	Not routinely commissioned	**Excluded**
Tattoo removal.	Not routinely commissioned	**Excluded**
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**
Endoscopic thoracic sympathectomy (ECT) for extreme facial blushing.	Not routinely commissioned	**Excluded**

Diagnostics

Procedures	Thresholds	Status
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).	**Prior Approval**

	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 **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.	
MRI scan of the hip for the diagnosis of Osteoarthritis (OA)	Do NOT request a hip MRI when the clinical presentation (history and examination) and X-rays demonstrate typical features of OA. MRI scans rarely add useful information to guide diagnosis or treatment. Requesting MRI scans further prolongs waiting times for patients. Importantly it can cause unnecessary anxiety while waiting for specialist consultation and can delay MRI scans for patients with diagnoses other than OA of the hip. The diagnosis of hip OA can be effectively made based upon the patient's history and physical examination. NICE recommends diagnosing osteoarthritis clinically without investigations in patients who: • Are 45 or over **AND** • Have activity-related joint pain **AND** • Have either no morning joint-related stiffness or morning stiffness that lasts no longer than 30 minutes. It is important to exclude other diagnoses, especially when red flags are present. If imaging is necessary, the first-line investigation should be plain x-ray. An MRI or urgent onward referral may be warranted in some circumstances. These include:	Restricted

	• Suggestions of infection, e.g. pyrexia, swollen and red joint, significant irritability, other risk factors of septic arthritis • Trauma • History or family history of an inflammatory arthropathy • Mechanical, impingement type symptoms • Prolonged and morning stiffness • History of cancer or corresponding risk factors • Suspected Osteonecrosis / Avascular necrosis of the hip • Suspected transient osteoporosis • Suspected periarticular soft tissue pathology e.g. abductor tendinopathy Important differential diagnoses include inflammatory arthritis (for example, rheumatoid arthritis), femoro-acetabular impingement, septic arthritis and malignancy (bone pain). This guidance applies to adults aged 19 years and over.	
Knee MRI when Symptoms are Suggestive of Osteoarthritis	In primary care, where clinical assessment is suggestive of knee OA, imaging is not usually necessary. If imaging is required then weight bearing radiographs are the first-line of investigation. Patients with persistent symptoms should, after three to four months, be referred to secondary care and should have imaging of the knee to investigate for OA and/or other pathology. Where imaging is necessary, in secondary care the first-line investigation of potential knee OA is weight bearing plain radiography. If the patient has a pattern of disease that allows surgical treatment to be adequately planned with plain radiographs, then MRI is not required. However, there are a number of situations where MRI of the osteoarthritic knee can be useful: • Patients who have severe symptoms but relatively mild OA on standard X-rays. In this situation the MRI offers more detail and can show much more advanced OA or Osteonecrosis within the knee • In working up a patient for possible HTO or partial knee replacement an MRI can be a very useful investigation focusing on the state of the anterior cruciate ligament and state of the retained compartments.	Restricted

Knee MRI in the Investigation of Suspected Meniscal Tears	Patients with a clear history of: • a significant acute knee injury **AND** • mechanical symptoms **OR** • who have a locked knee may have a repairable meniscal tear and should undergo referral to intermediate or secondary care and have MRI investigation. The majority of patients who initially present in primary care with knee symptoms, no red flags and no history of acute knee injury or a locked knee do not need an MRI investigation and can be treated with non-operative supportive measures. Patients with persistent mechanical knee symptoms should be referred to secondary care and should have an MRI scan of the knee to investigate for a meniscal tear and/or other pathology. This guidance applies to adults aged 19 years and over.	Restricted

Ear, Nose and Throat and Paediatric surgery
Any patient with clinical 'red flags' or paediatrics should be referred directly to the acute service.

Unless stated as an exemption, all cases for patients aged 18 years and over will be referred from primary care to the Tier 3 Community ENT provider for clinical triage. Following clinical triage patients will be assessed and treated within the local tier 3 community or if there are any patients who have clinical 'red flags' then they 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. It is the responsibility of the receiving Provider to seek approval for all restricted procedures that they undertake in-line with their contracts with the ICB. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

When a direct referral has been made directly to the Trust there is an expectation that all appropriate conservative and non-surgical treatment options have been tried and have failed prior to referral. Referrals should include appropriate imaging.

Procedures	Thresholds	Status
Adenoidectomy	Adenoidectomy will only be funded if undertaken in conjunction with Tonsillectomy and/or Grommets (*Please refer to policies for Tonsillectomy and/or Grommets)*. For adenoidectomy only, prior approval will need to be sought	**Prior Approval**
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 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.	**Restricted**
Tonsillectomy for Peritonsillar Abscess (Quinsy)	Prior approval will need to be sought. Supporting clinic letters **MUST** accompany request.	**Prior Approval**
Tonsillectomy for tonsilloliths or tonsil stones	Not routinely commissioned	**Excluded**

Surgical Treatment for Obstructive Sleep Apnoea (OSA) children	To be undertaken in line with agreed OSA pathway. 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	**Restricted**
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 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.	**Restricted**
Treatments for snoring Including, but not restricted to: Uvulopalatopharyngoplasty, Uvulopalatoplasty, Palate Implants and Radiofrequency Ablation of the Soft Palate	Not routinely commissioned	**Excluded**
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	**Restricted**

	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) 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.	
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 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.	**Restricted**
Surgical treatment of acute otitis media	Not routinely commissioned	**Excluded**

Surgical Treatment of Meniere's Disease	Not routinely commissioned.	**Excluded**
Open wound of ear drum - Tympanoplasty	This procedure will **ONLY** be commissioned in the following circumstances: Chronic discharging ear, with deafness.	**Prior Approval**
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**
Surgical Treatment of Chronic Sinusitis	Referral for specialist secondary care **assessment** for surgery for chronic rhinosinusitis (CRS) shall only be commissioned where the following criteria and clinical management has been undertaken in Primary Care/interface provider or by a Tier 3 provider prior to patient being referred for surgical opinion: **Primary Care or Tier 3 Provider** • A clinical diagnosis of CRS has been made (as set out in RCS/ENT-UK Commissioning guidance) in primary care and patient still has moderate / severe symptoms after a 3- month trial of intranasal steroids and nasal saline irrigation. **AND** • In addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5-10 days of oral steroids (0.5mg/kg to a max of 60 mg). **OR** • Patient has nasal symptoms with an unclear diagnosis in primary care. **OR** • Patient has unilateral symptoms or clinical findings, orbital, or neurological features should be referred urgently / via 2-week wait to depend on local pathways.	**Restricted**

	No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (e.g. X-ray, CT scan). There is no role for prolonged courses of antibiotics in primary care. **Surgical** criteria for chronic rhinosinusitis (CRS) shall only be commissioned where the following criteria are met: • A diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and/or CT scan. **AND** • Disease-specific symptom patient reported outcome measure confirms moderate to severe symptoms e.g. Sinonasal Outcome Test (SNOT-22) after trial of appropriate medical therapy (including counselling on technique and compliance) as outlined in RCS/ENT-UK commissioning guidance 'Recommended secondary care pathway'. **AND** • Pre-operative CT sinus scan has been performed and confirms presence of CRS. Note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient's pathway. **AND** • Patient and clinician have undertaken appropriate shared decision-making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention. **OR** Patient with recurrent acute sinusitis, nasal examination is likely to be normal. Ideally, the diagnosis should be confirmed during an acute attack, if possible, by nasal endoscopy and/or CT sinus scan.	
Simple ear wax removal	For Simple ear wax removal, undertaken in isolation of a clinical pathway, is **NOT** funded by the NHS / ICB. Patients should follow the NHS self-help guide: Earwax build-up - NHS	**Excluded**

Endocrinology

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**
Weight Management Injections Access to Tirzepatide (Mounjaro) for Weight Management - cohort 1 **(Aug 2025 – Jul 2026)** NHSE Eligibility changes in Aug 2026 This policy will be updated in June 2026 for cohort 2 inclusion group.	Under current NHS guidance, in response to NICE TA1026, patients identified as being in the highest-risk group and who will benefit the most will be considered and are identified as being eligible will be invited to participate in the weight-management program. For Patients to access treatment they **MUST** have been initially assessed in the locally commissioned Primary Care Weight-Management Hub **AND** have: - • BMI 40 or higher **AND have** • **FOUR** or more of the following weight-related health conditions and receiving treatment for them and don't have any of the prescribed medication exclusions: ➢ Type 2 Diabetes ➢ High blood pressure ➢ Heart disease – Atherosclerotic Cardiovascular Disease (ASCVD) ➢ Obstructive sleep apnoea ➢ Abnormal blood fats (dyslipidaemia) **NOTE: -** Staffordshire and Stoke-on-Trent ICB (SSOT ICB) weight-management program is a Primary Care non-consultant delivered model. Patients will be invited to attend the Weight Management Hub and will be called based on the information recorded within their Primary Care record, i.e. there is a BMI 40 or greater and the patient has four comorbidities. Patients that have been assessed as being eligible must agree to participate in either the locally delivered, nationally funded, weight-management wrap-around care and support	**Invitation only as per cohort criteria**

	program or the local Specialist weight-management program. Patients that disengage or don't engage with this will be withdrawn from the treatment. Access to this prescribed medication for weight management will **ONLY** be commissioned for patients that have been through the weight-management Hubs.	

General Surgery

Procedures	Thresholds	Status
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, restriction of joint movement, lesion causing regular pain requiring long-term medication, the lesion bleeds (more than twice weekly for at least four weeks) in the course of normal everyday activities, the lesion causes pressure symptoms which are unavoidable and cannot be managed conservatively and cause atrophy. Verruca on the feet do not normally meet this criterion as they can be pared back to avoid pressure symptoms. **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 the agreed prior approval route as agreed detailed in the contract. Where the lesion prevents the individual from being able to wear mandatory personal protective equipment (PPE) https://www.hse.gov.uk/ppe/ppe-regulations-2022.htmsafety following an occupational health assessment. The OcH assessment will need to evidence that all reasonable adjustments have been explored and are not suitable. The funding request together with the OcH report will need to be forwarded to the IFRTeam@staffsstoke.icb.nhs.uk for manual prior approval following a clinical decision.	**Restricted**

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 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.	**Restricted**
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 should be referred.	**Restricted**
Incisional Hernia	Asymptomatic incisional hernias will not be funded except where peritoneal dialysis is planned.	**Restricted**

	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	
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**
Rectal bleeding	Follow the British Society of Gastroenterology surveillance guidelines for colonoscopy in the management of hereditary colorectal cancer: https://www.bsg.org.uk/wp-content/uploads/2019/12/Guidelines-for-the-management-of-hereditary-colorectal-cancer.full_.pdf Follow the British Society of Gastroenterology surveillance guidelines for post-polypectomy and post-colorectal cancer resection: https://www.bsg.org.uk/clinical-resource/bsg-acpgbi-phepost-polypectomy-and-post-colorectal-cancer-resection-surveillanceguidelines/ Colonscopy will not be commissioned as a first line investigation	**Restricted**
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**

Bariatric Surgery for patients over 18 years of age.	For patients with a BMI of 50 or more, surgery should be considered as a first-line treatment intervention, and can be referred for a bariatric assessment, unless a patient has not tried GLP-1 and wishes to try Tirzepatide (Mounjaro) for 12 months prior to surgery. Patients with a BMI less than 50 should wait to be invited to attend the Primary Care Management Hub. **ALL** patients that have a BMI of less than 50 will need to be assessed by the Primary Care Weight Management Hub prior to being seen for a bariatric surgical assessment. For a bariatric surgical assessment patients **MUST** meet the following criteria: • The patient has a BMI of 40kg/m2 or more, or between 35kg/m2 and 40kg/m2 with significant obesity-related complications likely to improve with weight loss and have 4 out of the 5 co-morbidities stated in NHSE Guidance 2025, where GLP-1 have been ineffective in relation to weight loss • The patient has a BMI of 40kg/m2 or more, or between 35kg/m2 and 40kg/m2 with significant obesity-related complications likely to improve with weight loss and have been assessed by the Primary Care Weight Management Hubs and have been identified as not being suitable to have GLP-1 treatment **ALL** patients being considered for bariatric surgery must also meet the following criteria: • Appropriate non-surgical measures have been tried but the patient has not achieved or maintained adequate, clinically beneficial weight loss over 2 years **AND** • The patient has been receiving or will receive intensive management in a Tier 3 service or equivalent **AND** • The patient is otherwise fit for anaesthesia and surgery **AND** • The patient commits to long-term follow-up **AND**	**Restricted**

	• The patient and clinician have undertaken appropriate share decision-making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention and the patient's GP supports the shared care agreement and is willing to continue regular bariatric care when the patient is 2 years post-op and has been discharged. After surgery, the host bariatric surgery unit should follow up with the patient for 2 years. Thereafter the responsibility for follow-up should be handed over to either the local non-surgical Tier 3 service **OR** the patients GP, who should conduct yearly appointments. Primary Care follow-up should be conducted at least yearly, and these appointments should include weight measurement and a request for nutritional blood tests. See British Obesity & Metabolic Surgery Society (BOMSS) Guidance for more details.	
Endoscopic radiofrequency ablation for gastro oesophageal Reflux Disease (GORD).	Not routinely commissioned	**Excluded**
Linx Reflux Management system for Gastro Oesophageal Reflux Disease (GORD).	Not routinely commissioned	**Excluded**
Cholecystectomy	Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned. Cholecystectomy for Symptomatic Gallstones is commissioned in line with RCS and NICE Guidance.	**Excluded** **Restricted**
Sympathectomy for Raynaud's disease	Not routinely commissioned	**Excluded**
Gastroelectrical stimulation for gastroparesis.	Not routinely commissioned	**Excluded**

Implantation of a duodenal-Jejunal Bypass Liner (DJBL) for managing Type 2 Diabetes.	Not routinely commissioned	**Excluded**
Surgical Treatment of Diverification of Recti (DRAM).	Not routinely commissioned	**Excluded**
Treatment of Salmonella Enteritis (non-severe) - faecal transplant.	Not routinely commissioned	**Excluded**
Early Endoscopic Retrograde Cholangiopancreatography (ERCP) Management of Pancreatitis without cholangitis *Early ERCP in the treatment of acute gallstone pancreatitis with cholangitis	Not routinely commissioned. Will be routinely commissioned under the following circumstances: • Evidence of cholangitis **OR** • Obstructive jaundice with imaging evidence of a stone in the common bile duct **Refers to being performed on the same admission, ideally within 24 hours*	**Excluded** **Restricted**
Endoscopic Drainage of Pancreatic Pseudocyst.	Not routinely commissioned	**Excluded**
Surgical Drainage of Pancreatic Pseudocyst.	Not routinely commissioned	**Excluded**
Treatment of Atherosclerosis of Renal Artery.	Transluminal balloon angioplasty with or without stent is not routinely commissioned	**Excluded**

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**
Appendicetomy without confirmation of appendicitis	Where patients present with atypical or equivocal symptoms, imaging should be sought to reduce the negative appendicectomy rate. While both ultrasound and computed tomography (CT) are effective, ultrasound is preferred as a first-line investigation. This is particularly important in young patients or in female patients when there is a significant incidence of a gynaecological differential diagnosis (where US is superior to CT). CT may be more appropriate in obese patients where ultrasound is more challenging, or for older patients in whom the differential diagnosis may be broad and where CT is usually of more value. The diagnostic accuracy of MRI to diagnose appendicitis is similar to CT. Where specialist MRI is available it can be considered if CT is contraindicated, it is particularly useful for pregnant patients. This guidance applies to adults and children.	**Restricted**

Gynaecology

Any patient with clinical ‘red flags’ should be referred directly to the acute service.
Unless stated as an exemption, all cases for patients aged 18 years and over will be referred from primary care to the Tier 3 Community Gynaecology provider for clinical triage. Following clinical triage patients will be assessed and treated within the local tier 3 community or if there are any patients who have clinical ‘red flags’ then they 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. It is the responsibility of the receiving Provider to seek approval for all restricted procedures that they undertake in-line with their contracts with the ICB. Direct referrals into an acute setting that are not in line with above criteria should be returned to the referrer.

When a direct referral has been made directly to the Trust there is an expectation that all appropriate conservative and non-surgical treatment options have been tried and have failed prior to referral. Referrals should include appropriate imaging.

Procedures	Thresholds	Status
Infertility and Assisted Reproduction	Please see separate Commissioning Policy for Infertility and Assisted Reproduction Assisted Conception - Staffordshire and Stoke-on-Trent, Integrated Care Board Prior Approval to be sought via Blueteq	**Restricted (Prior Approval to be sought)**
Intra Uterine Contraceptive Devices (IUCDs) including Mirena coils.	Insertion, removal and checks of IUCDs should not routinely be undertaken within secondary care. It is not commissioned as a stand-alone secondary care service. Tier 3 Community Gynaecology Providers and/or Primary Care will fit ALL IUCDs unless:- • Patients requiring a fitting within secondary care for clinical reasons where a fitting in Tier 3 Community Gynaecology Provider and/or 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 the Tier 3 Community Gynaecology Provider/Primary Care. • IUCDs fitted as a secondary procedure/OPCS code will be commissioned within secondary care.	**Excluded** **Restricted**
Vaginal Ring Pessaries	Routine insertion, replacement and removal of vaginal pessaries WILL NOT be commissioned in an acute setting. Initial insertion, replacement and removal of vaginal pessaries should be routinely done in a community setting. Ring, shelf and gel horn pessaries can be fitted and replaced in commissioned community services (e.g. community gynaecology service, specialist pelvic health teams). Patients SHOULD NOT be referred to secondary care, specifically for the first fitting of vaginal pessaries. If removal or replacement of vaginal pessaries is required to carry out an investigation / diagnostic test within an acute setting, this is permitted.	**Restricted**

Surgery for Pelvic Organ Prolapse	Staffordshire and Stoke-on-Trent ICB will commission surgery for pelvic organ prolapse following a Tier 3 community gynaecological assessment **AND** where the following criteria are met:- • Symptomatic prolapse **AND** • Documented evidence that supervised physiotherapy including pelvic floor muscle training for a minimum of 3 months has not been successful **AND** • Documented evidence that risk factors have been addressed including weight loss advice, treatment for chronic cough and treatment for constipation **AND** • Documented evidence that a pessary (ring or shelf) has been unsuccessful or is contraindicated **OR** • Symptomatic prolapse that is visible at or below the vaginal introitus **OR** • Documented reports of associated obstructed defecation **OR** • Documented evidence that topical oestrogen therapy has been unsuccessful after 3 months or is contraindicated. The clinician undertaking the intervention is responsible for ensuring that documented evidence is recorded for audit purposes.	**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. **NOTE: vaginal ring pessaries are not commissioned in secondary care as a standalone procedure**	**Restricted**

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** • 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	**Restricted**
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** **(prior approval not required)**
Dilatation and curettage (D&C) in women for menorrhagia.	Not routinely commissioned	**Excluded**

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. **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.	**Restricted**

Haematology

Procedures	Thresholds	Status
Home Monitoring of INR	Not routinely commissioned	**Excluded**

Mental Health

Procedures	Thresholds	Status
Mental Health Assessments	All patients **MUST** be referred into the SSOT ICBs commissioned mental health provider North Staffordshire Combined Healthcare Trust/Midlands Partnership University NHS Foundation Trust (https://www.mpft.nhs.uk/services/adult-mental-health or https://www.combined.nhs.uk/services/https://www.mpft.nhs.uk/services/adult-mental-health). If their needs cannot be met through the commissioned service, then an IFR may be submitted once agreement has been obtained by the referrers Director.	**Restricted**
Out of area Mental Health Assessments	Not routinely commissioned All patients MUST be referred into the SSOT ICBs commissioned mental health provider. North Staffordshire Combined Healthcare Trust/Midlands Partnership University NHS Foundation Trust (https://www.mpft.nhs.uk/services/adult-mental-health or https://www.combined.nhs.uk/services/https://www.mpft.nhs.uk/services/adult-mental-health). If their needs cannot be met through the commissioned service, then an IFR may be submitted once agreement has been obtained by the referrers Director.	**Excluded**

Neurology

Procedures	Thresholds	Status
Trans-magnetic stimulation (TMS) for Migraine.	Not routinely commissioned	**Excluded**

Percutaneous Electro Neuro Stimulation (PENS) for Neuropathic pain.	Not routinely commissioned	**Excluded**
Targeted training to improve trunk (postural) control in children with cerebral palsy.	Not routinely commissioned	**Excluded**
Targeted training to improve trunk (postural) control in severely disabled children (inclusive of all gross motor classifications).	Not routinely commissioned	**Excluded**
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**
Ketogenic diet for the treatment of epilepsy in adults	Not routinely commissioned	**Excluded**
Seizure Detection Sensors/Systems for the management of Epilepsy	Not routinely commissioned	**Excluded**
Sodium Oxybate for treatment of narcolepsy and cataplexy in adults.	Not routinely commissioned	**Excluded**
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**
Sativex for multiple sclerosis (MS)	Not routinely commissioned	**Excluded**
Cranial Molding Orthosis (Helmet Therapy)	Not routinely commissioned	**Excluded**
Venous Angioplasty for the treatment of Multiple Sclerosis	Not routinely commissioned	**Excluded**

Chronic Fatigue Syndrome (CFS) and Myalgic Encephalomyelitis (ME) Residential Treatment Programmes	Not routinely commissioned The assessment and management of chronic fatigue syndrome (CFS) and myalgic encephalomyelitis (ME) at out of area specialist inpatient or outpatient units is not commissioned or funded by the ICB. The assessment and treatment of chronic fatigue syndrome (CFS) and myalgic encephalomyelitis (ME) should usually be managed by primary care, in the community, in line with assessment and treatment recommendations given in NICE guidance (https://www.nice.org.uk/guidance/ng206)	**Excluded**

Obstetrics

Procedures	**Thresholds**	**Status**
Routine Doppler ultrasound of umbilical and uterine artery in low-risk pregnancies.	Not routinely commissioned	**Excluded**

Planned Caesarean Section	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

Planned Caesarean Section	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
	• With orthopaedic anomalies impeding the patient's ability of having a vaginal delivery
	• In patients with HIV who:
	  ○ are not receiving any anti-retroviral therapy or
	  ○ is 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.
		Restricted

Ophthalmology
Any patient with clinical 'red flags' should be referred directly to the acute service.
Unless stated as an exemption, all cases for patients aged 18 years and over will be referred from community and primary care to the ICBs Choice and Referral Centre for clinical triage, where patient choice will be offered.

The assumption is that all cases referred for ophthalmology opinion by the community service will be eligible for surgery in keeping with the criteria set out for various conditions in this policy. It is the responsibility of the receiving Provider to seek approval for all restricted procedures that they undertake in-line with their contracts with the ICB.

When a direct referral has been made directly to the Trust there is an expectation that all appropriate conservative and non-surgical treatment options have been tried and have failed prior to referral. Referrals should include appropriate imaging.

Procedures	Thresholds	Status
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**

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**

Laser Treatment for myopia (short sightedness).	Not routinely commissioned	**Excluded**
Screening for diabetic retinopathy by consultant ophthalmologists.	Not routinely commissioned in secondary care.	**Excluded**
Screening for glaucoma by consultant ophthalmologists.	Not routinely commissioned in secondary care.	**Excluded**

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, viewing computer/mobile screens, 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 it refers to and which eye the cataract removal is being requested for. Other indications for cataract surgery include facilitating treatment for one or 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.	**Restricted**

Implantable Intraocular Lens Systems for Age Related Macular Degeneration.	Not routinely commissioned	**Excluded**

Respiratory

Procedures	Thresholds	Status
Sinus X ray	Not routinely commissioned	**Excluded**
Insertion of Endobronchial Nitinol coils to Improve Lung Function in Emphysema	Not routinely commissioned	**Excluded**
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**
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 respiratory muscle weakness, or voluntary	**Restricted**

Home monitoring to prevent sudden infant death syndrome (SIDS)	Not routinely commissioned	**Excluded**

Specialist Therapies

Procedures	Thresholds	Status
Themed Bimanual Training for Cerebral Palsy.	Not routinely commissioned	**Excluded**
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 18 years and over will be referred from Primary Care to the local tier 3 community service. Any case with clinical 'red flags or paediatrics should be referred directly into 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 a 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 acute setting that are not in line with above criteria should be returned to the referrer.

* These would be listed under each separate intervention and may also include 'red flags'

Procedures	Thresholds	Status
Low Back Pain & Radicular Back Pain Procedures/Treatments		
X-rays and MRI of the lumbar spine for non-specific pain	Do not routinely commission imaging in a non-specialist setting for people with low back pain with or without sciatica in the absence of red flags or suspected serious underlying pathology following medical history and examination. As part of a diagnostic pathway 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. Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to: cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease.	**Monitored via Audit**
Spinal injections, not limited to – Could include: • Intraarticular Facet joint injections • Intradiscal therapy • Prolotherapy • Platelet rich plasma • Stem cell therapy • Trigger point injections with any agent, including botulinum toxin. • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spine stenosis	Not routinely funded for the treatment of non-specific low back pain. Medial branch blocks (spinal injections) can be used diagnostically for patients with isolated lower back pain who have not responded to rehabilitation. Medial branch blocks should not be used therapeutically for patients with isolated lower back pain. (See Medial Branch Block criteria). Radiofrequency denervation should be offered for patients with isolated lower back pain who meet the criteria. (See Radiofrequency denervation criteria).	**Excluded**
Alternative therapy such as acupuncture and Tens	Are not funded within the NHS	**Excluded**

Medial nerve branch blocks as a diagnostic prior to the Radiofrequency denervation (rhizolysis)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • 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 HQ tool	**Restricted**

Radiofrequency denervation (rhizolysis)	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**
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**
Disc replacement	Disc replacement will not routinely be funded for patients with non-specific low back pain.	**Excluded**

Vertebral Augmentation (vertebroplasty or kyphoplasty) for Painful Osteoporotic Vertebral Fractures	Patient with vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures when clinically indicated and they meet the following criteria. Will be funded: Patient has severe (7/10 or greater on VAS scale) ongoing pain after a recent, unhealed vertebral fracture despite optimal pain management. **AND** • The acute vertebral fracture has been proven on imaging and correlates with the site of maximal pain on clinical examination **AND** • Multidisciplinary team discussions have taken place **AND** • The procedure will take place at a facility with access to spinal surgery services **AND** • Processes for audit and clinical governance are in place **AND** • Vertebroplasty must be performed in conjunction with additional measures to improve bone-health NOTE: Older patients (>60 years old) with fractures at most 6 weeks old and with severe pain despite optimal pain management benefit most from the procedure.	**Restricted**

Lumbar Radicular Pain		
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**

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. • 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 at least 6 weeks (conservative management including exercise, medication and education) 1. Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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.	**Restricted**

	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.	
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 **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • 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 need to be persisting despite non-operative treatment for at least 12 weeks (conservative management including exercise, medication and education). • Patient consents for surgical treatment • Patient is aged 19 years and over *(as per Evidence Based Interventions guidance on AOMRC website)* This policy restriction does not apply to patients with red flag symptoms.	**Restricted**

Endoscopic Laser Foraminoplasty	Not routinely commissioned	**Excluded**
Lower Limb Foot & Ankle		

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. Hallux Valgus in patients with diabetes should be treated in line with the diabetes pathway and referred to podiatry for an urgent assessment.	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 the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • 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.	**Restricted**

Autologous Chondrocyte Implantation in the Ankle	Not routinely commissioned	**Excluded**
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 not routinely commissioned by the ICB except if the following criteria are met: - Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • 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	**Restricted**

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: • Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • If the patient is unresponsive to conservative treatment or there is significant persistent pain or loss of function impacting on daily living • 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.	**Restricted**

Stage IV Disease - Pantalar fusion or a triple fusion and ankle replacement.	If the patient is unable to go up onto tiptoe unaided and standing only on the affected foot or if the foot is not correctable when assessed on the couch.	

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 MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. **AND** • Exhausted appropriate non operative interventions as specified in the OA pathway • Appropriate analgesia	**Restricted**
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 MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. **AND** • Be unresponsive to conservative treatment **AND** • Have symptomatic Osteoarthritis	**Restricted**

Arthroscopy & Debridement (ankle)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. **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	**Restricted**
Ankle Replacement – Arthroplasty is the responsibility of NHS England PRN00115-prescribed-specialised-services-manual-v6.pdf (england.nhs.uk)	Commissioned by NHS England	**Excluded**
Extracorporeal Shockwave Therapy (ESWT) for Achilles Tendinopathy https://www.nice.org.uk/guidance/ipg571	Not routinely commissioned	**Excluded**
Extracorporeal Shockwave Therapy for Refractory Plantar Fasciitis https://www.nice.org.uk/guidance/ipg311	Not routinely commissioned	**Excluded**
Functional Electrical Stimulation (FES) for Foot Drop (Please see separate policy for FES)	FES using skin surface electrodes will be commissioned for patients who meet the following criteria.	**Restricted**

	This is exempt from the requirement for Musculoskeletal (MSK) 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. • 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**
Lower Limb – Hip Procedures		
Diagnostic Arthroscopy of Hip	The ICB does not commission diagnostic arthroscopy	**Excluded**
Therapeutic Arthroscopy of the Hip	This is not routinely commissioned, and patients must have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode.	**Restricted**

Primary Total Hip Replacement Arthritic hip with severe acetabular bone loss, abnormal anatomy (such that non-standard implants may be necessary), prior fusion and cases secondary to infection should be undertaken in specialised centres.	The ICB will consider referral for hip replacement if all the criteria below have been met, for each group: - **1.** • Been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode • Has followed the agreed MSK OA hip pathway or has had previous surgery in the 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	**Restricted**

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 the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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, 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.	**Restricted**
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 the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode.	**Restricted**

Lower Limb – Knee Procedures		
Bespoke Knee Prosthetic	Not routinely commissioned	**Excluded**
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**
Hyaluronic Acid Injections into the Knees	Not routinely commissioned	**Excluded**
Implantation of a Shock or Load Absorber for mild to moderate symptomatic Medial Knee Osteoarthritis.	Not routinely commissioned	**Excluded**
Therapeutic Arthroscopy of OA knee	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. **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**

Primary Knee replacement	The ICB will consider referral for knee replacement if all the criteria below have been met: • Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. • 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.	**Restricted**
Partial Knee replacement – This involves the replacement of only one compartment of the arthritic knee Partial knee replacement is less	As well as the criteria for primary knee replacement patients should have: - • Symptomatic Osteoarthritis predominantly confined to a single joint compartment	**Restricted**

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)		
Knee Revision Surgery	Commissioners do not routinely fund Modular Rotating Hinge knees	**Excluded**
Upper Limb – Hand Procedures		
Carpal Tunnel Syndrome (CTS)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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 **AND** • Severe symptoms significantly interfering with daily activities and sleep which have been assessed	**Restricted**
Dupuytren's Disease – palmar fasciectomy	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. Referred into secondary care **must** have been through the Musculoskeletal (MSK) Service. Where MSK is not available (East Staffordshire PCN), all appropriate conservative management must have been undertaken including any relevant community diagnostics.	**Restricted**

	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	

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** • Significant nail deformity	**Restricted**

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**

Upper Limb – Shoulder Procedures		
Allograft reconstruction for glenoid bone loss in glenohumeral instability	Not routinely commissioned	**Excluded**

Arthroscopic Capsular Release (ARC) for Adhesive Capsulitis (Frozen Shoulder)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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. • Patients must have significant persistent pain preventing them from fulfilling vital activities of daily living. • Disturbance of sleep **AND** Have failed respond to a steroid injection in conjunction with physiotherapy	**Restricted**
Hydrodilatation for Adhesive Capsulitis (frozen shoulder)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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**

Ultrasound and/or MRI for soft tissue shoulder (if rotator cuff injury is suspected)	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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	**Restricted**

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**

Therapeutic Shoulder Arthroscopy	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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 • 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**	**Restricted**

	• `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.	
Therapeutic Arthroscopy for Minor (type I*) SLAP tear repair	The ICB does not routinely fund this procedure	**Excluded**
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 the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. 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 absence of muscle patterning deemed suitable for surgical intervention.	**Restricted**

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	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pain Management Service and exhausted all appropriate non-surgical options within current episode. **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**
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 shoulder surgery with rotator cuff pathology.	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pin Management Service and exhausted all appropriate non-surgical options within current episode 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)	**Restricted**

Reverse shoulder surgery with rotator cuff pathology	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pin Management Service and exhausted all appropriate non-surgical options within current episode**.** • 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.**	**Restricted**

Subcromial Decompression for shoulder pain	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pin Management Service and exhausted all appropriate non-surgical options within current episode 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	**Restricted**
Rotator Cuff Disorders	Patients **must** have been triaged or seen in the Musculoskeletal MSK Service or Chronic Pin Management Service and exhausted all appropriate non-surgical options within current episode **AND** have received: - • 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. 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	**Restricted**

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	Inclusion criteria: • 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 MSK Service or Chronic Pin Management Service and exhausted all appropriate non-surgical options within current episode **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	**Restricted**
Upper Limb – Other Procedures		
Lycra splinting for the prevention and correction of upper limb contractures for patients with neurological dysfunction.	All patients must undergo an assessment with the commissioned Orthotics Provider and demonstrate, with clinical evidence from this Provider, that their orthotic needs cannot be met before any prior approval request. Prior approval requests will not be accepted by the ICB if this assessment has not been undertaken or where clinical evidence has not been provided. Prior approval requests **MUST** be made to (IFRTeam@staffsstoke.icb.nhs.uk). Should approval be granted the ICB shall require clinical reports which include evidence of outcomes achieved from	**Manual Prior Approval only**

	the orthoses and patient concordance. The ICB shall not approve prior approval requests on the basis of a historical or previously agreed prior approvals.	
Orthotics (defined as a device used to compensate for impairments of the structure and function of the human body. Not limited to and sometimes referred to as splints, braces, collars, calipers, trusses, specialist footwear and insoles).	All patients must undergo an assessment with the commissioned Orthotics Provider and demonstrate, with clinical evidence from this Provider, that their orthotic needs cannot be met before any prior approval request. Prior approval requests will not be accepted by the ICB if this assessment has not been undertaken or where clinical evidence has not been provided. Prior approval requests **MUST** be made to (IFRTeam@staffsstoke.icb.nhs.uk). Should approval be granted the ICB shall require clinical reports which include evidence of outcomes achieved from the orthoses and patient concordance. The ICB shall not approve prior approval requests on the basis of a historical or previously agreed prior approvals.	**Manual Prior Approval only**
Orthotic Treatment for Pectus Excavatum	Not routinely commissioned	**Excluded**
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**
Intramedullary Nail in Lower Limb Length Discrepancy	Not routinely commissioned	**Excluded**
Orthopaedics – Other		
Phonophoresis Prolotherapy Cryotherapy Viscosupplementation	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	**Excluded** **Excluded** **Excluded** **Excluded**

Surgical treatment of synovitis and tenosynovitis	Not routinely commissioned.	**Excluded**
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**
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, fracture, ankylosing spondylitis and other inflammatory conditions, radicular pain resulting from nerve root compression or cauda equine syndrome.	**Excluded**
Therapeutic ultrasound in Physiotherapy	Not routinely commissioned	**Excluded**
Low Intensity Ultrasound (Exogen) for the Healing of Fractures	See separate commissioning policy	**Restricted**

Urology

Procedures	Thresholds	Status
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 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	**Restricted**
Reversal of Sterilisation: reversal of vasectomy or reversal of tubal ligation (Male and Female)	Not routinely commissioned	**Excluded**
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**

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 Incontinence Surgery where previous surgery has failed. NHS commissioning » Search Results » incontinence	**Restricted**

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	**N/A**
Sacral Nerve Stimulation for Constipation	Not routinely commissioned	**Excluded**
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**
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**
Penile Implants	Not routinely commissioned by ICBs – NHSE Responsibility https://www.england.nhs.uk/publication/penile-prosthesis-surgery/	**Excluded**
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**

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**
Surgical Removal of Kidney Stones	Renal stones that are 5-10mm and not suitable for watchful waiting, shockwave lithotripsy is to be offered as first-line treatment (unless contra-indicated or not targetable) OR Renal stones are 10-20mm shockwave lithotripsy (SWL) can be considered as first-line treatment (if treatment can be given in a timely fashion) Renal stones are 10-20mm and SWL is contraindicated or ineffective, then ureteroscopy can be considered Renal stones are over 20mm (including staghorn), percutaneous nephrolithotomy (PCNL) can be offered as first-line treatment Patient must be aged 19 years and over.	**Restricted**
Prostate-specific antigen (PSA) test	The guidance applies to male born with a prostate and trans, non-binary and intersex people with a prostate, aged 19 years and over. Note: PSA testing for prostate cancer should be avoided if man has: - An active or recent urinary infection (PSA may remain raised for many months). - Had a prostate biopsy in the previous 6 weeks. Both of which are likely to raise PSA and give a false positive result. PSA testing for prostate cancer is not recommended in asymptomatic men (unless they are at high risk of prostate cancer i.e. Black and/or family history). This is because the benefits have not been shown to clearly outweigh the harms. In particular, there is concern about the high risk of false positive results. Where PSA test results are mildly raised above the age specific range for an individual patient, it may be appropriate to repeat the test within two to three months to monitor the trend. Criteria: - The man is asymptomatic and over age 40 and at higher risk of prostate cancer (e.g. they are	**Restricted**

	Black and/or have a family history of prostate cancer) OR - Symptomatic men with lower urinary tract symptoms (LUTS), such as nocturia, urinary frequency, hesitancy, urgency or retention, visible haematuria - Erectile dysfunction - Symptoms that could be due to advanced prostate cancer (for example lower back pain, bone pain, weight loss). AND - A careful discussion about the potential risks and benefits of PSA testing has been held, allowing for shared decision	
Cystoscopy for Men with Uncomplicated Lower Urinary Tract Symptoms	Cystoscopy should be offered to men with (lower urinary tract symptoms) LUTS only when clinically indicated, for example in the following features from their history: Patient has LUTS and suffers from recurrent urinary tract infections AND Patient has LUTS and has sterile pyuria AND Patient has LUTS and haematuria AND Patient has LUTS and profound symptoms OR Additional contextual information may also inform clinical decision-making around the use of cystoscopy in men with LUTS. Such factors might include, but not be limited to: Patient has LUTS and risk factors but not limited to smoking history, travel or occupational history suggesting a high risk of malignancy or previous surgery.	**Restricted**

Vascular Surgery

Procedure	Thresholds	Status
Interventions for theTreatment of Telangiectasia varicose veins (known as thread or spider veins) and asymptomatic varicose veins	Not routinely commissioned.	**Excluded**
Interventions for the Treatment of symptomatic varicose veins	Varicose Vein Interventions (Symptomatic) - treatment for symptomatic varicose veins is routinely commissioned when the patient has a confirmed varicose veins and truncal reflux diagnoses (as per NICE CG168) and the patient meets one or more of the following criteria:- - Symptomatic (veins found in association with troublesome lower limb symptoms, typically pain, aching, discomfort, swelling, heaviness and itching) **OR** - Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence **OR** - Lower-limb skin changes thought to be caused by chronic venous insufficiency such as pigmentation or eczema **OR** - A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks) **OR** - A healed venous ulcer **OR** - Bleeding varicose veins requiring treatment Surgical treatment will only be funded if the following procedures have been offered prior to surgery if appropriate - Endothermal ablation. - Ultrasound-guided foam sclerotherapy. • - If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery.	**Restricted**

Carotid endarterectomy	Not routinely commissioned for asymptomatic or mild to moderate carotid stenosis.	**Restricted**
Geko device for reducing the risk of venous thromboembolism	Not routinely commissioned	**Excluded**