

PART 1: LIST OF INTERVENTIONS NOT NORMALLY UNDERTAKEN BY THE CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Children and Women

Elective Caesarean Section

Sterilisation- Reversal of (male and female)

Heavy Menstrual Bleeding- Dilation and curettage/Hysteroscopy

Heavy Menstrual Bleeding- Hysterectomy

Assisted Conception Techniques

Labioplasty

Laparoscopic Uterine Nerve Ablation (LUNA) for Chronic Pelvic Pain

Clinical Diagnostics and Therapeutics

Open MRI Scans

Complementary Therapies

Mirror Therapies

Dental

Dental Implants

Apicectomy

Orthodontic treatments of essentially cosmetic nature

Wisdom teeth- removal of symptomatic

Surgery- Ophthalmology

Corneal implants for the correction of refractive error in the absence of other ocular pathology

Scleral expansion surgery for presbyopia

Laser treatment for short sight

Photodynamic Therapy for late Age-related Macular Degeneration

Xanthelasma Palpebrum

Blepharoplasty- eyelid

Chalazia

Surgery – Cardiac/Vascular

Percutaneous laser revascularisation for refractory angina pectoris

Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris

Surgery- Orthopaedics

Therapeutic use of ultrasound in hip and knee osteoarthritis

Ganglia – Surgical Removal (Wrist)

Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage

Electrical & electromagnetic field treatments bone non- union

Abrasion arthroplasty

Low Back Pain (Non- specific) – Plain X- rays of lumbar spine & MRI scans

Low Back Pain (Non- specific) - Management

[Spinal Injections for Spinal Surgery](#)

[Spinal Injections for Pain Medicine](#)

[Hallux valgus \(bunion\): Surgical correction](#)

[Hip Resurfacing Techniques apart from in-line with published NICE guidance](#)

[Endoscopic Lumbar Decompression and Laser Disc Decompression](#)

[Laser Lumbar Micro- Discectomy](#)

[Hip Arthroscopy & Debridement](#)

[Hip Prostheses](#)

[Arthroscopic knee washout with or without debridement for the treatment of osteoarthritis](#)

[Dupuytren's disease](#)

[Plantar Fasciitis- surgical treatment](#)

Surgery – ENT

[Tonsillectomy – children & adults](#)

[Soft-palate implants for obstructive sleep apnoea](#)

[Nasal surgery for snoring](#)

[Pinnaplasty/Otoplasty- Correction of prominent ears](#)

[Cochlear Implants](#)

[Rhinoplasty](#)

Surgery to remodel the external ear (excludes Pinnaplasty)

Grommets - Drainage of middle ear in otitis media with effusion (OME)

Surgery- General

Varicose Veins

Laparoscopic Uterine Nerve Ablation for Chronic Pelvic Pain

Capsule Endoscopy/ Pillcam

Cholecystectomy

Haemorrhoidectomy

Subthalamic nucleotomy for Parkinson's disease

Treatment for Erectile Dysfunction (ED)

Benign skin lesions- Anal Skin Tags, Lipomata, other skin lesions

Removal of viral warts (non-genital)

Inguinal Hernia

Circumcision

Transaxial interbody lumbosacral fusion

Bariatric Surgery

Rhinophyma – Surgery or Laser Treatment

Breast Enlargement- Female

Breast Lift

Breast Prosthesis Removal or Replacement

Breast Reduction- Female

Breast- Revision of augmentation/mammoplasty

Male breast reduction for Gynaecomastia

Intrathecal Baclofen Therapy

Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

Medicine

pH/Manometry Impedance Studies

Fibromyalgia in adults: In patient pain management/ specialised fibromyalgia programmes

Melatonin for delayed sleep phase disorder

Acne vulgaris

Hyperbaric Oxygen Therapy (HBOT) for all indications

Sleep Apnoea

Botulinum Toxin

Mental Health

Electroconvulsive Therapy (ECT)

Process to add interventions to the INNU policy intervention list outside of policy review schedule.

Clinical Board	Office of Population Censuses & Surveys (OPCS) code	Intervention	Criteria for Use without an Individual Patient Funding Request	Links to Further Information or Clinical Evidence Base
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<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>R17.1 R17.2 R17.8 R17.9 R18.1 R18.2 R18.9</p>	<p>Elective Caesarean Section (CS)</p>	<p>Can be undertaken when patients meet one or more of the following:</p> <ul style="list-style-type: none"> • HIV (only if recommended by a HIV consultant) • Both HIV and Hepatitis C (as above, there is no evidence that CS should be performed for Hepatitis C alone) • Primary genital herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta previa • Previous upper segment caesarean section / type unknown • Previous significant uterine perforation/surgery breaching cavity • A term singleton breech (if external cephalic version is contraindicated, failed or declined) • A twin pregnancy regardless of chorionicity with breech or smaller first twin • A monochorionic twin pregnancy after appropriate discussion about the risks of acute TTTS • A previous caesarean section if VBAC (Vaginal Birth after Caesarean) has been declined or is felt to be inappropriate • A previous traumatic vaginal delivery if VBAC has been fully explored but declined • A fetus at high risk of fetal distress in labour e.g. known severe placental insufficiency • A woman with tocophobia who has requested caesarean section, providing that her concerns have been fully explored and documented AND support and counselling has been made available AND the patient has attended the Birth Choices Clinic (she should have been offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her fears in a supportive manner. If, after providing such support, a vaginal birth is still not an acceptable option, an elective c-section can be supported). • Patient request Where vaginal birth is still not an acceptable option after discussion of the benefits and risks with a senior midwife or obstetrician and offer of support, then a planned Caesarean section should be offered." <p>An IPFR is required for all other circumstances.</p>	<p>NICE Clinical Guideline 192 Caesarean Section (2021) https://www.nice.org.uk/guidance/ng192</p>
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<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>Q37.- Q29.- N18.1</p>	<p>Sterilisation – Reversal of (male and female</p>	<p>Should NOT be used EXCEPT in the following circumstances:</p> <ul style="list-style-type: none"> · If death of an existing child has occurred · Remarriage following death of spouse · Loss of unborn child when vasectomy has taken place during the pregnancy <p>An IPFR is required for all other circumstances.</p> <p>The evidence suggests that reversal of sterilisation for both females and males appear to be effective methods of restoring fertility. Those seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians and Gynaecologists guidelines that the procedure is intended to be permanent.</p>	<p>Royal College of obstetricians and Gynaecologists. FRSH Clinical Guidance Male and female sterilisation. September 2014: https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/</p>
<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>Q10.3 Q10.8 Q10.9</p>	<p>Heavy Menstrual Bleeding - Dilation and curettage (D&C)/ Hysteroscopy</p>	<p>D&C should NOT be used as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so will not receive prior approval for these conditions. The risk of anaesthesia, uterine perforation and cervical laceration outweighs the minimum potential benefit.</p> <p>Hysteroscopy can be used when it is carried out:</p> <ul style="list-style-type: none"> • As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive • When undertaking endometrial ablation <p>An IPFR is required for all other circumstances.</p>	<p>NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88</p>

<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>Q07.1>6 Q07.8>9 Q08.1>3 Q08.8>9</p>	<p>Heavy Menstrual Bleeding - Hysterectomy</p>	<p>Can be undertaken when a patient meets one or more of the following criteria:</p> <ul style="list-style-type: none"> · other treatment options have failed, are contraindicated or are declined by the woman · there is a wish for amenorrhoea · the woman (who has been fully informed) requests it · the woman no longer wishes to retain her uterus and fertility. <p>There is evidence that the woman fits the clinical criteria of heavy menstrual bleeding (HMB). This is defined as excessive menstrual blood loss which interferes with the woman’s physical, emotional, social, and material quality of life, and which can occur alone or in combination with other symptoms. Women offered hysterectomy should have a full discussion of the implications of surgery and the increased risk of serious complications. Any interventions should aim to improve quality of life measures.</p> <p>For hysterectomy a patient must have documented evidence of heavy bleeding due to fibroids greater than 3cm and the following must apply:</p> <ul style="list-style-type: none"> · Other symptoms (e.g. pressure) are present · There is evidence of severe impact on quality of life · Other pharmaceutical options have failed · Patient has been offered myomectomy and/or uterine ablation (unless medically contra-indicated) <p>For HMB alone hysterectomy should not be the first line of treatment.</p> <p>In line with NICE hysterectomy guidelines for HMB, surgery should only be undertaken when there is documented evidence that there has been an unsuccessful use of a levonorgestrel intrauterine system (e.g. Mirena) unless medically contraindicated and at least two of the following treatments have failed, are not appropriate or are contra-indicated:</p> <ul style="list-style-type: none"> · Non –steroidal anti-inflammatory agents · Tranexamic acid · Injected progesterone’s · Combined oral contraceptives 	<p>NICE Guideline 88 Heavy menstrual bleeding: Assessment and management: https://www.nice.org.uk/guidance/ng88</p>
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A hysterectomy patient with HMB should meet all of the following criteria:

- There is evidence that all other treatment options have failed, are contraindicated or have been offered and declined by the woman
- There is a wish for amenorrhoea
- The woman has been fully informed of all options and requests it
- The woman no longer wishes to retain her uterus and fertility

In women with HMB alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation should be considered preferable to hysterectomy.

An IPFR is required for all other circumstances.

<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>N34.2 N34.4>6 Q13.1>9 Y96</p>	<p>Assisted Conception Techniques - IVF, ICSI, Donor Insemination, MESA, TESE, PESA. Egg sperm & gonadal tissue cryostorage, Other micro-manipulation techniques, Egg donation where no other treatment is available, IVF surrogacy</p>	<p>Can only be undertaken in line with JCC guidance.</p> <p>An IPFR is required for all other circumstances.</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/specialist-fertility-services-commissioning-policy-cp38-feb-2020/</p>
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<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>P21.3</p>	<p>Labiaplasty</p>	<p>Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely funded.</p> <p>Requests for Labiaplasty will be considered for the following indicators:</p> <ul style="list-style-type: none"> • Where the labia are directly contributing to recurrent disease or infections (should have two consultant gynaecologists concurring with this view); • Where repair of the labia is required after trauma • Where the labia show marked hypertrophy more than 2 SD above the mean (i.e >7 cm in length whether unilateral or bilateral) <p>An IPFR is required for all other circumstances.</p>	<p>Should be undertaken in line with JCCBody Contouring Policy</p> <p>This policy does not apply to genital reconstruction for gender reassignment. See Specialised Services policy: CP21 Specialised Adult General Identity Services</p> <p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/body-contouring-commissioning-policy-cp44-july-2013/</p>
<p>Children and Women</p> <p>Obstetrics and Gynaecology</p>	<p>A60.8 Y75.2 Z11.8</p>	<p>Laparoscopic Uterine Nerve Ablation (LUNA) for Chronic Pelvic Pain</p>	<p>Based on NICE evidence: the evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should NOT be used.</p> <p>There are no agreed criteria for use without an IPFR.</p>	<p>Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain Interventional procedures guidance</p>

<p>Clinical Diagnostics and Therapeutics</p> <p>Radiology</p>	<p>U01.2 U05.2 U05.5 U07.2 U08.5 U09.3 U13.3 U37.1</p>	<p>Open MRI Scans</p>	<p>Conventional MRI scanning is provided locally by Cardiff and Vale UHB. It is expected that all patients requiring an MRI scan would use this service. Open MRI scanning will usually only be used when patients meet one of the criteria:</p> <p>Category 1 – Claustrophobia</p> <p>In the first instance, the Radiology department can meet with a patient that has concerns regarding claustrophobia and MRI scanning - a member of staff can describe the process to the patient and show them the scanner. If these fears cannot be alleviated by the Radiology Department, there is an option to attempt the MRI scan under sedation. If suitable, the patient will be referred to their General Practitioner for a prescription of an oral sedative which can be used during the scan. In most cases this is sufficient to enable an MRI scan to be performed.</p> <p>The patient must have had a failed attempt at conventional (closed) MRI with oral sedation, where appropriate, prior to acceptance for Open MRI.</p> <p>If the conventional option is not suitable (after review) and the referring clinician still feels that an Open MRI scan is needed, then the patient could be considered for an Open MRI scan.</p> <p>Category 2 - Patient Size</p> <p>The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patients, the body part being imaged and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI. In the first instance, the patient should be invited to attend the radiology department and be formally assessed by an MRI radiographer for suitability. The patient can be talked through the procedure, and shown the scanner. The Radiographer will examine the evidence presented, and make a judgement on whether to proceed with the MRI scan.</p> <p>If the closed MRI is not suitable (after review) and the referring clinician still feels that an MRI scan is needed, then the patient could be considered for an Open MRI. It should be noted that MRI may not be the imaging</p>	
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<p>Clinical Diagnostics and Therapeutics</p>	<p>70.6 X61.1>4 X61.8>9</p>	<p>Complementary Therapies</p>	<p>Complementary medicine/ alternative therapies are generally NOT used by the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. On existing available evidence, the UHB will not support referral outside of the NHS for these services. Prior approval is required on a case-by-case basis for any requests outside the above criteria. The request for referral would need to be supported by evidence of the clinical effectiveness of the treatment and be to appropriately trained and qualified practitioners with recognised qualifications.</p> <p>The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of NHS Library.</p> <p>An IPFR is required for all other circumstances.</p>	<p>The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of NHS Library.</p>
<p>Clinical Diagnostics and Therapeutics</p> <p>ALAS</p>	<p>X21.2</p>	<p>Mirror Therapies</p>	<p>There are no agreed criteria for use without an IPFR.</p>	<p>http://www.publichealthwalesobservatory.wales.nhs.uk/evidence-summary-mirror-therapy-innu-</p>

<p>Dental</p>	<p>F11.5 F11.6</p>	<p>Dental Implants</p>	<p>Can be used for patients who need post cancer reconstruction, hypodontia, major trauma with bone loss, or on the advice of NHS specialists as outlined in the Dental Hospital Referral Criteria for Restorative Dentistry:</p> <p>Dental hospital referral guidelines.PDF .</p> <p>Request for exemption required in all other cases.</p>	<p>Royal College of Surgeons Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS (2012): https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines-20121009_final.pdf?la=en Updated 2019 guidance https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/implant-guidelines.pdf</p> <p>The evidence suggests that dental implants have been shown to be a successful treatment. However, dental implant treatment should only be provided by appropriately trained dentists in accordance with General Dental guidance</p>
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<p>Dental</p>	<p>F12 F12.2</p>	<p>Apicectomy</p>	<p>Can be used for:</p> <ul style="list-style-type: none"> • Presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or where conventional re-treatment may be detrimental to the retention of the tooth • Presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • Where biopsy of periradicular tissue is needed • Where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected • Where procedures are required that need either tooth sectioning or root amputation • Where it may not be expedient to undertake prolonged non-surgical root canal re-treatment because of patient considerations. <p>An IPFR is required for all other circumstances</p>	<p>Royal College of Surgeons of England. Guidelines for surgical endodontics 2012: https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/surgical_endodontics_2012.pdf?la=en</p> <p>The evidence suggests that the success rate of apical surgery on molar teeth is low.</p>
<p>Dental</p>	<p>F14.1>3 F14.8>9 F15.1>4 F15.9 F16.1>9</p>	<p>Orthodontic treatments of essentially cosmetic nature</p>	<p>Can be undertaken for patients who meet one or more of the following:</p> <ul style="list-style-type: none"> • have a high Index of Orthodontic Treatment Need Scores - 5, 4 and 3 where a significant aesthetic component can be demonstrated • have other major conditions e.g. cancers, craniofacial deformity. <p>Should NOT be used for cases categorised as 1, 2 or 3 using the Index of Orthodontic Treatment Need (IOTN) EXCEPT for those cases in group 3 where the aesthetic component (AC) has been classified as 6 or higher.</p> <p>An IPFR is required for all other cases</p>	<p>Evidence based on expert opinion suggests that orthodontic treatment should be directed at those individuals in which the greatest benefit can be achieved</p> <p>Richmond S, Shaw WC, Stephens CD et al. Orthodontics in the general dental services of England and Wales: Critical assessment of standards. Br Dent J 1993; 174: 315</p>

<p>Dental</p>	<p>F09.1 F09.3</p>	<p>Wisdom teeth - removal of symptomatic</p>	<p>Should not been done except where there is evidence of pathology or removal is required due to other surgery or trauma.</p> <p>NICE guidance states that impacted wisdom teeth that are free from disease should not be operated on. The practice of prophylactic removal of pathology-free impacted third molars should be discontinued on the NHS.</p> <p>An IPFR is required for all other circumstances.</p>	<p>NICE Technology Appraisal 1 Guidance on the extraction of wisdom teeth: http://guidance.nice.org.uk/TA1</p> <p>Impacted wisdom teeth free from disease should not be operated on.</p>
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<p>Surgery</p> <p>Ophthalmology</p>	<p>C46.4</p>	<p>Corneal implants for the correction of refractive error in the absence of other ocular pathology e.g.keratoconus.</p>	<p>Can be undertaken in line with NICE guidance: "Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error which can be procedure for patients with refractive error which can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery. Therefore, corneal implants should not be used for the treatment of refractive error in the absence of other ocular pathology such as keratoconus".</p> <p>An IPFR is required for all other circumstances.</p>	<p>NICE Interventional Procedures Guidance 225 Corneal implants for the correction of refractive error: http://guidance.nice.org.uk/IPG225/guidance/pdf/English</p> <p>NICE Do not do recommendation</p> <p>Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error that can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery.</p>
<p>Surgery</p> <p>Ophthalmology</p>	<p>C55.4</p>	<p>Scleral expansion surgery for presbyopia</p>	<p>NICE Do not do recommendation: Current evidence on the safety and efficacy of scleral expansion surgery for presbyopia very limited. There is no evidence of efficacy in the majority of patients. There are also concerns about potential risks of the procedure.</p> <p>There are no agreed criteria for use without an IPFR.</p>	<p>NICE Interventional Procedures Guidance 70 Scleral expansion surgery for presbyopia: http://guidance.nice.org.uk/IPG70</p> <p>NICE Do not do recommendation</p> <p>Current evidence on the safety and efficacy of scleral expansion surgery for presbyopia is very limited. There is no evidence of efficacy in the majority of patients. There are also concerns about potential risks of the procedure.</p>

<p>Surgery</p> <p>Ophthalmology</p>	<p>C44.4 C44.5 C44.2 C46.1</p>	<p>Laser therapy for short sight</p>	<p>Should NOT be used EXCEPT if the patient has a biometry error following cataract surgery.</p> <p>Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and contact lenses.</p> <p>An IPFR is required for all other circumstances.</p>	<p>NICE Interventional Procedures Guidance 164 Photorefractive (laser) surgery for the correction of refractive errors: https://www.nice.org.uk/guidance/ipg164</p> <p>Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and contact lenses.</p>
<p>Surgery</p> <p>Ophthalmology</p>	<p>C88.2</p>	<p>Photodynamic Therapy (PDT) for late Age-related Macular Degeneration (AMD) (wet active)</p>	<p>Should NOT be used EXCEPT for individuals who have a confirmed diagnosis of classic with no occult subfoveal choroidal neovascularisation (CNV) (that is, whose lesions are composed of classic CNV with no evidence of an occult component) and best-corrected visual acuity 6/60 or better.</p> <p>NICE Do not do recommendations: Do not offer photodynamic therapy alone for late AMD (wet active). Do not offer photodynamic therapy as an adjunct to anti-VEGF as first line treatment for late AMD (wet active).</p> <p>[NB: PDT is NOT recommended for the treatment of people with predominantly classic subfoveal CNV (that is, 50% or more of the entire area of the lesion is classic CNV but some occult CNV is present) associated with wet age-related macular degeneration, except as part of research]</p>	<p>NICE Guideline 82 Age-related macular degeneration: https://www.nice.org.uk/guidance/ng82/resources/agerelated-macular-degeneration-pdf-1837691334853</p> <p>NICE Do not do recommendations: Do not offer photodynamic therapy alone for late AMD (wet active). Do not offer photodynamic therapy as an adjunct to anti- VEGF as first-line treatment for late AMD (wet active).</p>

Surgery Ophthalmology Plastic Surgery	C13	Xanthelasma Palpebrum (Fatty deposits on the eyelids)	Can only be undertaken in line with the JCC Policy on Plastic Surgery. An IPFR is required for all other circumstances.	https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/treatment-of-benign-skin-conditions-commissioning-policy-cp42-july-2013/
Surgery Ophthalmology	C13	Blepharoplasty- Eyelid	Can only be undertaken in line with the JCC Policy on Facial Surgery. An IPFR is required for all other circumstances.	https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/facial-surgery-procedures-commissioning-policy-cp43-july-2013/
Surgery Ophthalmology	No Code	Chalazia (Lesions on eyelids)	Can only be undertaken in line with the NICE CKS Meibomian cyst (chalazion) An IPFR is required for all other circumstances.	https://cks.nice.org.uk/topics/meibomian-cyst-chalazion/

<p>Surgery</p> <p>Cardiac/vascular</p>	<p>K23.4 + Y08.5</p>	<p>Percutaneous laser revascularisation for refractory angina pectoris</p>	<p>No routine exemption criteria. Request for exemption required in all cases.</p>	<p>NICE Interventional Procedures Guidance 302 Percutaneous laser revascularisation for refractory angina pectoris : http://www.nice.org.uk/nicemedia/pdf/IPG302Guidance.pdf</p> <p>NICE Do not do recommendation</p> <p>Current evidence on percutaneous laser revascularisation (PLR) for refractory angina pectoris shows no efficacy and suggests that the procedure may pose unacceptable safety risks.</p>
<p>Surgery</p> <p>Cardiac</p>	<p>K23.4 + Y08.5</p>	<p>Transmyocardial laser revascularisation (TMLR) for refractory angina pectoris</p>	<p>No routine exemption criteria. Request for exemption required in all cases.</p>	<p>NICE Interventional Procedures Guidance 301 Transmyocardial laser revascularisation for refractory angina pectoris: http://www.nice.org.uk/nicemedia/pdf/IPG301FullGuidance.pdf</p> <p>NICE Do not do recommendation</p> <p>Current evidence on TMLR for refractory angina pectoris shows no efficacy, based on objective measurements of myocardial function and survival. Current evidence on safety suggests that the procedure may pose unacceptable risks.</p>

Surgery Orthopaedics	W85.2 ICD-10 -M17.9	Arthroscopic knee washout with or without debridement for the treatment of osteoarthritis	Current evidence suggests that arthroscopic knee washout alone should not be used as a treatment for osteoarthritis because it cannot demonstrate clinically useful benefit in the short or long term. Request for exemption required in all cases.	Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis (nice.org.uk)
Surgery Orthopaedics	W83.4	Abrasion arthroplasty	No routine exemption criteria. Request for exemption required in all cases.	
Surgery Orthopaedics	T59.1>4 T59.8>9 T60.1>.4 T60.8>9	Ganglia – Surgical Removal (wrist)	Can only be undertaken in line with the Health Board’s Ganglion Cyst Referral Guidelines. The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children. An IPFR is required for all other circumstances	The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children
Surgery Orthopaedics	W58.1	Hip Resurfacing Techniques apart from in-line with published NICE guidance	Can be used in line with NICE guidance. As of 29 th September 2025 NICE guidance states: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. IPFR is required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304

<p>Surgery</p> <p>Orthopaedics</p> <p>Clinical Diagnostic and Therapeutics</p> <p>Radiology</p>	<p>U21.1 Z66.5</p>	<p>Low Back Pain (Non- specific) – Plain X- rays of lumbar spine & MRI scans</p>	<p>MRI scans can be used in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected: Spinal malignancy Infection Fracture Cauda Equina Syndrome Ankylosing Spondylitis or another Inflammatory Disorder.</p> <p>Request for exemption required in all other cases.</p>	<p>NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59</p>
<p>Surgery</p> <p>Orthopaedics / anaesthetics</p> <p>Clinical Diagnostic and Therapeutics</p> <p>Therapies</p>	<p>M45.59 (ICD10 code)</p>	<p>Low Back Pain (Non- specific) - Management</p>	<p>Do not offer the following for the management of low back pain with or without sciatica: Belts or corsets Foot orthotics Rocker sole shoes Traction Acupuncture Ultrasound Percutaneous electrical nerve stimulation (PENS) Transcutaneous electrical nerve stimulation(TENS) Interferential therapy</p> <p>The following referrals should NOT be offered for the early management of persistent non-specific low back pain: Radiofrequency facet joint denervation Percutaneous electrothermal treatment of the intervertebral disc annulus Percutaneous intradiscal radiofrequency treatment (PIRFT)</p>	<p>NICE Guideline 59 Low back pain and sciatica in over 16s: assessment and management: https://www.nice.org.uk/guidance/NG59</p> <p>NICE IPG 544 Percutaneous electrothermal treatment of the intervertebral disc annulus for low back pain and sciatica https://www.nice.org.uk/guidance/ipg544</p> <p>NICE IPG 545 Percutaneous intradiscal radiofrequency treatment of the intervertebral disc nucleus for low back pain https://www.nice.org.uk/guidance/ipg545</p>

<p>Surgery</p> <p>Orthopaedics</p> <p>Specialist Services</p> <p>Neurosurgery</p>	<p>A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4</p>	<p>Spinal Injections for Spinal Surgery</p>	<p>Before the use of spinal injections is considered, all patients must have been treated using conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control.</p> <p>Spinal injections serve both a therapeutic and diagnostic role. The specific indications for which each of the three types of spinal injection may routinely be used are:</p> <p>Lumbar and sacral epidural injections (A52.1, A52.2, A52.8) should only be used for therapeutic reasons where the diagnosis of spinal stenosis has been made and for post spinal stabilisation radicular pain where a nerve block might be difficult due to anatomical reasons.</p> <p>Facet joint and sacro-iliac injections (V54.4) should be used for diagnostic purposes only. This may need to be repeated to ascertain consistency.</p> <p>Spinal Nerve root blocks (A577) may be used for radicular pain.</p> <p>Injections should not be used more than twice in the same individual for the same episode of pain. If pain persists beyond this and no significant surgical target has been identified, the patient may require referral to the Pain Team to be assessed for management of chronic pain.</p> <p>Request for exemption required for the use of spinal injections in all other circumstances.</p>	
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<p>Surgery</p> <p>Anaesthetics: Pain Medicine</p>	<p>A52.1 A52.2 A52.8 A52.9 A54.9 A57.7 V54.4</p>	<p>Spinal Injections for Pain Medicine</p>	<p>Before the use of spinal injections is considered, all patients must have been treated using appropriate conservative management techniques, as described in the UHB back pain pathway, and failed to achieve sufficient pain control.</p> <p>The specific indications for which each of the three types of spinal injection may routinely be used are:</p> <p>Lumbar and sacral epidural injections (A52.1. A52.2, A52.8) may be used for the following therapeutic reasons:</p> <p>Where the diagnosis of spinal stenosis has been made.</p> <p>For post spinal stabilisation radicular pain, where a nerve block might be difficult due to anatomical reasons.</p> <p>In patients with leg pain, either before or after back surgery, presenting with stenotic or radicular leg pain.</p> <p>Facet joint and sacro-iliac injections (V54.4, W90.3) may be used for diagnostic and therapeutic purposes in patients suffering from chronic low back pain for greater than one year, as detailed below.</p> <p>Diagnostic facet joint injections may be used in order to identify patients that benefit from therapeutic Radiofrequency ablation of nerve to the facet joint in specific facet joint related back pain identified as such.</p> <p>Therapeutic facet and sacroiliac injections may be used in patients with specific facet or sacroiliac related back pain and/or referred leg pain</p> <p>Spinal Nerve root blocks (A57.7) may be used for radicular pain. Repeat spinal nerve root block may be required if pain persists and no significant surgical target has been identified.</p> <p>Repeated therapeutic injections may be required in patients unable to tolerate oral medications, the independent older adults intolerant of analgesics, patients with drug dependence issues, patients trying to avoid medication related side effects for example to not negatively impact their economic status, or to care for a family or continue study, and patients with concomitant worsening mental illness due to chronic pain uncontrolled despite optimal medical management.</p> <p>Spinal injections should not be used more than twice in the same individual for the same episode of pain. Such repeated injections should only be carried out if the patient reports ongoing pain relief (measured at first follow up) of greater than 50%, with improved physical functioning as demonstrated utilising suitable standardised outcome</p>	<p>In the pain clinic, spinal injections serve both a therapeutic and diagnostic role. All spinal injections will be performed following a thorough bio psychosocial assessment and discussion with a consultant in pain medicine. They will always be performed as a part of a comprehensive pain management plan with the intention of improving patients' physical functioning and enabling participation in rehabilitative physiotherapy and/ or psychotherapy as appropriate within individualised pain management plans. The goal of spinal injections will be facilitation of pain management via reduction of the intensity of physical symptoms in order to promote patient engagement with self-management strategies in the long term.</p>
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			measures, 3 months or more post procedure. Request for exemption is required for the use of spinal injections in all other circumstances.	
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<p>Surgery</p> <p>Orthopaedics</p>	<p>W79.1>2</p>	<p>Hallux valgus (bunion): Surgical correction</p>	<p>The HB will fund specialist advice and surgical treatment if the following surgical criteria are met:</p> <ul style="list-style-type: none"> · Osteoarthritis affecting the 1st Metatarsophalangeal joint · Impending or actual skin compromise · Severe deformity causing pain in adjacent toes · Inability to wear steel toe capped boots preventing ability to work <p>Guidance in NICE IPG332 Surgical correction of hallux valgus using minimal access techniques (2010) reports that current evidence on the efficacy of surgical correction of hallux valgus using minimal access techniques is limited and inconsistent.</p> <p>An IPFR is required for all other circumstances. Any other referral should explicitly state reasons (e.g. Hallux rigidus, or specialised shoes).</p>	
<p>Surgery</p> <p>Orthopaedics</p>	<p>W71.4 W85.3</p>	<p>Autologous Chondrocyte implantation for knee/ ankle problems caused by damaged articular cartilage</p>	<p>Not provided in CAVUHB</p> <p>Can be used in line with NICE guidance.</p> <p>As of 29th September 2025 NICE guidance states: Autologous chondrocyte implantation (ACI) is recommended as an option for treating symptomatic articular cartilage defects of the knee, only if:</p> <ul style="list-style-type: none"> • the person has not had previous surgery to repair articular cartilage defects • there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis) • the defect is over 2 cm² <p>and</p> <ul style="list-style-type: none"> • the procedure is done at a tertiary referral centre. <p>Request for exemption required in all other cases.</p>	<p>NICE Technology Appraisal 477: Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee: https://www.nice.org.uk/guidance/ta477</p>

Surgery Orthopaedics	U13.2/ Y53.2 + Z84.3	Therapeutic use of ultrasound in hip and knee osteoarthritis	No routine exemption criteria. Request for exemption required in all cases.	
Surgery Orthopaedics	V33.8 V55 V56 V58.3 Y53.4 Y59.3 Y76.3 Y08.3	Endoscopic Lumbar Decompression and Laser Disc Decompression	Can be used in line with NICE guidance. IPFR is required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570
Surgery Orthopaedics	V33.8 V55 Y76.3 Y08.3	Laser Lumbar Micro-Discectomy	Can be used in line with NICE guidance. IPFR is required in all other cases.	NICE Interventional Procedures Guidance 570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica: https://www.nice.org.uk/guidance/ipg570
Surgery Orthopaedics	W33.2 W33.6	Hip Arthroscopy & Debridement	Can be used in line with NICE guidance. IPFR is required in all other cases.	NICE Interventional Procedures Guidance 408 Arthroscopic femoro–acetabular surgery for hip impingement syndrome: https://www.nice.org.uk/guidance/ipg408
Surgery Orthopaedics	W37.- W38.- W39.- W93.- W94.- W95.-	Hip Prostheses	Can be used in line with NICE guidance. As of 29 th September 2025 NICE guidance states: Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years. IPFR is required in all other cases.	NICE Technology Appraisal 304 Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip: https://www.nice.org.uk/guidance/ta304

Surgery Orthopaedics	M72.0	Dupuytren's disease	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances	Dupuytren's disease Health topics A to Z CKS NICE Overview Radiation therapy for early Dupuytren's disease Guidance NICE
Surgery Orthopaedics	M72.2	Plantar Fasciitis- Surgical treatment	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.	Plantar fasciitis Health topics A to Z CKS NICE

Surgery ENT	No code	Nasal surgery for snoring	No routine exemption criteria. Request for exemption required in all cases.	Included on National Do Not Do list
Surgery ENT	D15.1	Grommets - Drainage of middle ear in otitis media with effusion (OME)	<p>Can be used where there has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist or GP with special interest in ENT AND the child is placed on a waiting list for the procedure at the end of this period; AND otitis media with effusion persists after three months AND the child (who must be over three years of age) suffers from at least one of the following:</p> <ul style="list-style-type: none"> • At least 3-5 recurrences of acute otitis media in a year • Evidence of delay in speech development • Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss) • A significant second disability such as Down's syndrome. <p>Request for exemption required in all other cases.</p>	<p>NICE Clinical Guideline 60 Otitis media with effusion in under 12s surgery: http://www.nice.org.uk/nicemedi a/pdf/CG60fullguideline.pdf</p>

<p>Surgery</p> <p>ENT</p>	<p>D03.3</p>	<p>Pinnaplasty/Otoplasty- Correction of prominent ears</p>	<p>Can only be undertaken in line with the JCC Policy on Facial Surgery.</p> <p>Eligibility criteria:</p> <ul style="list-style-type: none"> • Patient age over 7 years and under 19 years old at the point of referral; <p>AND</p> <ul style="list-style-type: none"> • Prominence of the ear(s) is of a severity that it presents as disfigurement; <p>AND</p> <ul style="list-style-type: none"> • There is evidence of severe bullying and harassment arising from the appearance of their ears that prevents the child from undertaking daily living activities (e.g. the child is unable to effectively engage in education); <p>AND</p> <ul style="list-style-type: none"> • It is the opinion of the patient's GP or previous mental health assessment that this is likely to be remedied through correction of the ear deformity. <p>An IPFR is required for all other circumstances.</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/facial-surgery-procedures-commissioning-policy-cp43-march-2025/</p>
<p>Surgery</p> <p>ENT</p>	<p>D06.2</p>	<p>Surgery to remodel the external ear (excludes Pinnaplasty)</p>	<p>Can only be undertaken in line with the JCC Policy on Facial Surgery.</p> <p>Do Not Do Intervention.</p> <p>An IPFR is required for all other circumstances.</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/facial-surgery-procedures-commissioning-policy-cp43-march-2025/</p>

Surgery ENT	F34	Tonsillectomy – children & adults	<p>Can be used if patients meet ALL of the following criteria prior to referral:</p> <ul style="list-style-type: none"> • Sore throat is due to tonsillitis • Five or more episodes of sore throat per year • Symptoms for at least one year • Episodes of sore throat are disabling and prevent normal function <p>Request for exemption required in all other cases.</p>	<p>A six-month period of watchful waiting is recommended prior to tonsillectomy to establish firmly the patterns of symptoms and allow the patient to consider fully the implications of the operation.</p> <p>Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximise the period of benefit before natural resolution of symptoms might occur.</p>
Surgery ENT	F32.8	Soft-palate implants for obstructive sleep apnoea	<p>No routine exemption criteria.</p> <p>As of 29th September 2025 NICE Guidance states: Current evidence on soft-palate implants for obstructive sleep apnoea raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist. Therefore, soft-palate implants should not be used in the treatment of this condition.</p> <p>Request for exemption required in all cases.</p>	<p>NICE Interventional Procedures Guidance 241 Soft-palate implants for obstructive sleep apnoea: http://www.nice.org.uk/nicemedia/pdf/IPG241Guidance.pdf</p> <p>NICE Do Not Do recommendation</p>
Surgery ENT	D13 D16 D24 D241 D242 D243 D246	Cochlear Implants	<p>Can only be undertaken in line with the JCC Policy on Cochlear Implants.</p> <p>An IPFR is required for all other circumstances.</p>	<p>JCC Policy CP35 (2020): Cochlear Implant for children and adults with severe to profound deafness</p> <p>https://whssc.nhs.wales/commissioning/whssc-policies/auditory-implants/cp35-cochlear-implant-for-children-and-adults-with-severe-to-profound-deafness</p>
Surgery ENT	E02.3 E02.4 E02.5 E02.6	Rhinoplasty	<p>Can only be undertaken in line with the JCC Policy on Facial Surgery.</p> <p>An IPFR is required for all other circumstances.</p>	

<p>Surgery</p> <p>Vascular</p>	<p>L86.1 L86.2 L87.7 L88.2 L88.3 V53.2 Z39.5 Z98.5 Z98.6</p>	<p>Varicose Veins – asymptomatic & mild/moderate cases</p>	<p>Evidence from recent population surveys indicates very little relationship between symptoms and varicose veins – substantial numbers of patients without varicose veins have similar symptoms. Mild symptoms can be managed by compression and skin care. When bleeding or ulceration occurs referral may be appropriate and of these some may benefit from surgical intervention.</p> <p>Can be undertaken in the following circumstances:</p> <ul style="list-style-type: none"> • Symptomatic with pain, aching, discomfort, swelling, heaviness or itching. • Ulcers/history of ulcers secondary to superficial venous disease • Lipodermatosclerosis • Varicose eczema • History of phlebitis. • Bleeding directly from varicose veins <p>An IPFR is required for all other circumstances</p> <p>** Will only be offered for veins classified as C4, C5, C6 that is where there are skin changes, ulceration or bleeding (May 2025)</p>	<p>NICE Guidance CG168 Varicose veins: diagnosis and management (nice.org.uk)</p> <p>In some people varicose veins are asymptomatic or cause only mild symptoms, but in others they cause pain, aching or itching and can have a significant effect on their quality of life. This policy relates to asymptomatic and mild/ moderate cases.</p> <p>Most varicose veins require no treatment. The most common complaint about varicose veins is their appearance. When bleeding or ulceration occurs referral may be appropriate and of that number some may benefit from surgical intervention.</p>
<p>Surgery</p> <p>Gynaecology</p>	<p>A60.8 Y75.2 Z11.8</p>	<p>Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain</p>	<p>No routine exemption criteria.</p> <p>As of 29th September 2025 the NICE guidance states: The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that it is not efficacious and therefore should not be used.</p> <p>Request for exemption required in all cases.</p>	<p>NICE Interventional Procedures Guidance 234 Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain: http://guidance.nice.org.uk/IPG2_34</p>

<p>Surgery Gastroenterology</p>	<p>G80.2</p>	<p>Capsule Endoscopy/ Pillcam</p>	<p>Other investigations should be considered prior to wireless capsule endoscopy particularly in patients with Crohn's disease in whom strictures are suspected.</p> <p>Capsule endoscopy should NOT be used EXCEPT for disease of the small bowel for</p> <ul style="list-style-type: none"> • Crohn's Disease (or suspected Crohn's Disease) in whom strictures are not suspected Other investigations should be considered prior to wireless capsule endoscopy particularly in patients with Crohn's disease in whom strictures are suspected. <p>Capsule endoscopy should NOT be used EXCEPT for disease of the small bowel for</p> <ul style="list-style-type: none"> • Crohn's Disease (or suspected Crohn's Disease) in whom strictures are not suspected • hereditary GI polyposis syndromes. <p>An IPFR is required for all other circumstances.</p>	<p>NICE Interventional Procedures Guidance 101: Wireless capsule endoscopy for investigation of the small bowel: http://guidance.nice.org.uk/IPG1_01</p>
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<p>Surgery Gastroenterology</p>	<p>J18.1 J18.2 J18.3 J18.4 J18.5 J18.8 J18.9</p>	<p>Cholecystectomy</p>	<p>Gallstone disease occurs when hard fatty or mineral deposits (gallstones) form in the gallbladder. Approximately 15% of the adult population are thought to have gallstone disease, and most of these people experience no symptoms.</p> <p>Asymptomatic gallstones can be defined as stones that are found incidentally, as a result of imaging investigations unrelated to gallstone disease in people who have been completely symptom free for at least 12 months before diagnosis. These patients should not be referred to secondary care except in specific circumstances (see below)</p> <p>Patients should only be referred into hospital for a cholecystectomy assessment if they meet one of these criteria:</p> <ul style="list-style-type: none"> • Symptomatic gallstones with a thickened gallbladder wall • A dilated common bile duct on ultrasound • Asymptomatic gallstones with abnormal liver function test (LFT) results • Asymptomatic gall bladder polyp(s) reported on ultrasound • Symptomatic gall bladder ‘sludge’ reported on ultrasound <p>Cholecystectomy should only be undertaken if patients meet one of the following criteria:</p> <ul style="list-style-type: none"> • Recurrent biliary colic at least 2 attacks in past 12 months • Cholecystitis requiring hospital or outpatient antibiotic treatment • Acute pancreatitis 	<p>There is insufficient evidence of clinical effectiveness of cholecystectomy (for asymptomatic gallstones). Gallstone disease: diagnosis and management (nice.org.uk)</p>
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			<ul style="list-style-type: none">• Common Bile Duct stones with or without obstruction• Gallbladder polyps larger than 8mm or growing rapidly <p>AND</p> <ul style="list-style-type: none">• The patient is fit for surgery• In high BMI patients the risk of surgery should be weighed up against the potential risk of future gallstone complications e.g. development of pancreatitis, recurrent cholecystitis and the possibility of delaying intervention until weight is optimized. <p>Patients presenting acutely with gallstone complications should have their operation done on the index admission through SDEC lists or CEPOD. If no capacity then they should be added to the urgent Laparoscopic cholecystectomy list for early appointment in Day Surgery. All other patients should be listed in Day Surgery as default.</p>	
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<p>Surgery Gastroenterology</p>	<p>H51.1 H51.3</p>	<p>Haemorrhoidectomy</p>	<p>Haemorrhoids, also known as piles, are enlarged and swollen blood vessels in and round the lower rectum and anus. Symptoms range from temporary and mild, to persistent and painful. In many cases, haemorrhoids are small, and symptoms settle down without treatment. In many patients haemorrhoids come and go intermittently. Conservative management including high fibre diet, exercise, weight loss and topical preparations, is often sufficient to ease symptoms and should be exhausted before referral to secondary care is considered. Initial treatment is secondary care will usually be undertaken in outpatients in the form of haemorrhoid banding. Where symptoms persist despite banding more invasive surgical options may be considered.</p> <p>Referral to secondary care can be made based on the following criteria: Conservative management has failed, using such measures as:</p> <ul style="list-style-type: none"> • Altering the patient’s diet with emphasis on increased fluids and fibre intake to ensure soft, easily passed stools with no straining • Adequate pain relief • Soothing and astringent treatments <p>AND</p> <ul style="list-style-type: none"> • The patient’s symptoms have been documented to have been present for at least three months. <p>The majority of haemorrhoids referred to secondary care will be managed through non-operative interventions mainly haemorrhoid banding in clinic. Surgical excisional haemorrhoidectomy should only be undertaken if the following criteria are met:</p> <ul style="list-style-type: none"> • Persistent symptoms of bleeding form grade 1 (rare) or 2 haemorrhoids that have not improved with non-operative measures (at least 2 x 	<p>https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/rectal-bleeding--commissioning-guide.pdf</p> <p>The evidence suggests that first and second degree haemorrhoids are classically treated with some form of non- surgical ablative/ fixative intervention, third degree treated with rubber band ligation or haemorrhoidectomy, and fourth degree with haemorrhoidectomy.</p>
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			<p>banding procedures, NB. Repeat banding has been shown to be as effective as THD)</p> <ul style="list-style-type: none">• Severe (grade 3 or grade 4), which combine internal/external haemorrhoids with persistent pain or bleeding	
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<p>Surgery Neurosurgery</p>	<p>A10.8 Y11.4</p>	<p>Subthalamic nucleotomy for Parkinson's disease</p>	<p>Can be used in line with NICE guidance. As of 29th September 2025 the NICE guidance states: Current evidence on the safety and efficacy of subthalamotomy for Parkinson's disease does not appear adequate to support the use of this procedure without special arrangements for consent and for audit or research. Request for exemption required in all other cases.</p>	<p>NICE Interventional Procedures Guidance 65 Subthalamotomy for Parkinson's disease: https://www.nice.org.uk/guidance/ipg65</p>
<p>Surgery Urology</p>	<p>N29.1</p>	<p>Treatment for Erectile Dysfunction (ED)</p>	<p>Can be used in accordance with the agreed service specification of:</p> <ul style="list-style-type: none"> a. Assessment by specialist ED providers for patients with ED referred by GPs. b. Treatment (drug or mechanical device) for ED in line with WHC (1999) 06 i.e. for patients suffering from ED who fall into the eligible groups for NHS prescriptions from GPs. c. Treatment (drug or mechanical device) by specialist ED providers for patients categorised as suffering with ED and severe distress who do not fall into 1(b). <p>Request for exemption required in all other cases.</p>	<p>Cardiff and Vale Formulary and Erectile Dysfunction Care Pathway http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ico</p>

<p>Surgery</p>	<p>S04 S05 S06 S09 S10 S11 H48.2</p>	<p>Anal Skin Tags</p>	<p>Anal skin tags are common and usually harmless growths that hang off the skin around the outside of the anus. They may be mistaken for warts or piles (haemorrhoids). Anal skin tags are not a risk to health and are typically painless or only cause minor symptoms such as itchiness. Anal skin tags can usually be managed conservatively with reassurance and advice regarding anal hygiene and should not be referred to secondary care. Any ulceration or atypical appearance to a skin tag should prompt an USC referral to Colorectal surgery.</p> <p>Where patients are experiencing significant symptoms despite conservative management they may be referred to secondary care for consideration of surgical removal. Surgical removal can cause bleeding, pain and infection. Only the following situations will be considered for surgical removal:</p> <ol style="list-style-type: none"> 1. The skin tag is impacting on faecal continence resulting in regular stool seepage. 2. OR The skin tag is causing obstruction of an orifice to the extent that function is significantly impaired. 3. OR The skin tag is causing continuous pressure symptoms in the course of daily activities such that pain is now restricting normal daily life. 4. OR Unavoidable trauma in the course of normal daily activities causes the skin tag to frequently bleed. 5. OR There is documented evidence of significant recurrent infection. 	
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<p>Surgery General Surgery</p>	<p>T20 T21</p>	<p>Inguinal Hernia</p>	<p>An inguinal hernia (IH) is a protrusion in the peritoneum, usually consisting of intestine or intraabdominal fat. The protrusion occurs as a result of weakness within the lower abdominal/groin area wall of muscle. IH presents as a lump, which can be asymptomatic for around one third of patients. Some patients can experience discomfort, which can restrict daily activities including the ability to work. IH can occasionally be life threatening if the protruding bowel becomes obstructed and strangulated. Around 98% of all IH occur in men because of the vulnerability of the male anatomy to the formation of hernias within this region.</p> <p>Watchful waiting is the most appropriate form of management for asymptomatic/minimally symptomatic IH as this type of hernia is not considered as being a serious threat to health and surgery can cause on occasions significant complications such as haematoma and chronic pain from nerve entrapment. Patients should be reassured and managed without referral to secondary care.</p> <p>Surgery for inguinal hernia will be considered in the following situations:</p> <ul style="list-style-type: none"> • All femoral hernias (symptomatic femoral hernias should be referred as urgent) • All inguinal hernias in women • Symptomatic inguinal hernia in men affecting daily activities, work or quality of life. • Non-reducible or inguino-scrotal hernias (patients with significant pain, obstructive symptoms or suspicion of stangulation should be referred to the emergency surgical service) • Hernias rapidly increasing in size over a period of months <p>AND</p>	
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			<ul style="list-style-type: none">• The patient is fit for surgery <p>In high BMI patients the risk of surgery should be weighed up against the potential risk of future complications. Where intervention can be delayed for weight optimisation patients should normally not be listed for surgery until BMI<35 achieved.</p> <p>Note patients with groin pain and no palpable hernia (Sportsman's Groin) will <u>not</u> be considered for surgery. Patients with small hernias diagnosed on ultrasound/CT/MRI and no clinically overt hernia will <u>not</u> be considered for surgery.</p>	
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<p>Surgery General Surgery Dermatology</p>	<p>ICD10-17</p>	<p>Skin Lesions - Lipomata</p>	<p>Removal of lipoma is considered cosmetic surgery and will only be considered for treatment by the NHS in the following circumstances:</p> <ul style="list-style-type: none"> • The lipoma (-ta) is / are symptomatic; OR • There is functional impairment; OR • The lump is rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular). <p>Patients with multiple subcutaneous lipomata may require biopsy to exclude neurofibromatosis.</p>	
<p>Surgery General Surgery</p>	<p>S04 S05 S06 S09 S10 S11</p>	<p>Skin Lesions -Viral Warts</p>	<p><u>Rationale</u> Most viral warts will clear spontaneously or following application of topical treatments.</p> <p><u>Eligibility criteria</u> Surgical treatment will only be funded in the following circumstances:</p> <ul style="list-style-type: none"> • Viral warts are painful and persistent; OR • Extensive warts (particularly in the immuno-suppressed patient) <p>Patients with the above symptoms may need specialist assessment, by a dermatologist. For a small proportion surgical removal (cryotherapy, cautery, laser or excision) may be appropriate.</p>	

<p>Surgery General Surgery Dermatology</p>	<p>S04 S05 S06 S09 S10 S11 H48.2</p>	<p>Other skin lesions</p>	<p>The removal/treatment of the following benign skin lesions are not routinely commissioned: CP 42 Version: 1.0 Specialised Services Policy: Treatment of Benign Skin Conditions Page 11 of 23</p> <ul style="list-style-type: none"> • Sebaceous cyst (pillar and epidermoid); • Skin tags; • Milia; • Molluscum contagiosum; • Seborrhoeic keratoses (basal cell papillomata); • Spider naevus (telangiectasia); • Dermatofibromas; or • Benign pigmented moles (naevi). <p>Exceptions where prior approval is NOT required: Prior approval is not required when the following criteria are met. The expectation is that the majority of these procedures are undertaken in primary care; practice or locality services:</p> <ul style="list-style-type: none"> • Actinic Keratoses; OR • Sebaceous cysts subject to recurrent infection and which are greater than 0.5 cm in diameter; OR • Lesions which are subject to repeated trauma, bleeding or cause functional impairment due to size or locations. 	
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<p>Surgery</p> <p>Urology Children and Womens</p>	<p>N30.3</p>	<p>Circumcision</p>	<p>Should NOT be used EXCEPT in the following cases:</p> <ul style="list-style-type: none"> · Phimosis · Paraphimosis · Balanitis and Balanoposthitis · Penile Cancer affecting the foreskin <p>Circumcision carried out for medical reasons should be rare and should only be carried out for urgent medical conditions.</p> <p>Female circumcision or female genital mutilation is prohibited by the law (The Prohibition of Female Circumcision Act 1995) and will therefore not be funded.</p> <p>Male circumcision for religious or cultural reasons should only be carried out and paid for on a private basis</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/circumcision-for-children-commissioning-policy-cp34-march-2019/</p>
<p>Surgery</p> <p>Neurosurgery</p>	<p>V38.6</p>	<p>Transaxial interbody lumbar fusion</p>	<p>Can only be undertaken in line with NICE guidance.</p> <p>An IPFR is required for all other circumstances.</p>	<p>Transaxial interbody lumbar fusion for severe chronic low back pain (nice.org.uk)</p>

<p>Surgery</p> <p>General Surgery JCC (formerly WHSSC)</p>	<p>G282 G283 G288 G289 G301 G302 G303 G304 G308 G309 G321 G328 G329 G611 G612 G613 G618 G619</p>	<p>Bariatric Surgery</p>	<p>Can only be undertaken in line with JCC Policy on Bariatric Surgery.</p> <p>To be considered for bariatric surgery the following criteria will need to be met: The person is:</p> <ul style="list-style-type: none"> • aged 18 years or over and • has a BMI of 40 kg/m² or more and other interventions have not been effective or • has a BMI range between 35 kg/m² and 40 kg/m² and other significant disease (for example, type 2 diabetes, or high blood pressure) that could be improved if they lost weight or • is an individual with newly diagnosed diabetes (30 kg/m² to < 35kg/m² and as long as they have or will receive assessment in a Level 3 service and • all appropriate non-surgical measures have been tried but clinically beneficial weight loss has not been achieved or adequately maintained. <p>In addition to the above criteria, the person being considered for bariatric surgery should:</p> <ul style="list-style-type: none"> • have been receiving and complied with a local specialist weight management programme (Level 3 or Level 4 in some urgent or complex cases) described as: <ul style="list-style-type: none"> • for a minimum period of 6 months if deemed appropriate by the MDT. For patients with BMI > 50kg/m² attending a specialist obesity service, this period should include the stabilisation and assessment period prior to obesity surgery. Patients with new onset type 2 diabetes may have their surgical assessment concurrently with the Level 3 specialist multi-disciplinary weight management service • be generally fit for anaesthesia and surgery • be able to commit to long-term follow-up post-surgery. A formalised MDT led processes for the screening of co-morbidities 	<p>Bariatric Surgery (2014 due for update 2021)</p> <p>https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/bariatric-surgery-commissioning-policy-cp28a-pdf/</p>
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			<p>and the detection of other significant diseases should be in place</p> <p>An IPFR is required for all other circumstances.</p>	
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<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>S04 S05 S06 S09 S10 S11</p>	<p>Rhinophyma – Surgery or Laser Treatment</p>	<p>Can only be undertaken in line with the JCC Policy on Plastic Surgery.</p> <p>An IPFR is required for all other circumstances.</p> <p>Do Not Do intervention</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/treatment-of-benign-skin-conditions-commissioning-policy-cp42-july-2013/</p>
<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B301 B302</p>	<p>Breast Enlargement - Female (Augmentation Mammoplasty)</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures.</p> <p>An IPFR is required for all other circumstances</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/breast-surgery-procedures-commissioning-policy-cp69-march-2013/</p>
<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B313</p>	<p>Breast Lift - Female (Mastopexy)</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures.</p> <p>An IPFR is required for all other circumstances</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/breast-surgery-procedures-commissioning-policy-cp69-march-2013/</p>

<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B301 B302 B304 B308 B309 B312 B314 B375</p>	<p>Breast Prosthesis Removal or Replacement</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures. Replacement of implants will be considered, for clinical reasons, if the original implants were funded by the NHS.</p> <p>Removal of implants will be considered, but not replacement, if at least ONE of the following criteria are met:</p> <ul style="list-style-type: none"> • Rupture of silicone- filled gel; • Implants complicated by recurrent infection; • Extrusion of implant through skin; • Implants with Baker Class IV contracture associated with severe pain; • Implants with severe contracture which interferes with mammography. <p>Baker classification: Class I - Augmented breast feels soft as a normal breast. Class II - Augmented breast is less soft and implant can be palpated but is not visible. Class III - Augmented breast is firm, palpable and the implant (or distortion) is visible. Class IV - Augmented breast is hard, painful, cold, tender, and distorted.</p> <p>Separate guidance for PIP breast implants (2012) An IPFR is required for all other circumstances</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/breast-surgery-procedures-commissioning-policy-cp69-march-2013/</p>
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<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B311</p>	<p>Breast Reduction - Female (Reduction Mammoplasty)</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures.</p> <p>Surgical intervention will be considered for patients experiencing enduring significant clinical symptoms which include: At least TWO of the following for at least one year with documented evidence of GP visits in relation to these problems:</p> <ul style="list-style-type: none"> • Significant chronic pain in the neck • Significant chronic pain in the upper back Significant chronic pain in the shoulders • Painful kyphosis documented by x ray • Skin problems including pain, discomfort, and ulceration. Chronic intertrigo, eczema or dermatitis alone will not be considered as grounds for this procedure unless the patient has failed to respond to 6 months of conservative treatment. • Significant chronic pain symptoms persist as documented by the referring clinician despite a 6-month trial of therapeutic measures including ALL of the following (supporting evidence to be submitted with application): <ul style="list-style-type: none"> • Supportive devices e.g. bra of the correct size with wide straps and fitted by a trained bra fitter; • Analgesic/ NSAID interventions A completed programme of physical therapy/exercises/posturing manoeuvres supervised by an appropriately trained therapist. AND Estimated reduction greater than 550 grams per breast on each side (American Medical Association guidelines, 2008) AND BMI 2 standard cup sizes*) to the extent that it is not possible to get a bra which fits * Standard cup. <p>An IPFR is required for all other circumstances.</p>	
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<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B302 B314</p>	<p>Breast- Revision of augmentation/ mammoplasty</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures.</p> <p>An IPFR is required for all other circumstances</p>	
<p>Surgery</p> <p>Plastic Surgery JCC (formerly WHSSC)</p>	<p>B311 B275</p>	<p>Male Breast Reduction for Gynaecomastia</p>	<p>Can only be undertaken in line with the JCC Policy on Breast Surgery Procedures.</p> <p>An IPFR is required for all other circumstances</p>	<p>https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/breast-surgery-procedures-commissioning-policy-cp69-march-2013/</p>
<p>Surgery</p> <p>Neuroscience</p>	<p>A48.3 A48.7</p>	<p>Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin</p>	<p>CAVUHB is centrally commissioned to deliver this service for Wales.</p> <p>Can be undertaken in line with NICE guidance.</p> <p>An IPFR is required for all other circumstances</p>	<p>Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin (nice.org.uk)</p>
<p>Surgery</p> <p>Neuroscience</p>	<p>A54.2</p>	<p>Intrathecal Baclofen Therapy</p>	<p>CAVUHB is centrally commissioned to deliver this service for Wales.</p> <p>Evidence suggests that in carefully selected patients with severe spasticity and disability IBT may improve patient quality of life.</p> <p>There are no agreed criteria for use without an IPFR</p>	<p>Spasticity in under 19s: management https://www.nice.org.uk/guidance/cg145</p>

<p>Medicine</p>	<p>X52.1</p>	<p>Hyperbaric Oxygen Therapy (HBOT) for all indications</p>	<p>JCC will only commission emergency HBOT. JCC will be notified by the hyperbaric chamber of emergency admission retrospectively and will not require prior approval.</p> <p>HBOT should not be used for:</p> <ul style="list-style-type: none"> · Mild / Moderate Carbon Monoxide Poisoning responding to Normobaric Oxygen treatment · Osteoradionecrosis · Non-healing diabetic wounds/ulcers <p>An IPFR is required for all other circumstances</p>	<p>CP07 Hyperbaric Oxygen Therapy (June 2021)</p> <p>https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/hyperbaric-oxygen-therapy-policy-commissioning-policy-cp07-june-2021/</p>
<p>Medicine</p> <p>Respiratory</p>	<p>A84.7 U33.1</p>	<p>Sleep Apnoea</p>	<p>Can be undertaken in line with NICE guidance.</p> <p>An IPFR is required for all other circumstances</p>	<p>Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome https://www.nice.org.uk/guidance/ta139/chapter/1-Guidance</p> <p>Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s https://www.nice.org.uk/guidance/ng202/chapter/1-Obstructive-sleep-apnoeahypopnoea-syndrome#treatments-for-mild-osahs</p>

<p>Medicine Respiratory</p> <p>Children & Women CAMHS</p>	<p>No code</p>	<p>Melatonin for delayed sleep phase disorder</p>	<p>No routine exemption criteria for use in adults. Request for exemption required in all adult cases.</p> <p>Use in children and adolescents should be specialist initiated and in line with Shared Care Protocol CV54</p> <p>Please refer to Cardiff and Vale formulary http://cardiffandvaleuhb.inform.wales.nhs.uk/favicon.ic o</p>	<p>Shared care protocol CV54: Melatonin for children and adolescents (up to and including 18 years) with significant sleep onset difficulties https://www.wmic.wales.nhs.uk/cv54-melatonin/</p>
<p>Medicine Rheumatology</p>	<p>M79.09 (ICD10 code)</p>	<p>Fibromyalgia in adults: In patient pain management/specialised fibromyalgia programmes</p>	<p>There is no cure for fibromyalgia syndrome and treatment is aimed at alleviation of symptoms. There are no agreed criteria for referral to inpatient pain management or specialised fibromyalgia programmes without an Individual Patient Funding Request (IPFR).</p>	
<p>Medicine Gastroenterology</p>	<p>G21.1 G47.1</p>	<p>pH/Manometry Impedance Studies</p>	<p>NICE [IPG187] (2006) states that: Current evidence on the safety and efficacy of catheter less oesophageal pH monitoring appears adequate to support the use of this technique provided that normal arrangements are in place for consent, audit and clinical governance.</p> <p>There are no agreed criteria for use without an IPFR</p>	<p>Catheter less oesophageal pH monitoring https://www.nice.org.uk/guidance/ipg187</p>

<p>Medicine</p> <p>Dermatology/ General Medicine/ Gynaecology/ Neurology/ Ophthalmology /Orthopaedics/ Urology/Plastic Surgery</p>	<p>X85.1</p>	<p>Botulinum Toxin</p>	<p>Botulinum Toxin should Not be used EXCEPT for the treatment of pathological conditions by appropriate specialists in cases of:</p> <ul style="list-style-type: none"> · Frey’s syndrome · Blepharospasm · Cerebral Palsy · Spasticity in adults following neurological illness or injury · Hyperhidrosis whose condition is appropriately managed for medication overuse · Treatment of overactive bladder in women <p>Botulinum Toxin type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine):</p> <ul style="list-style-type: none"> • that has not responded to at least three prior pharmacological prophylaxis therapies and whose condition is appropriately managed for medication overuse. • whose condition is appropriately managed for medication overuse. <p>Botulinum Toxin is not available for the treatment of facial ageing or excessive wrinkles.</p> <p>For treatment of overactive bladder in women, bladder wall injection should only be used in the treatment of idiopathic detrusor over activity only in women who have not responded to conservative treatments (including antimuscarinic drugs e.g. oxybutynin) and who are willing and able to self-catheterize. NICE notes that there is a gap in treatment between conservative treatment and surgery and Botulinum Toxin has been adopted to fill this position, however, this is in advance of high-quality data on efficacy, safety and long-term outcomes.</p> <p>An IPFR is required for all other circumstances.</p>	<p>Urinary incontinence and pelvic organ prolapse in women: management. https://www.nice.org.uk/guidance/ng123</p> <p>Botulinum toxin type A for the prevention of headaches in adults with chronic migraine https://www.nice.org.uk/guidance/ta260</p>
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Medicine Dermatology	S04.1>3 ; 8 S05.1>5 ; 8>9 S06.1>5 ; 8>9 S09.1>5 ; 8>9 S10.1>5 ; 8>9 S11.1>5 ; 9	Acne Vulgaris	Can only be undertaken in line with JCC policy on Treatment of benign skin lesions. An IPFR is required for all other circumstances	https://whssc.nhs.wales/commissioning/whssc-policies/plastic-surgery/treatment-of-benign-skin-conditions-commissioning-policy-cp42-july-2013/
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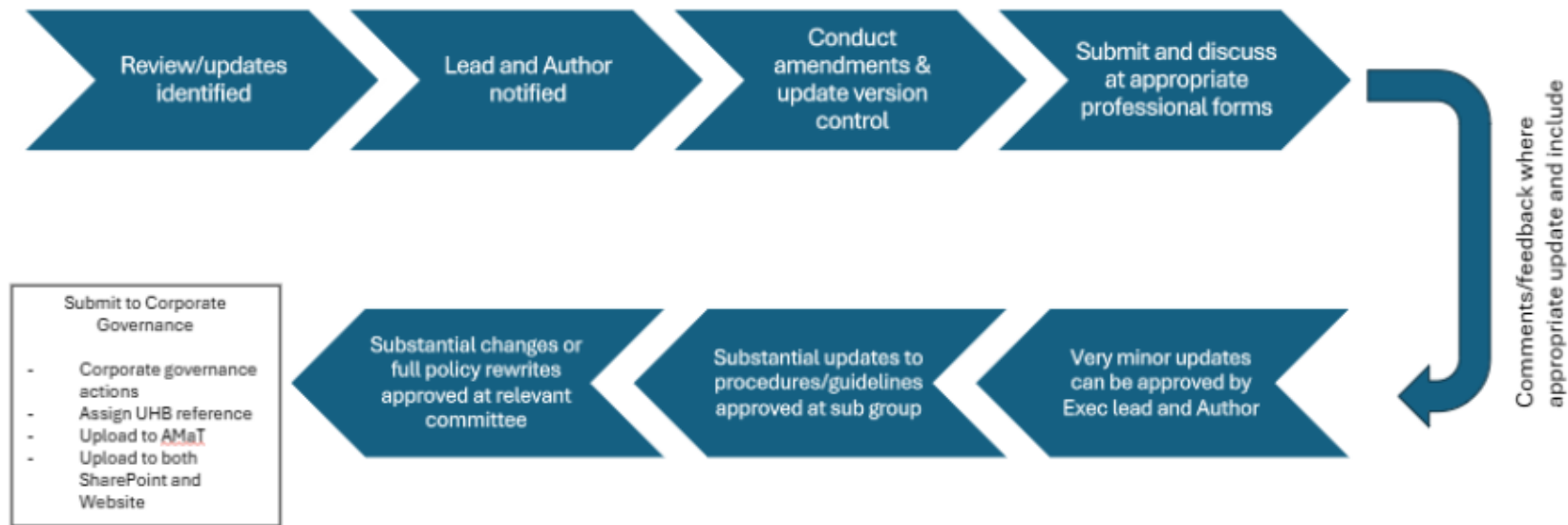
Mental Health				
Mental Health	No Code	Electroconvulsive Therapy (ECT)	<p>It was noted that this policy statement is in line with NICE guidance which states that ECT is recommended only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with:</p> <ul style="list-style-type: none"> • Catatonia • A prolonged or severe manic episode <p>All patients with clinical need can access this intervention according to the criteria outlined by NICE. No evidence of negative impact was identified based on protected characteristics.</p> <p>An IPFR is required for all other circumstances</p>	<p>NICE Technology Appraisal 59 Guidance on the use of electroconvulsive therapy: www.nice.org.uk/Guidance/TA59</p> <p>NICE Clinical Guideline 222 Depression in adults: recognition and management: https://www.nice.org.uk/guidance/ng222</p>

Please refer to the Cardiff and Vale Prescribing Formulary for a list of medicines and their indications approved for use within Cardiff and Vale UHB. The formulary can be found at: <http://cardiffandvaleuhb.inform.wales.nhs.uk>

Technology appraisal decisions produced by the National Institute of Health and Care Excellence (NICE) and medicines appraisal decisions from All Wales Medicines Strategy Group can be found at: <https://www.nice.org.uk/guidance/published?type=ta>
<http://www.awmsg.org/awmsgonline/app/report;jsessionid=4f4bcc7791af5daa9bfd99212284?execution=e1s1>

Process to add interventions to the INNU policy intervention list outside of policy review schedule.

This process aligns with the *Written Control Documents - Development and Approval Procedure*.



Professional forums: Planned Care Programme Board

Sub Group: Clinical Effectiveness Committee

Committee: Quality Committee

Exec lead: David Fluck