

Clinical Commissioning Policy

Varicose Veins

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

Ref:	CMICB_Clin049
Version:	1
Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
Supersedes:	Previous Clinical Commissioning Group (CCG) Policy
Author (inc Job Title):	
Ratified by: (Name of responsible Committee)	ICB Board
Cross reference to other Policies/Guidance	
Date Ratified:	1 April 2023
Date Published and where (Intranet or Website):	1 April 2023 (Website)
Review date:	1 April 2026
Target audience:	All Cheshire & Merseyside ICB Staff and Provider organisations

This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

Document control:		
Date:	Version Number:	Section and Description of Change
April 2023	1	Policy ratified by Cheshire & Merseyside ICB

1. Introduction

- 1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.
- 1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.
- 1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.
- 1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication <https://www.aomrc.org.uk/ebi/clinicians/varicose-vein-interventions/>.

2. Purpose

- 2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Summary of intervention

- 3.1 There are various interventional procedures for treating varicose veins. These include endothermal ablation, ultrasound guided foam sclerotherapy and traditional surgery (this is a surgical procedure that involves ligation and stripping of varicose veins) all of which have been shown to be clinically and cost effective compared to no treatment or treatment with compression hosiery. Varicose veins are common and can markedly affect patients' quality of life, can be associated with complications such as eczema, skin changes, thrombophlebitis, bleeding, leg ulceration, deep vein thrombosis and pulmonary embolism that can be life threatening.

4. Policy statement

- 4.1 Surgical management of varicose veins is routinely commissioned in patients who have any of the following:
 - 4.1.1 Symptomatic * primary or recurrent varicose veins.
 - 4.1.2 Lower limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
 - 4.1.3 Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
 - 4.1.4 A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).
 - 4.1.5 A healed venous leg ulcer

*" Symptomatic" = Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).

- 4.2 Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.
- 4.3 For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment

5. Exclusions

- 5.1 People with bleeding varicose veins should be referred to a vascular service immediately

6. Rationale

- 6.1 International guidelines, NICE guidance and NICE Quality standards provide clear evidence of the clinical and cost-effectiveness that patients with symptomatic varicose veins should be referred to a vascular service for assessment including duplex ultrasound.
- 6.2 Open surgery is a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein), this is still a valuable technique, it is still a clinically and cost-effective treatment technique for some patients but has been mainly superseded by endothermal ablation and ultrasound guided foam sclerotherapy.
- 6.3 Recurrence of symptoms can occur due to the development of further venous disease, that will benefit from further intervention (see above). NICE guidance states that a review of the data from the trials of interventional procedures indicates that the rate of clinical recurrence of varicose veins at 3 years after treatment is likely to be between 10–30%.
- 6.4 For people with confirmed varicose veins and truncal reflux NICE recommends:
 - Offer endothermal ablation of the truncal vein
 - If endothermal ablation is unsuitable, offer ultrasound-guided foamsclerotherapy.
 - If ultrasound-guided foam sclerotherapy is unsuitable, offer surgery
 - Consider treatment of tributaries at the same time
 - Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable.
- 6.5 Complications of intervention include recurrence of varicose veins, infection, pain, bleeding, and more rarely blood clot in the leg. Complications of non-intervention include decreasing quality of life for patients, increased symptomatology, disease progression potentially to skin changes and eventual leg ulceration, deep vein thrombosis and pulmonary embolism.

7. Underpinning evidence

- 7.1 NICE Guidance: <https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article>
- 7.2 NICE Guidance (2013) Varicose veins: diagnosis and management [CG168]
- 7.3 NICE Quality Standard (2014) Varicose veins in the legs [QS67]
- 7.4 Editor's Choice -Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). Wittens C, Davies AH, Bækgaard N, Broholm R, Cavezzi A, Chastanet S, de Wolf M, Eggen C, Giannoukas A, Gohel M, Kakkos S, Lawson J, Noppeney T, Onida S, Pittaluga P, Thomis S, Toonder I, Vuylsteke M, Esvs Guidelines Committee, Kolh P, de Borst GJ, Chakfé N, Debus S, Hinchliffe R, Koncar I,

Lindholt J, de Ceniga MV, Vermassen F, Verzini F, Document Reviewers, De Maeseneer MG, Blomgren L, Hartung O, Kalodiki E, Korten E, Lugli M, Naylor R, Nicolini P, Rosales A. Eur J Vasc Endovasc Surg. 2015 Jun;49(6):678-737. doi: 10.1016/j.ejvs.2015.02.007. Epub 2015 Apr 25.

- 7.5 The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. Gloviczki P1, Comerota AJ, Dalsing MC, Eklof BG, Gillespie DL, Gloviczki ML, Lohr JM, McLafferty RB, Meissner MH, Murad MH, Padberg FT, Pappas PJ, Passman MA, Raffetto JD, Vasquez MA, Wakefield TW; Society for Vascular Surgery; American Venous Forum. J Vasc Surg. 2011 May;53(5 Suppl):2S-48S. doi: 10.1016/j.jvs.2011.01.079.
- 7.6 A Randomized Trial of Early Endovenous Ablation in Venous Ulceration. Gohel MS1, Heatley F1, Liu X1, Bradbury A1, Bulbulia R1, Cullum N1, Epstein DM1, Nyamekye I1, Poskitt KR1, Renton S1, Warwick J1, Davies AH1; EVRA Trial Investigators. N Engl J Med. 2018 May 31;378(22):2105-2114. doi: 10.1056/NEJMoa1801214. Epub 2018 Apr 24.

8. Force

- 8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

9. Coding

SQL code

```
WHEN left(der.Spell_Dominant_Procedure,4) IN  
( 'L832','L838','L839','L841','L842','L843','L844','L845','L846','L848','L849'  
, 'L851','L852','L853','L858','L859','L861','L862','L863','L868','L869','L871'  
, 'L872','L873','L874','L875','L876','L877','L878','L879','L881','L882','L883','L888','L889')  
AND der.Spell_Primary_Diagnosis like ('%I8[03]%' )  
AND APCS.Admission_Method not like ('2%' )  
THEN 'Q_var_veins'
```

Global cancer exclusion

```
WHERE 1=1  
-- Cancer Diagnosis Exclusion  
AND (apcs.der_diagnosis_all not like '%C[0-9][0-9]%' )  
AND apcs.der_diagnosis_all not like '%D0%' )  
AND apcs.der_diagnosis_all not like '%D3[789]%' )  
AND apcs.der_diagnosis_all not like '%D4[012345678]%' )  
OR apcs.der_diagnosis_all IS NULL
```

10. Monitoring And Review

- 10.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
 - Post activity monitoring through routine data
 - Post activity monitoring through case note audits
- 10.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
<http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx> and
<http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx>

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrlist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrlist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.