



Kent and Medway

Kent & Medway Referral and Treatment Criteria

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This document sets out referral and treatment criteria for elective pathways of care in Kent and Medway, which have been developed by GPs, consultants, pharmacists, optometrists, dentists and many other health professionals locally, to ensure that patients consistently get the right treatment at the right time.

They are based on best practice and NICE guidance to enable the NHS to minimise the risks of planned treatment for patients and maximise its benefits, so that people get the best possible care.

Many of the criteria in this document set out steps to be followed by GPs or other referrers to ensure that treatments involving minimal disruption to patients are attempted first, before referral for surgery.

Where surgery still remains essential, patients are encouraged (where appropriate) to prepare for it in a way which will enhance its success.

Even for those procedures which, under these criteria, will not be routinely funded (such as body contouring and tattoo removal), there is no blanket ban. There is an established mechanism for dealing with individual funding requests / exceptions. The application form for clinicians wishing to request funding for individuals who are eligible against the definitions of a “rarity request” or an “exceptionality request” (as set out in each of the PCTs’ Policy and Operating Procedures for dealing with IFRs) is attached to this document as Appendix A.

This document covers referral and treatment criteria across primary, community, secondary and specialised care. Not all sections will be relevant to all providers but, to support a single document for Kent and Medway, the list will not be separated for provider / contract purposes.

A summary of different types of NICE guidelines, their impact on referral and treatment criteria, and the process for adding or amending procedures to the document list is outlined in Appendix B.

For some treatments, review by the Individual Funding Request panel is specified within the criteria.

Patients who fulfil the criteria for the other treatments do not need to be considered by the panel.

However, these procedures will be subject to periodic audits to ensure adherence to the criteria. An audit framework is set out in Appendix F.

Patients inadvertently referred for treatment who do not meet the criteria will be discharged back to the care of their GP and will have their 18 week clock stopped (recorded as ‘no treatment required’).

The referral and treatment criteria will be reviewed, with Clinical Commissioning Group input, when new guidance or policy is issued. All amendments will be ratified through the relevant PCT process and communicated to stakeholders.

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Acne Scarring

The treatment of active acne vulgaris should be provided in primary care, or where appropriate by a dermatology service.

Procedures (resurfacing and any other interventions) for acne scarring are not routinely funded.

Arthroscopy of the knee

Arthroscopy of the knee can be undertaken where a competent clinical examination (or MRI scan if there is diagnostic uncertainty or red flag symptoms/signs/conditions) has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body) and where conservative treatment has failed or where it is clear that conservative treatment will not be effective. Arthroscopy should not be the primary investigation for knee pain.

Knee arthroscopy can therefore be carried out for:

- Removal of loose body
- Meniscal surgery (repair or resection)
- Ligament reconstruction/repair (including lateral relapse)
- Synovectomy

Knee arthroscopy should not be carried out for any of the following indications:

- Investigation of knee pain
- Treatment of osteoarthritis including arthroscopic washout and debridement. In line with NICE guidance CG59 this should not be offered as part of treatment for osteoarthritis unless the individual has knee osteoarthritis with a clear history of mechanical locking (not gelling, 'giving way')

Bariatric Surgery in Adults

Morbid Obesity funding requests will be considered by the South East Coast Specialised Commissioning Group (SECSCG) Morbid Obesity team.

In considering the requests the SECSCG will review against the following aspects of National Institute for Clinical Excellence (NICE) criteria for surgery for morbid obesity and HPSU criteria for the same:-

1. The patient's age is 18 years or over at the point of referral, and
2. The patient's BMI is greater than 35kg/m² but less than 40kg/m² with co-morbidities that would be improved by losing weight.

Co-morbidities include:

- a) Established ischæmic heart disease
- b) Type 2 diabetes requiring oral medication or insulin
- c) Life-threatening sleep apnoea
- d) Severe uncontrolled hypertension
- e) Benign intracranial hypertension
- f) History of transient ischæmic attacks or stroke
- g) Severe lower limb major joint disease requiring orthopaedic intervention which is precluded on safety grounds due to patient's BMI;

- h) Other co-morbid condition which has been agreed by the PCT as exceptional, on an individual patient basis,
3. Or, the patient's BMI is greater than 40kg/m² with or without obesity related co-morbidities, and
 4. The patient has tried to lose weight over the course of 1 recent full year (i.e. a continuous 12 month period that ceases at the point of referral), without success. This includes but is not restricted to:
 5. Weight management programme under the supervision of a dietician or GP or membership of a weight loss organisation, with evidence that a programme has been followed over a 12- month period without successful weight reduction.
 6. And, it is imperative that the patient has received support from their GP throughout this non-surgical management phase and that there is evidence of the patient's attendance of weight loss programmes, including drug therapy. The weight loss programmes do not have to be provided by the NHS.

In instances where the SECSCG does not support funding for referral to Specialised Morbid Obesity Services, patients may need to be referred to local PCT services as per individual PCT policy on non-Specialised Morbid Obesity Services.

Criteria for funding and a funding application form can be found at www.secscg.nhs.uk/home/specialised-services/morbid-obesity/

Appeals against SCG decisions can be made to PCT Individual Funding Panels.

Bone anchored hearing aids

This intervention is funded under the criteria stated in the application for funding form attached to this document (Appendix E)

Prior Approval from the relevant PCT is required.

Body Contouring Procedures

These procedures are not routinely funded in line with South East Coast Policy Recommendation – PR 2009-09.

Bariatric surgeons, GPs and other clinicians supporting patients in losing weight should document discussions with patients regarding the possibility of being left with excess skin after profound weight loss, and informing patients that surgery to remove excess skin is not routinely available on the NHS.

Please note that psychological/psychiatric morbidity is not a criteria for funding aesthetic procedures.

This should be part of the consent process.

Abdominoplasty / Apronectomy ('Tummy Tuck')

This procedure is not routinely funded.

Brachioplasty / Upper Arm Lift

This procedure is not routinely funded.

Buttock Lift

This procedure is not routinely funded.

Calf Implants

This procedure is not routinely funded.

Liposuction

Cosmetic liposuction not available but may be used as a technique in the management of true lipodystrophies, lymphoedema or lipomas, or as part of other surgery, e.g. thinning of transplanted flap.

Neck Lift

This procedure is not routinely funded

Thigh Lift

This procedure is not routinely funded.

Upper Arm Reduction

This procedure is not routinely funded.

Breast Procedures

This policy does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer.

No procedure is to be undertaken until consultant confirms that development is complete.

Please note that psychological/psychiatric morbidity is not a criteria for funding aesthetic procedures

Breast Augmentation

This procedure is not routinely funded within the local NHS for any patient group.

Revision of Breast Augmentation

Replacement of breast implants is not funded within the local NHS for any patient group, this includes following removal of breast implants where this is considered clinically necessary and available on the local NHS.

This applies both to patients who underwent their original breast augmentation surgery privately and those who received it on the NHS.

Removal of Breast Implant for Clinical Need

Breast implants may be removed in secondary care without requiring individual funding where there is confirmed clinical, rather than cosmetic, need. However, implants will not be replaced (see Revision of Breast Augmentation).

Breast Reduction

Breast reduction should only be considered an option for patients who fulfil all of the following criteria on one or both breasts:

- Documented evidence of treatment received for physical symptoms of back, neck and/or shoulder pain due to large breasts;
- Requires more than 500g tissue removed from each breast;
- BMI of <26kg/m²; AND
- Non-smoker

GPs should not refer patients into secondary care if they do not fulfil the above outlined criteria.

Nipple Eversion

This procedure is not routinely funded within the local NHS for any patient group.

Gynaecomastia

This policy does not apply to patients undergoing treatment for prostate cancer.

This procedure is not routinely funded within the local NHS for any patient group.

Mastopexy

This procedure is not routinely funded within the local NHS for any patient group.

Carpal tunnel syndrome (Surgical Techniques for the Treatment of)

The PCTs will only fund this intervention if:

Acute, severe symptoms persist after conservative therapy with either local corticosteroid injection and/or nocturnal splinting

OR Mild to moderate symptoms persist for at least 4 months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least 8 weeks)

OR There is neurological deficit e.g. sensory blunting, muscle wasting or weakness of thenar abduction

OR Severe symptoms significantly interfere with daily activities

Cataract surgery

Referral for cataract should only occur following a consultation with an optometrist or ophthalmologist who has confirmed the patient experiences both of the following:

- Impairment of functions of daily living attributable to impairment of visual function due to cataract;

And

- Willingness to have surgery; the referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral

Patients should undergo treatment of the second eye when they meet the criteria above.

Cerebellar Stimulator Implants

This procedure is not routinely funded.

Chalazia

This procedure is not routinely funded.

Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve within 6 months. Treatment consists of regular (four times daily) application of heat packs.

The PCTs will fund excision of chalazia when all of the following criteria are met:

- The chalazia has been present for more than 6 months
- Where it is situated on the upper eyelid
- Where it is causing blurring of vision

Children under 10 years old are excluded from the above and should be referred and treated as appropriate due to the risk of amblyopia.

In common with all types of lesions, the PCTs will fund removal where malignancy is suspected.

Chronic Fatigue Syndrome

Patients should be referred to the local Chronic Fatigue Service provided by Kent & Medway NHS Partnership Trust. Inpatient treatment will not be routinely funded

Circumcision

This procedure is not routinely funded.

The PCTs will only provide funding for therapeutic reasons in line with the criteria below:

- Patients with severe phimosis
- Severe recurrent balanitis
- Suspicion or evidence of malignancy, dermatological disease (such as lichen planus or eczema) which is unresponsive to other treatment and where biopsy is required.

- Balanoposthis

Closure of Patent Foramen Ovale for Migraine

This procedure is not routinely funded.

Cochlear Implants

This intervention is funded under the criteria stated in the relevant NICE guidance.

The application form for funding is attached to this document (Appendices C & D)

Prior Approval from the relevant PCT is required.

Complimentary and Alternative Therapies

These treatments are not routinely funded. These include: Acupuncture, Aromatherapy, Chinese Medicines, Chiropractic Therapy, Clinical Ecology, Herbal Remedies, Homeopathy, Hypnotherapy, Massage, Osteopathy and Reflexology. This list is not exhaustive and other procedures not listed here but that are considered 'alternative' therapies will be considered in the same way.

Some procedures may be available through services in hospices and hospitals as part of a palliative care package; these are through charitable services and not commissioned services.

Some patients may be treated as part of an integrated conventional and complimentary service for a specific condition where these are commissioned.

Collagen Cross Linking Treatment for Corneal Ectasias Including Kkeratoconus.

Collagen cross-linking using UVA light and riboflavin (vitamin B2) is an acceptable treatment, in some cases, for corneal ectasias including keratoconus.

Treatment should be with the standard protocol using 0.1% riboflavin in 20% dextran.

Following current NICE guidance, treatment should only be performed in centres who are performing the treatment as part of audit or research.

Acceptable clinical criteria are those patients with corneal ectasia, including keratoconus, whose minimum corneal thickness in the eye to be treated is greater than 330um and in whom progression is clinically likely.

Alternatives such as spectacles, standard contact lenses, and contact lenses specially designed for irregular corneas should have been tried first.

Cryotherapy for Localised Prostate Cancer

This procedure is not routinely funded in line with NICE Clinical Guidance 58.

Cyberknife for Cholangiocarcinoma (Bile duct cancer)

This procedure is not routinely funded.

DaVinci Robotic Radical Prostatectomy for the Treatment of Prostate Cancer

Not routinely funded however an evidence review will be undertaken for this procedure.

Dental Procedures

Asymptomatic Impacted Third Molars

Surgical extraction of asymptomatic impacted third molars is not routinely funded except in the circumstances recommended by NICE as set out below.

NICE have issued the following guidance:

“Surgical removal of impacted third molars should be limited to patients with evidence of pathology. Such pathology includes unrestorable caries, non-treatable pulpal and/or periapical pathology, cellulites, abscess and osteomyelitis, internal/external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst/tumour, tooth/teeth impeding surgery or reconstructive jaw surgery and when a tooth is involved in or within the field of tumour resection”.

Dental Extraction of Non-Impacted Teeth

Extraction of non-impacted teeth will not be routinely funded **in secondary care**.

However, the PCTs will consider funding for patients with the risk factors listed below through the agreed mechanism.

- Difficult extractions deemed beyond the capability of a General Dental Practitioner by the Hospital Consultant/Specialist Dentist/IMOS DwSI
- Those at high risk of endocarditis who require intravenous antibiotics
- Those undergoing a course of intravenous bisphosphonates
- Those who have suffered a myocardial infarct or undergone coronary revascularisation within 6 months of referral
- Those who are known to have brittle asthma
- Those who have a clear need for a general anaesthetic

Dental extraction of wisdom teeth in children under general anaesthetic

This procedure is not routinely funded. Exceptions may include unerupted teeth prior to Orthodontic treatment.

Dental Implants

The PCTs have agreed protocols for implant treatment

Dental implants are not routinely funded except under the following conditions:

Edentulous in one or both jaws - Severe denture intolerance

- Physical due to severe gagging or severe ridge resorption with unacceptable stability or pain.
- Psychological.

Edentulous in one or both jaws - Prevention of severe alveolar bone loss

- Moderate ridge resorption in young individuals - under 45yrs.
- Moderate ridge resorption in one jaw opposing natural teeth with a good prognosis.

Partially dentate - Preservation of remaining healthy intact teeth in individuals with otherwise healthy dentitions. The teeth may be missing due to the following factors:

- Developmental - Oligodontia/Anodontia, Cleft palate
- Trauma
- Complete unilateral loss of teeth in one jaw where dentures are not tolerated or an edentulous span is considered too difficult to manage by other means

Maxillofacial and cranial defects

- Intraoral prostheses for patients considerable amounts of hard and soft tissues and teeth. They result from developmental disorders, trauma and treatment of tumours. And include extensive ridge deformities (>3cm span), patent clefts, major jaw resections
- Extraoral/ Cranial prostheses. Ears; congenital absence or deformity of pinna or loss of pinna following trauma or surgical ablation of malignant disease. Eyes, loss of globe of eye with exenteration of orbit due to malignant disease. Nose, partial or total loss of nose following trauma or surgical ablation of malignant disease

Orthodontics (Grade 3.5 and below on the Index of Orthodontic Treatment Need)

These procedures are not routinely funded but may be if determined as necessary in complex cases by an Orthodontic Consultant.

The referral proforma guides a dentist as to where a patient should be referred. Inappropriate referrals to a hospital Consultant should be returned to the dentist.

Dilation and Curettage

In line with NICE Clinical Guideline CG44, D&C is not recommended as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so is not approved for these conditions.

Ultrasound should be considered the first line diagnostic tool for the identification of structural pathology in heavy menstrual bleeding.

Hysteroscopy with biopsy is an accurate method for the identification of endometrial and some submucosal pathology, but should be considered only where ultrasound outcomes are inconclusive

D&C may still be used to evacuate products of conception [see www.whbs.org.uk]. This does not require prior approval. Observational evidence suggests that D&C may cause adverse effects including uterine perforation and cervical laceration, as well as the usual risks of general anaesthesia.

The PCTs will fund dilation and curettage for **diagnostic purposes for suspected malignancy** and for **evacuation of retained products of conception**.

Dupuytren's Contracture

This procedure is not routinely funded.

The PCTs will fund this procedure where

- there is a metacarpophalangeal joint contracture of 30° or more
- OR any degree of proximal interphalangeal joint contracture
- OR patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 10° or more

Electrolysis

This procedure is not routinely funded.

Refractive Eye Surgery

These procedures are NOT routinely funded

Excision of Redundant Skin or Fat

This procedure is not routinely funded. (See body contouring)

Facial Procedures

Blepharoplasty

This procedure is not routinely funded for cosmetic reasons or if excessive skin in the lower lid may cause eyebags, but does not affect eyelid function or vision and therefore does not need correction.

Funding will be provided for:

- The correction of ectropion and entropion
- Removal of lesions of the eyelid skin or lid margin

Ptosis of Eyelid (Lift)

This procedure is not routinely funded. However, the PCTs will fund this procedure if there is documented evidence of encroachment of the central 20 degrees of visual field. Children under 10 years old are excluded from the above and should be referred and treated as appropriate due to the risk of amblyopia.

Brow Lift

This procedure is not routinely funded.

Face Lift

This procedure is not routinely funded.

It will not be available on cosmetic grounds or to treat the natural processes of ageing but will be considered for the treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin e.g. cutaneous laxa, neurofibromatosis, pseudoxanthoma elasticum
- To correct the consequences of trauma
- To correct deformity following surgery

Pinnaplasty

This procedure is not routinely funded for adults on cosmetic grounds. Available for children only (less than 16 years age), where the child, rather than parents alone, express concern. (Continued on next page)

Exceptional requests cannot be made on the basis that the request was not made before the child's 16th birthday; other exceptional circumstances must be demonstrated.

Repair of Lobe of External Ear

This procedure is not routinely funded.

Surgery will be funded for the repair of completely split ear lobes as a result of direct trauma. Advice should be given regarding likely success rate, the risk of keloid and hypertrophic scarring at this site, the risks of further trauma with re-piercing of the ear lobule.

Rhinophyma

Treatment for this condition is not routinely funded.

The PCTs will consider funding if there is evidence of impairment of visual fields in the relaxed, non compensated state. An initial referral to an ophthalmologist is required to allow field testing so an assessment can be made

Rhinoplasty / Septorhinoplasty

These procedures are not routinely funded.

Post traumatic rhinoplasty available. Rhinoplasty for complex congenital conditions e.g. cleft lip and palate or airway problems available. Straightforward cosmetic rhinoplasty is not available.

Prior Approval is required for complex or severe cases of the nasal septal deviation that are not post traumatic'.

Septo-rhinoplasty will not be funded for aesthetic reasons only. An application for non-traumatic septorhinoplasty must demonstrate a clear clinical need for surgery and must be made by a Consultant.

A prior approval checklist should be completed and submitted to the relevant PCT.

Submental Lipectomy

This procedure is not routinely funded.

Female genital prolapse (Surgical management of)

This procedure is not routinely funded for asymptomatic or mild pelvic organ prolapse.

Referral for specialist assessment is indicated for:

- Prolapse combined with urethral sphincter incompetence or faecal incontinence
- Failure of pessary

- Women with symptomatic prolapse (including those combined with urethral sphincter incompetence or faecal incontinence)
- Women with moderate to severe prolapse who want to have definite treatment but do not want ring pessary.

Female Sterilisation

Sterilisation will not be available on non medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable. (*in line with the UK Medical Eligibility Criteria for Contraceptive Use (2009)*). If a woman has a personal history of breast or other hormonal cancer and wishes to avoid all hormonal methods then a copper intrauterine device (IUCD) should be suggested for the trial

The PCTs will fund this procedure if:

- Where sterilisation is to take place at the time of another clinically appropriate gynaecological procedure such as caesarean section.
- Where there is a clinical contraindication to the use of a Mirena/Implanon.
- Where there is an absolute clinical contraindication to pregnancy, including but not limited to:
 - young women (under 45 years of age) undergoing endometrial ablation for heavy periods
 - women with severe diabetes
 - women with severe heart disease

For a sterilisation to be considered on the above grounds, the patient must also pass the following criteria with regards to expert counselling. Regret rates after female sterilisation are quoted as between 6% and 20% (Hillis et al. *Obstet Gynecol* 1999;93: 889-95) often because of a change of relationship or just a change of mind. It is therefore important that women requesting sterilisation understand that this procedure is considered irreversible and have tried other long term methods first:

- Is the woman certain her family is complete or that she never wants children?
- Is the woman aware that the procedure is considered permanent and that reversal is not routinely funded on the NHS?
- Has the woman received counselling about her options including consideration of all other forms of long-acting contraceptives and her other contraceptive options? The referring GP should ensure the patient is properly counselled on this decision and this counselling evidenced before making a referral.
- Does the woman have sound mental capacity? (Please see RCOG UK National sterilisation guidelines 2004)

An exception to this is where the woman has an absolute clinical contraindication to pregnancy and therefore it is felt that counselling regarding the irreversibility of the procedure is inappropriate. However, counselling relating to the psychological effects of having such a procedure should be offered.

Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.

Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.

Functional Electrical Stimulation (FES)

This procedure is available for drop foot of central neurological origin as per NICE Interventional Procedure Guidance 278 (January 2009).

Ganglia (Wrist and Foot: Surgical Techniques for the Treatment of)

Wrist:

This procedure is not routinely funded unless there is:

- Painful seed ganglia or
- Mucoïd cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint) or
- Symptoms associated with the ganglion such as pain, increase in size, loss of sensation in parts of the hand, neurological loss or weakness of the wrist or
- The ganglion has resulted in functional impairment which prevents the individual from fulfilling work/study/carer or domestic responsibilities or
- Where there is doubt about the diagnosis

Foot:

This procedure is not routinely funded unless there is one of the following present:

- Significant functional impairment and the patient is unable to wear typical 'off the shelf' footwear
- Reduced ability to walk
- Localised pressure effects including pain and/or increasing size
- Mucoïd cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal inter-phalangeal joint)
- Where there is doubt about the diagnosis

Gender Dysphoria

Gender re-assignment is a highly specialised area of clinical practice and NHS funding and treatment approval should only be considered for the agreed NHS pathway of care. Each case will be considered on its individual merits.

The care pathway for individuals with gender dysphoria includes diagnostic assessment, supportive psychotherapy, the "real life" experience, hormone therapy and surgical interventions.

The real life experience is a period of time, usually minimum of two years, living in the gender role with which the individual identifies, with the aim of assisting the patient and the professionals in decisions about how to proceed.

GPs should refer to Kent & Medway NHS Partnership Trust who will assess the patient for referral to West London Mental Health Trust and potential subsequent Sex Reassignment Surgery.

The patient should be seen by a local psychiatrist to assess or confirm the absence of significant mental illness, before referral to West London Mental Health Trust's - Gender Identity Clinic. At the Gender Identity Clinic the patient will be assessed for gender dysphoria (ICD-10 criteria (as below) for trans-sexualism) before they can start the care pathway

ICD-10 Diagnosis of trans-sexualism:-

- *The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment.*

- *The transsexual identity has been present persistently for at least two years.*
- *The disorder is not a symptom of another mental disorder or a chromosomal abnormality.*

The PCT will be requested to confirm funding prior to the patient being seen at West London Mental Health Trust.

The PCTs do not routinely fund the following procedures for gender re-assignment:

- Blepharoplasty / Eye Lid Surgery
- Breast Augmentation / Mammoplasty
- Electrolysis / Hair Removal
- Facial Bone Reconstruction
- Facelift
- Laser Treatment / Hair Removal
- Liposuction
- Phono Surgery / Larynx Surgery
- Rhinoplasty
- Thyroid Chondroplasty
- Voice Modification Surgery
- Waist Lipoplasty
- Wig Provision

Surgical site hair removal, if required, will be funded.

Bilateral mastectomy will be funded for female to male gender reassignment, although prior approval is required via the Specilaised Commissioning Team.

The Kent and Medway Gender Dysphoria and Sex Re-assignment Surgery Policy contains the full pathway. A copy can be requested from the individual funding request lead in the PCT.

Grommets

Adults

The PCTs will only fund grommets for adults in the following circumstances:

- A middle ear effusion* causing measured conductive hearing loss and resistant to medical treatments where the patient has been managed and monitored for a minimum period of 3 months in secondary care before a decision is made to treat.
- Persistent Eustachian tube dysfunction resulting in pain (e.g. flying)
- As treatment for Meniere's disease.
- Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma.

***Unilateral effusion requires urgent assessment and is detailed as criteria on the Kent & Medway Cancer Network Head and Neck Cancer referral form. Patients should be referred and treated in line with agreed rapid access pathways.**

Any suspicion of malignancy at any stage of the pathway should be managed and treated appropriately.

Children

Grommets for children under the age of 12 years should be undertaken in accordance with NICE Clinical Guidance 60 (Feb 2008) Surgical Management of the Otitis Media with Effusion in Children:

Primary Care: Assess features suggestive of OME and refer for formal assessment if necessary

- Hearing difficulty
- Indistinct speech or delayed language development
- Repeated ear infections or earache
- Poor educational progress
- Recurrent upper respiratory tract infections or frequent nasal obstruction
- Behavioural problems
- Less frequently, balance difficulties, tinnitus, intolerance of loud sounds

Following formal assessment; children who will benefit from surgical intervention will be considered for surgery where:

- Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention.
- Persistent bilateral OME with hearing loss less than 25–30 dBHL and significant impact on child's developmental, social or educational status
- Once a decision has been taken to offer surgical intervention for OME in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.

Management of OME in children with Down's syndrome

- Hearing aids should normally be offered to children with Down's syndrome and OME with hearing loss.

Management of OME in children with cleft palate

- Insertion of ventilation tubes at primary closure of the cleft palate should be performed only after careful otological and audiological assessment.
- Insertion of ventilation tubes should be offered as an alternative to hearing aids in children with cleft palate who have OME and persistent hearing loss.

The PCT will also fund in the following instances:

- Severe collapse (retraction) of the ear drum
- Progressive atelectasis of the tympanic membrane

Adenoidectomy for Otitis Media in children will not be routinely funded but combined with grommets will be considered in children who fulfil the criteria.

Hair Transplant / Hair Graft / Hair replacement

Hair replacement/ hair transplant/grafting is not routinely funded. Hair pieces and wigs for patients experiencing total hair loss as a result of alopecia totalis, previous surgery or trauma are available from local NHS Trusts.

Hip & Knee replacements

Patients should be referred for consideration of total joint replacement when all conservative means have failed to alleviate the patient's pain and disability, which should be significantly interfering with their activities of daily living and their ability to sleep.

Referral for specialist assessment should only be considered if the patient has:

- Moderate to severe pain not adequately relieved by an extended course of non-surgical treatment (such as adequate doses of analgesia, weight control and physical therapies)
- AND clinically significant functional limitation resulting in diminished quality of life
- AND radiographic evidence of joint damage

The following conservative management should have been attempted (where appropriate):

1. Advice to reduce BMI to less than 30 and the patient having complied with this. All reasonable attempts should be made to reduce weight to a BMI below 30 prior to referral.
2. Simple analgesia.
3. Anti-inflammatory analgesia (where appropriate)
4. Advice on exercise and if appropriate physiotherapy.
5. Advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling on the potential risks and benefits of joint replacement surgery
6. Underlying medical conditions should have been investigated and the patients condition optimised prior to referral

Ideally patients should have had efforts to reduce/eradicate open ulcers, recurrent infections or MRSA colonisation

Hirsutism Treatment

Hair removal procedures for hirsutism are not routinely funded.

Hyperbaric Oxygen Therapy for Wound Healing

This procedure is not routinely funded.

Hyperhidrosis

Hyperhidrosis is not an uncommon condition and is not considered a priority.

Most patients with mild-moderate hyperhidrosis should be offered the more conservative treatments first before consideration for surgery.

Botulinum Toxin is not routinely funded for Hyperhidrosis.

Secondary Care treatment is not funded unless there are exceptional clinical circumstances for an individual, as compared to a cohort of similar patients. As the condition is often associated with the onset of puberty, exceptions will not be considered for patients under 25 years old.

Endoscopic Thoracic Sympathectomy for Facial Blushing and/or sweating is not routinely funded.

A proforma (where available) should be completed and accompany the IFR submission form where a case is being made on the basis of exceptionality.

Hysterectomy for Heavy Menstrual Bleeding

Where there has been a prior trial, after appropriate clinical assessment, with a levonorgestrel intrauterine system (Mirena®), or other hormone methods in line with NICE guidance which has not successfully relieved symptoms.

And

Other treatments (such as non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, thermal balloon ablation, microwave endometrial ablation, endometrial resection, uterine-artery embolisation in selected cases) have failed, are not appropriate or are contraindicated in line with NICE guidelines. (Uterine artery ablation is performed in tertiary centres as defined in NICE guidance).

Endometrial ablation techniques (including Uterine Artery Embolisation for the treatment of Fibroids) offer a less invasive surgical alternative to hysterectomy. The more modern devices (second generation ablation) take less time to perform than the older first generation devices and were more likely to be performed under local anaesthesia when the woman is awake. Side effects are generally similar and mostly mild.

For those who for ethical reasons cannot accept the use of Mirena®, or the alternative LARC methods, they should have tried at least two of the alternative treatments above.

Inguinal hernia in adults (Elective surgical repair of)

This procedure is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Patients should be referred for surgical assessment if they:

- Demonstrate pain or discomfort significantly interfering with activities of daily living

And

- Meet at least one of the following:
 1. A history of incarceration of, or real difficulty reducing, the hernia
 2. An inguino-scrotal hernia
 3. Increase in size month to month

Patients with femoral hernias should be referred for consultation.

Intra-uterine insemination (IUI), In vitro fertilisation (IVF) and Intracytoplasmic sperm injection (ICSI) - Assisted Conception Treatments for Sub-Fertility

Scope of services provided

These criteria apply the following forms of assisted conception in eligible patients:

- I. Intra-uterine insemination (IUI)
 - In vitro fertilisation (IVF)
 - Intracytoplasmic sperm injection (ICSI).

The criteria will apply to all three forms of treatment unless otherwise stated. The details of these treatments can be found in the National Institute for Clinical Excellence Clinical Guideline 11. Other forms of assisted conception that are not part of the standard NICE recommended guidelines are not included. Any new treatments or research trial treatments are not included – patients taking part in trials of new treatments will be considered separately and will be within the governance arrangements of that research trial. New developments in assisted conception treatments will be dealt with through the

national reviews of evidence and revisions to the national NICE guidelines. Future updates of these criteria will take these into account.

These criteria are applicable to couples who have clinically-defined sub-fertility and who require specialised fertility treatments. They do not apply to:

- Investigations of general fertility problems and the primary treatment of conditions found during such investigation. These are managed within usual primary and secondary care provision.
- Those seeking to use assisted conception techniques for reasons other than the treatment of sub-fertility (e.g. as part of a screening process to exclude abnormalities as in pre-implantation genetic diagnosis (PGD)). PGD uses the technology of IVF but not for infertility reasons. It is a method of testing embryos for genetic disorders (that the parent may carry the genes for) and only transferring those that are healthy and disease free. NICE therefore, understandably, excluded this from its remit on infertility.
- Patients who require fertility because they are undergoing gonadotoxic treatments (e.g. cancer treatments). There is a separate SEC policy on this.

Criteria for the provision of services

The following criteria describe the characteristics of patients who can be offered NHS assisted conception treatments. These can be divided into:

- Clinical criteria – i.e. the clinical characteristics that are associated with effective outcomes of treatment (as shown by the NICE clinical guideline and related review of evidence).
- Social and other criteria – i.e. those criteria which are based on current values of healthcare commissioning, such as prioritising according to patient needs, equity etc.

Clinical criteria

Clinical criteria for NHS funding of assisted conception treatment		Rationale and comments
Duration of sub-fertility	IVF and ICSI will be funded in couples that have been attempting to conceive for at least 36 months unless they have an identifiable cause and unless clinical judgement dictates otherwise.	The likelihood of couples conceiving increases with time. In the general population, it is estimated that 84% of women would conceive within one year of regular unprotected sexual intercourse. This rises cumulatively to 92% after two years and 93% after three years ^{1,2} .

<p>Age of woman</p>	<p>Funding is available for couples where the woman is aged 23-39 at the time of treatment.</p> <p>An exception will be made for women who are aged 39 at the point of referral to an IVF unit but they must be treated within six months of their 40th birthday.</p> <p>For women undergoing full cycles that include subsequent frozen embryo transfers (if the initial fresh cycle was unsuccessful), then the same age stipulation applies, i.e. that they must commence the final frozen cycle within 6 months of their 40th birthday.</p>	<p>The likelihood of a live birth following IUI, IVF and ICSI falls with the age of the female partner. The Human Fertilisation and Embryology Authority (HFEA) publish data on the live birth rates following IVF and ICSI. The live birth rate is the number of births achieved for every 100 IVF treatment cycles commenced. It is expressed as a percentage.</p> <p>The most recent data from the HFEA suggests that the live birth rate for IVF /ICSI amongst women of less than 39 years is 27.3 % whereas for women aged between 40-42 years this rate is 11.1% decreasing to 4% in women over 44 years³.</p>
<p>Previous cycles</p>	<p>Couples will not be funded if either partner has already had three previous fresh cycles of IVF/ICSI (irrespective of how these were funded).</p> <p>This means that couples will be funded:</p> <ul style="list-style-type: none"> • For up to six cycles of initial IUI, as clinically indicated and at the discretion of the referring gynaecologist • For two fresh cycles of IVF or ICSI if no previous cycles have been funded by the NHS, or if they have already received one non-NHS funded fresh cycle • For one fresh cycle of IVF or ICSI if the couple has already received one NHS funded fresh cycle or two non-NHS funded 	<p>Most live births (82%) following IVF occur within the first two fresh cycles of treatment⁴. The birth rate drops at the third and subsequent attempts.</p>

	<p>fresh cycles</p> <p>Overall, eligible couples will be funded for a maximum of 6 cycles of IUI and four embryo transfers (including no more than two transfers from fresh cycles)</p>	
Body Mass Index	<p>Women must have a Body Mass Index (BMI) within the range 19-29</p>	<p>A weight loss programme has been associated with improvements in ovulation and pregnancy outcomes in obese sub-fertile women for all forms of fertility treatment^{5,6}. Higher body mass index has been associated with decreased chances of pregnancy following IVF treatment^{7,8}.</p>

Social and other criteria

Social and other criteria for NHS funding of assisted conception treatment		Rationale and comments
Previous children	<p>Neither partner in a couple should have a living child from their relationship or any previous relationship. A child adopted by the couple or adopted in a previous relationship is considered to have the same status as a biological child. 'Child' refers to</p>	<p>It is recognised nationally that NHS organisations need to focus their budgets on patients who have the most need and can obtain the maximum health gain. Local priority is therefore being given to those who are completely childless.</p>
Previous sterilisation	<p>Assisted conception will not be provided to couples if their sub-fertility is the result of sterilisation in either partner.</p>	<p>Sterilisation is offered within the NHS as an irreversible method of contraception. Considerable time and expertise are expended in ensuring that individuals are made aware of this at the time of the procedure. Since the majority of requests arise for non medical reasons, the Primary Care Trusts consider that it is inappropriate that NHS funds are used in reversing these procedures.</p>

		This position should be reflected in the information and documentation that accompanies sterilisation procedures.
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Labiaplasty

Labiaplasty is considered primarily to be a cosmetic procedure (even if the patient is complaining of discomfort) and is a procedure of low clinical priority. This procedure is therefore not routinely funded by the PCT.

Laser Therapy / Laser Treatment for Aesthetic Reasons / Tunable Dye Laser

The PCT will not routinely fund this procedure for cosmetic problems.

Only cases of post haemangioma involution redness (head and neck area) in children up to age 18 years inclusive and Rhynophyma when referred by an ENT consultant will be funded. The refinement of laser technology has created new therapeutic options for cosmetic problems ranging from insignificant blemishes and tattoos to extreme and disfiguring birth marks. Potential demand for this new service is greater than available resources.

Male Sterilisation

This service will be provided by commissioned primary or community providers.

An Acute Provider will provide a male sterilisation service in the following situation:

- Patient requires an inpatient stay for medical or surgical reasons.
- Explicit approval by the Commissioner on an individual patient basis.

Minor Irregularities of Aesthetic Significance

This procedure is not routinely funded.

Open MRI Scan

Open MRI scanning is not routinely available and should be used only where one of the following two criteria are met. Applications may be made directly to the relevant commissioner.

Category 1 - Claustrophobic

In the first instance all referrals will be reviewed by a Radiologist, the Radiology department can meet with any patient that has concerns regarding MRI scanning to alleviate any fears. Some patients will decide to try and undergo the MRI scan without sedation following this.

If fears cannot be alleviated or the patient fails an MRI scan without sedation, if suitable, the patient will be referred for sedation under consultant anaesthetist care. Other modalities should be considered at this stage also.

To approve under this category, the referral would need to evidence that the sedation pathway has been followed.

Prior approval from the PCT is only required for direct access request referrals to an Open MRI scanner; any unauthorised referrals will not be funded. The request must come from the Radiologist and be supported by appropriate evidence.

Category 2 - Patient Size

The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patients 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 the Radiologist for suitability. The patient can be talked through the procedure, and shown the scanner. The Radiologist will examine the evidence presented, and make judgement on whether to proceed with the MRI scan. If the closed MRI is not suitable (after review) and the referring consultant still feels that an MRI scan is needed, then the patient could be considered for an Open MRI scan.

To approve under this category, the radiographer will need to evidence the issues of size.

Prior approval from the PCT is required for referrals to an Open MRI scanner; any unauthorised referrals will not be funded. The request must come from the Radiologist and be supported by appropriate evidence.

Penile Implants

This procedure is not routinely funded.

Plastic Operations on Umbilicus

This procedure is not routinely funded.

Polysomnography in the Investigation of Children with Sleep-related Disorders

This procedure is not routinely funded.

Private Treatment Available on the NHS

When clinicians retire from the NHS they may continue to practice privately. There are often patients who wish to continue seeing them, rather than see a new NHS clinician. The PCTs will not routinely fund private consultations in these circumstances.

Refashioning of Scar

This procedure is not routinely funded.

Patients may be eligible for treatment of documented post-surgical keloid scarring and abnormal post-surgical scarring, i.e. traumatic, poorly designed, poorly healed, or disease-related scar where consultant confirms scarring is abnormal.

Removal of Benign Skin Lesions

GP's should refer to services available in Primary and Community Care in the first instance before considering referral to secondary care.

Available only where there is a pre-malignant potential or where patient meets one or more of the criteria; In most cases the most clinically appropriate pathway would be to a Consultant Dermatologist. Any variations to this pathway will be locally agreed, along with associated treatment setting:

- the lesion has been subject to repeated (i.e. more than one documented episode of) infection
- the lesion bleeds repeatedly in the course of normal activity
- the lesion is causing pain sufficient to require regular analgesia
- the lesion is producing pressure symptoms on surrounding tissues/organs
- the lesion is adversely affecting the function of a limb or neighbouring structure
- the lesion is obstructing sense of smell, vision or hearing and has not responded to non-surgical treatments
- the lesion is a sinus, fistula or fissure
- the lesion, although benign, has a natural prognosis of malignant change
- where there is a significant clinical suspicion that the lesion is or may be malignant

Benign intradermal facial naevii or benign facial moles will not be considered.

PLEASE NOTE: The PCTs funds biopsy or excision of a lesion whenever there is concern that the lesion might have malignant potential. Such cases do not need approval by the PCT. The degree of suspicion of malignancy is a matter of clinical judgement by the referring clinician.

Residential Pain Management Programmes

Residential Pain Management Programmes are not routinely funded.

Retractile Penis Surgery

This procedure is not routinely funded.

Reversal of Vasectomy / Reversal of Sterilisation

The PCTs will not routinely fund reversal of vasectomy and female sterilisation reversals.

Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.

Salvage Cryotherapy for Recurrent Prostate Cancer

This procedure is not routinely funded in line with NICE clinical guidance 58.

Skin Grafts for Scars

This procedure is not routinely funded

The PCTs will fund this treatment for burns and as part of reconstruction following major trauma.

Skin Resurfacing Techniques

Chemical Peels and Dermabrasion are not routinely funded.

Spinal Cord Stimulation (SCS) for Ischaemic Pain

This procedure is not routinely funded.

As an exception to this general policy, The PCTs consider that treatment may be considered an option in refractory angina and cardiac syndrome X if the patient meets all of the following criteria:

- has coronary heart disease or cardiac syndrome X which cannot be treated satisfactorily by medication;
- is not suitable for a revascularisation procedure (in the case of coronary heart disease);
- has been assessed and treated by a pain clinic but still suffers unacceptable symptoms;
- has been referred to the National Refractory Angina Centre at Broadgreen Hospital;
- is recommended by the National Refractory Angina Centre to have spinal cord stimulation;
- shows a reduction in pain after trial spinal cord stimulation of at least 50%.

Spinal Fusion for the Treatment of Lower Back Pain

Patients should be managed in line with NICE CG88 within the available primary and secondary care services prior to referral to a secondary care consultant.

This means that the PCTs expect patients to have been offered appropriate self management advice, offered appropriate drug treatments to manage pain and referred for conservative treatment prior to referral to a secondary care consultant.

Secondary care should not consider spinal fusion for patients who have not received appropriate management in primary and secondary care.

Stereotactic Radiation Therapy

Stereotactic surgery is only available for specific conditions where specific criteria are to be met. The detail of this can be requested direct from the PCT.

Surgical procedures for the treatment of 'First Metatarsalphalangeal Joint pathology'.

Patient is in pain – (cosmetic problems are not covered by the NHS and the patient should be given advice and information on self management).

And

One or more of the following is present:

1. There is an inter metatarsal angle of greater than 15 degrees, the pain is superficial and the patient cannot wear footwear

2. There is an inter metatarsal angle of greater than 15 degrees, the pain is inter-articular, with joint pain on passive flexion/extension, and the patient feels the pain is not manageable
3. There is Dorsal lipping or other osteophytic enlargement, with joint pain on passive flexion/extension, and patient feels pain is not manageable

Tattoo Removal

This procedure is not routinely funded.

Not available unless the tattoo was applied under duress and where it is a source of continuing allergic phenomena. Prior approval is required.

Temporomandibular Joint Replacement

This procedure is not routinely funded.

Termination of Pregnancy

This service will be provided by specialist termination services.

Acute Trusts will only provide a termination of pregnancy service in the following situations:

- Women with pre-existing medical conditions
- Specialist terminations e.g. where indicated for foetal abnormality or where ITU support post operatively is indicated.

Tonsillectomies +/- adenoidectomies

This procedure is not routinely funded except in children and adults who fulfil the criteria outlined below.

Patients may be considered for tonsillectomy if they meet all of the following criteria:

- Sore throats **must** be due to tonsillitis
- **Five** or more documented episodes of sore throat per year
- Symptoms for at least a year
- The episodes of sore throat must be 'disabling and prevent normal functioning'

OR

The PCT will also consider patients with the following symptoms even if the patient does not meet all of the above criteria.

- Sleep apnoea (demonstrated by a sleep study or other accepted method of diagnosis, including clinical judgement)
- Two or more quinsy's (peri tonsillar abscesses) which usually result in hospital stay for drainage and IV antibiotics and fluids. Tonsillectomy should be indicated in cases of recurrent PTA (quinsy) or with a pre-PTA history of tonsillitis i.e if there is a background of chronic or recurrent tonsillitis.

The first line of treatment for the first episode of PTA is incision and drainage and intravenous antibiotics/hydration. Tonsillectomy should not be the first line treatment after a single episode of PTA unless the abscess cannot be drained.

- Co-existing complications such as neck abscess or Tonsillar enlargement causing upper airway obstruction. This is rare in adults but can occur following glandular fever

Once a decision is made for tonsillectomy, this should be performed as soon as possible, to maximize the period of benefit before natural resolution of symptoms might occur (without tonsillectomy).

Patients identified as having significant health risks but who don't meet the criteria should be considered via the Individual Funding Request (IFR) route as 'exceptional clinical circumstances'.

Any suspicion of malignancy requires urgent assessment and should be referred using the Kent & Medway Cancer Network Head and Neck Cancer referral form. Patients should be referred and treated in line with agreed rapid access pathways.

Any suspicion of malignancy at any stage of the pathway should be managed and treated appropriately.

Traumatic Clefts due to Avulsion of Body Piercing

This procedure is not routinely funded.

Trigger Finger (surgical techniques for the treatment of)

This procedure is not routinely funded.

The PCTs will fund this procedure if

- a patient has failed to respond to conservative treatment (including at least 2 corticosteroid injections)
- OR has a fixed flexion deformity that cannot be corrected.

Upper GI Endoscopy for the Investigation of Dyspepsia.

Criteria for upper GI endoscopy for the investigation of dyspepsia should be based on NICE guidance:

Urgent specialist referral for endoscopic investigation is indicated for patients of any age with dyspepsia when presenting with any of the following:

- chronic gastrointestinal bleeding
- progressive unintentional weight loss
- progressive difficulty swallowing
- persistent vomiting
- iron deficiency anaemia
- epigastric mass or suspicious barium meal.

Routine endoscopic investigation of patients of any age, presenting with dyspepsia and without alarm signs, is not necessary. However, in patients aged 55 years and older with unexplained and persistent recent onset dyspepsia alone despite treatment, an urgent referral for endoscopy should be made.

The benefits of this addition to the RaTC are to ensure equity of treatment across Kent and Medway as well as ensuring adherence to clinical best practice. Clinicians will have clear guidance on when to refer and providers will have clear guidance on when not to

treat. This will support the delivery of 18 weeks RTT through the planned management of demand as well as ensuring adherence to NICE guidance.

Varicose Veins

Conservative treatment of venous disease, including varicose veins, includes diet and lifestyle advice, compression therapy and pharmacotherapy

A patient with varicose veins needs referral to a specialist when they may be suitable for treatment in secondary care (see table 1). The specialist can assess in detail whether the patient is likely to benefit from treatment.

Patients should only be referred when one of the following criteria is met:

- Venous oedema where 6 months of compression therapy has been unsuccessful in controlling symptoms
- Superficial thrombophlebitis
- Varicose veins with limited skin changes at the ankle with the possibility of further complications
- Skin changes ascribed to venous disease
- Late stage venous disease

Table 1: Referral criteria

CEAP Classification	Description	Signs	Consider referral to specialist
C1	Telangiectasis, reticular veins, malleol flare	None	No
C2	Varicose veins	None	Only patients with superficial thrombophlebitis
C3	Varicose veins with limited skin changes at the ankle with the possibility of further complications	Oedema, venous eczema, superficial phlebitis	Yes
C4	Skin changes ascribed to venous disease	Oedema, venous eczema lipodermosclerosis, superficial phlebitis	Yes
C5 and C6	Late stage venous disease	Severe skin changes, active or healed ulceration, bleeding from varicose vein	Yes

Revised CEAP clinical classification of chronic venous disease of the leg

Class	Definition	Comments	
C0	No visible or palpable signs of venous disease		
C1	Telangiectasis, reticular veins, malleol flare	Telangiectasis defined by dilated intradermal venules <1mm diameter	
		Reticular veins defined by dilated, nonpalpable, subdermal veins ≤3mm	

C2		Varicose veins	Dilated, palpable, subcutaneous veins generally >3mm diameter	
C3		Oedema without skin changes		
C4		Skin changes ascribed to venous disease		
	C4 A		Pigmentation, venous eczema, or both	
	C4 B		Lipodermatosclerosis, atrophie blanche, or both	
C5		Skin changes with healed ulceration		
C6		Skin changes with active ulceration		

*Adapted from: Eklof et al(2004),<http://www.hkma.org/english/cme/onlinecme/cme200908main.htm>]

Ventral/incisional Hernias (Surgical Repair of)

The surgical repair of ventral / incisional hernias is only funded where the hernia is symptomatic rather than a cosmetic/appearance issue.

Viral Warts

Viral warts are usually of aesthetic significance only and surgical removal is not routinely funded by the PCTs. However, the PCTs will fund removal of viral warts in patients who are immunocompromised.

Most viral warts will clear spontaneously or following application of topical treatments so should normally be treated in primary care. Painful, persistent or extensive warts (particularly in immuno-suppressed patient) may need specialist assessment by a GPwSI or a Dermatologist. For a small proportion surgical removal (cryotherapy,, cautery, laser or excision) may be appropriate. However, treatment of viral warts on the eyelid is problematic and these should be referred for consideration of treatment.

There are no restrictions on treatment of genital warts.

Xanthelasma

This procedure is not routinely funded.

APPENDIX A
INDIVIDUAL FUNDING REQUEST (IFR) SUBMISSION FORM

Clinicians can request funding for individuals that are eligible against the definitions of a **“rarity request”** or an **“exceptionality request”** as set out in the Policy and Operating Procedures for dealing with IFRs.

The IFR submission forms for Kent & Medway are available at:

www.westkentpct.nhs.uk/You and Your Health/Your Rights/Individual Funding Request

Contact for IFR Manager: 01732 375214

APPENDIX B
NICE GUIDANCE and ADDING ADDITIONAL PROCEDURES to the
REFERRAL & TREATMENT CRITERIA LIST

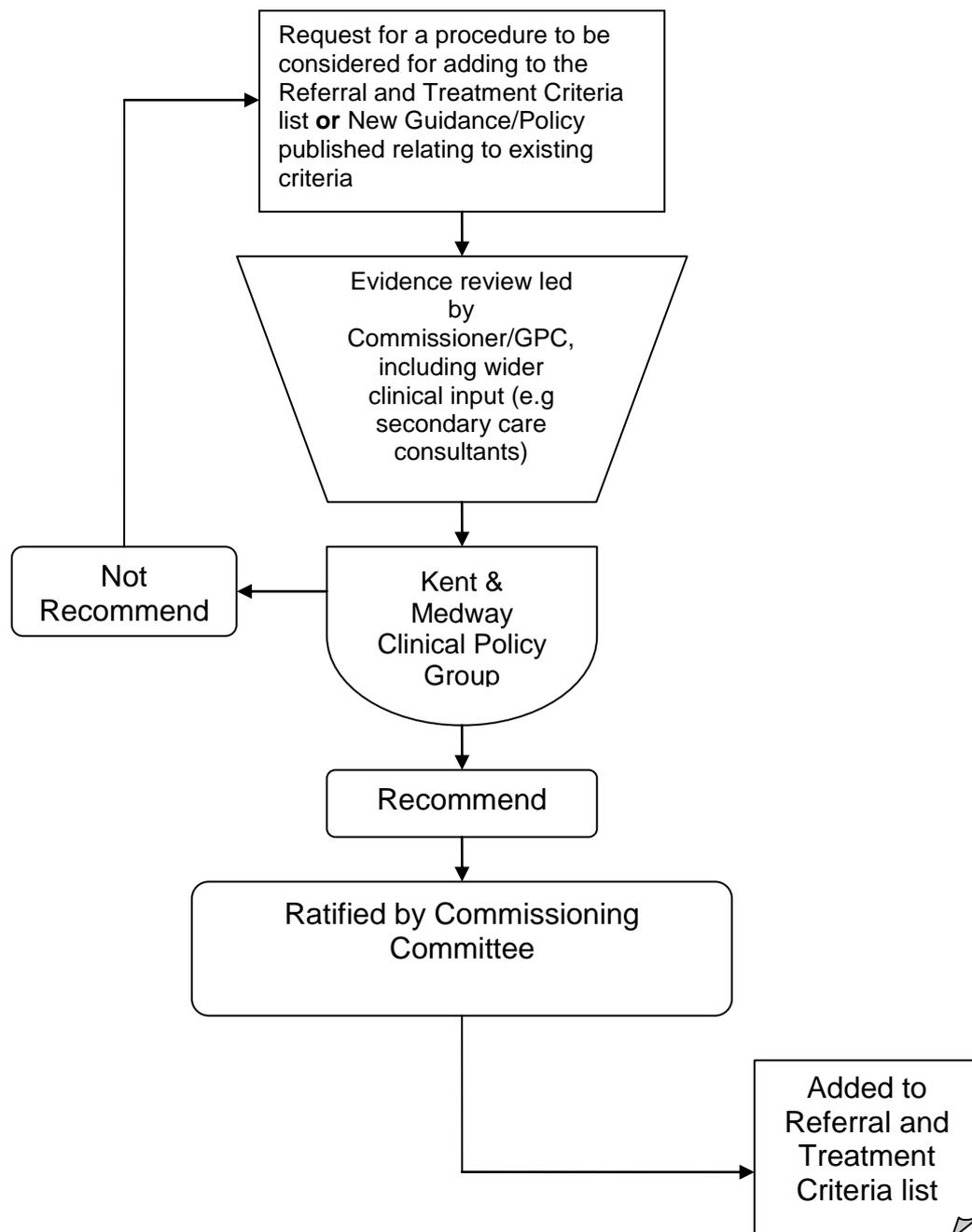
NICE Guidance

The Referral and Treatment Criteria will be reviewed by the relevant group in each PCT on an annual basis (a lead PCT will be agreed for each area), or when new guidance or policy issued.

NICE Guidance is summarised as follows:

1. Technology appraisals (TA) - PCTs must identify funding within 3 months of publication. The payment by results uplift includes funding for drugs which are not PbR excluded. Where the drug is PbR excluded funding arrangements must be agreed between the PCT and provider within 3 months of issue.
Impact on Referral and Treatment Criteria document – Automatically updated and amended in line with TA, policy change signed off through relevant PCT groups.
2. Clinical guidelines (CG) – These are recommendations of best practice but do not replace a clinician's knowledge or skills. CG's would be reviewed through the relevant PCT Strategic Change/Service Improvement groups. Clinical Guidelines can require changes in commissioning of services (including medicines management) and require full review.
Impact on Referral and Treatment Criteria document – Does not automatically change criteria. Full review would take place within PCTs and recommendations made regarding any changes.
3. Interventional procedures (IP) - NICE interventional procedures guidance protects patients' safety and supports people in the NHS in the process of introducing new procedures. Many of the procedures that NICE investigates are new, but they also look at more established procedures if there is uncertainty about their safety or how well they work. NICE do not look at cost effectiveness of IPs. Following the publication of an IP, Clinician's wishing to introduce a new service or change an existing service should submit a business case in the usual manner through the Trust and PCT.
Impact on Referral and Treatment Criteria document – Does not automatically change criteria. . Full review would take place within PCTs, following receipt of business case, and recommendations made regarding any changes.
4. NICE cancer service guidance – These are part of the national Improving Outcomes guidance and supports the implementation of the NHS Cancer Plan for England. The focus of this guidance is to guide commissioning decisions. It can be used to identify gaps in current provision and check appropriateness of existing services.
Impact on Referral and Treatment Criteria document – The PCTs would take advice and recommendations from the K&M Cancer Network and Lead Cancer Commissioners regarding guidance that may impact.
5. Public health guidance – This is taken into account by public health and will be embedded in their strategies for improving the health of the population.

To submit additional procedures to the referral and treatment criteria list the following process will be followed.



APPENDIX C
CHECK LIST FOR APPLICATION FOR CONSIDERING FUNDING FOR
COCHLEAR IMPLANTS IN UNDER 18'S

Please complete the check list below to indicate which of the following criteria the patient meets

Name of Consultant:	
NHS Trust :	
Consultant contact details:	e-mail: Tel:
Patient Name:	
Patient DOB:	
Patient NHS Number:	
GP Name:	

Does the child already have a cochlear implant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the child have severe to profound deafness (defined as hearing only sounds that are louder than 90dB HL at 2 and 4kHz without acoustic hearing aids in the better hearing ear)? Please provide relevant test results – audiograms etc.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has the child had a minimum of 3 months use of optimal digital hearing aids, prior to referral for assessment (unless contraindicated or inappropriate)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the patient receive adequate benefit from acoustic hearing aids?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has the child had a multidisciplinary assessment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has there been a failure to develop, progress or maintain speech, language and listening skills appropriate to the child's age, developmental stage and cognitive ability?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Has testing taken into account the child's disabilities (such as physical and cognitive impairments) or linguistic and other communication difficulties and taken into account the child's primary language?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Is the child morphologically suitable for electrode placement?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Is the child physically fit for surgery and rehabilitation?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Is there a willingness and commitment from parents and child to participation in implantation and long-term rehabilitation programme?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Have the parents and child been counselled and have realistic expectations of the outcome of implantation?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Is there support from relevant local services ?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Kent & Medway requests should be sent to:

ifr.wkpct@nhs.net

APPENDIX D
CHECK LIST FOR APPLICATION FOR CONSIDERING FUNDING FOR
COCHLEAR IMPLANTS IN OVER 18'S

Please complete the check list below to indicate which of the following criteria the patient meets

Name of Consultant:	
NHS Trust :	
Consultant contact details:	e-mail: Tel:
Patient Name:	
Patient DOB:	
Patient NHS Number:	
GP Name:	

Does the patient already have a cochlear implant?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Does the patient have severe to profound deafness (defined as hearing only sounds that are louder than 90dB HL at 2 and 4kHz without acoustic hearing aids in the better hearing ear) ? Please provide relevant test results	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Has the patient had a minimum of 3 months use of optimal digital hearing aids, prior to referral for assessment (unless contraindicated or inappropriate)?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Does the patient receive adequate benefit from acoustic hearing aids?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Has the patient had a multidisciplinary assessment?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Does the patient have a score of less than 50% on the Bamford-Kowal-Bench (BKB) sentence testing at a sound intensity of 70 dB SPL ? Please provide relevant test results	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Has testing taken into account the patient's disabilities (such as physical	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

and cognitive impairments) or linguistic and other communication difficulties and taken into account their primary language?	
Is the patient morphologically suitable for electrode placement?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is the patient physically fit for surgery and rehabilitation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is there a willingness and commitment from the patient to participation in implantation and a long-term rehabilitation programme?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Has the patient been counselled and has realistic expectations of the outcome of implantation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is there support from relevant local services?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is the patient blind or has other disabilities that increase their reliance on auditory stimuli as a primary sensory mechanism for spatial awareness?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Kent & Medway requests should be sent to:

ifr.wkpct@nhs.net

APPENDIX E
CHECK LIST FOR APPLICATION FOR CONSIDERING FUNDING FOR BONE
ANCHORED HEARING AIDS

Please complete the check list below to indicate which of the following criteria the patient meets

Name of Consultant:	
NHS Trust :	
Consultant contact details:	e-mail: Tel:
Patient Name:	
Patient DOB:	
Patient NHS Number:	
GP Name:	

Does the patient have abnormalities of the middle, outer or external parts the ear or a chronic ear infection, which makes wearing a conventional hearing aid difficult or impossible ?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the patient have at least moderate permanent hearing loss in one or both ears (≥ 41 -60dB) that cannot be effectively treated by conventional audiological, medical or surgical interventions e.g. cannot be operated on and for which conventional hearing aids are not felt to suitable ? Please provide the relevant test results	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Can the patient hear sounds well via bone conduction?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Can the patient understand 60% or more of speech on a standard test (i.e word recognition scores), using bone conduction? <i>(Not mandatory as part of checklist)</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the patient able to keep the area around the fixture clean?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the patient older than 5 years?	<input type="checkbox"/>	

	YES		NO	<input type="checkbox"/>
Does the patient have sufficient manual dexterity to remove or attach the external processor?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Is the patient able to accept the abutment that protrudes from the side of the head?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Kent & Medway requests should be sent to:

ifr.wkpct@nhs.net

APPENDIX F
PROCEDURE AND DIAGNOSTIC CODES AND AUDIT FRAMEWORK

The framework outlines the procedures and thresholds that will be identified and challenged through the monthly contracting processes.

PCTs may agree an audit schedule with providers in 2012/13 or may agree ad-hoc audits as a follow up to the audits completed in previous years..

Procedure	ACT to identify and challenge	PCT to Audit	OPCS Codes	Diagnosis Code	Specialty for audit	Comments
Acne Scarring	X		S601-2 S091-3,8-9 S103 S113 S601-2		Dermatology	
Arthroscopy of the knee		X	W871-879		Orthopaedics	
Bariatric surgery	X					
Bone Anchored hearing Aids			D132-6, 8-9		ENT	
Body Contouring Procedures:	X					
· Abdominoplasty/Apronectomy	X		S021-2,8-9		General Surgery	
· Brachioplasty / Upper Arm Lift	X		S033,8-9		General Surgery	
· Buttock Lift	X		S031,8-9		General Surgery	
· Calf Implants	X				General Surgery	
· Liposuction	X		S621-2		General Surgery	
· Neck Lift	X				General Surgery	
· Thigh Lift	X		S032-3,8-9		General Surgery	
· Upper Arm Reduction	X		S033,8-9		General Surgery	
Breast Procedures	X					
· Breast Augmentation	X		B312			
· Revision of Breast Augmentation			B295,B302,B314, B332, B374			
· Breast Reduction	X		B311			
· Nipple Eversion	X		B356		General Surgery	
· Gynaecomastia	X		B311	N62 N62X (See comment)	General Surgery	Male only. All activity with diagnosis codes N62 or N62X (Hypertrophy of Breast) should also be included
· Mastopexy	X		B312-3		General Surgery	
Carpal Tunnel Syndrome		X	A651,8-9		Orthopaedics	
Cataract Surgery		X	C751		Ophthalmology	
Cerebellar Stimulator Implants						
Chalazia	X		C121-6,8-9		Ophthalmology	
Chronic Fatigue Syndrome	X					
Circumcision		X	N303, Z426		General Surgery	
Closure of Patent Foramen Ovale for Migraine						
Cochlear Implants			D241-2	H653	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
Complimentary and Alternative Therapies						
· Acupuncture						
· Aromatherapy						
· Chinese Medicines						
· Chiropractic Therapy						
· Clinical Ecology						
· Herbal Remedies						
· Homeopathy						
· Hypnotherapy						
· Massage						
· Osteopathy						
· Reflexology						
Collagen Cross Linking					Ophthalmology	
Cryotherapy for Localised Prostate Cancer						
Cyberknife for Cholangiocarcinoma						
DaVinci Robotic Radical Prostatectomy for the Treatment of Prostate Cancer						
Dental Procedures						
· Asymptomatic Impacted Third Molars		X			Oral Surgery	

· Dental Extraction of Non-Impacted Teeth	X	X	F10		Oral Surgery	
· Dental extraction of wisdom teeth in children under general anaesthetic	X	X	F091-3		Oral Surgery	
· Dental Implants	X	X	F115 F08		Oral Surgery	
· Orthodontics		X	F14 F15		Oral Surgery	
Dilation and Curettage	X	X	Q101-3,8-9 Q181,8-9		Gynaecology	
Dupuytren's contracture	X	X	T521-2,8-9 T541,8-9		Orthopaedics	
Electrolysis			S606			
Excimer Laser Surgery for Short Sight	X		C461			
Excision of Redundant Skin or Fat	X		S031-3			
Facial Procedures						
· Blepharoplasty	X	X	C131-4,8-9		Ophthalmology	
· Brow Lift	X		S014-6,8-9			
· Face Lift	X		S011-3,8-9			
· Ptosis of eyelid	X	X	C151-2, C181-6,8-9		Ophthalmology	
· Pinnaplasty	X	X	D033	Q175	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Repair of Lobe of external ear	X		D031-2,4,8-9 D062		ENT	
· Rhinophyma	X		E011,8-9	L711	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Rhinoplasty/Septorhinoplasty	X		E021-6,8-9, E036 E073		ENT	
· Submental Lipectomy						
Female genital prolapse		X	M358-9 M531 P221-3,8-9 P231-4,8-9 P241-4,8-9		Gynaecology	
Female Sterilisation	X	X	Q271-2,8-9 Q281-4,8-9		Gynaecology	
Functional Electrical Stimulation (FES) for drop foot of central neurological origin					Neurology	
Ganglia (Wrist and Foot: Surgical Techniques for the Treatment of)	X	X	T591-4,8-9 T601-4,8-9		Orthopaedics	
Gender Dysphoria	X		X151-2			
Grommets		X	D151, 8-9 D202-3,8-9, D288-9	18 and under H650, H651, F80, Q90, Q35 Over 18 H654, H659, H919, H810, H68	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
Hair Transplant / Hair Graft/ Hair Replacement			S331-4,8-9 S341-2,8-9			
Hip & Knee replacements						
· Hip		X	W370-3,8-9 W380-3,8-9 W390-4,8-9		Orthopaedics	
· Knee		X	W400-3,8-9 W410-3,8-9 W420-4,8-9		Orthopaedics	
Hirsutism Treatment	X		S606	L680	Dermatology	
Hyperbaric Oxygen Therapy for Wound Healing	X		X521			
Hyperhidrosis	X					
Hysterectomy for Heavy Menstrual Bleeding		X	Q071-5,7-8 Q081-3,8-9		Gynaecology	

Inguinal hernia in adults		X			General Surgery	
Intra-uterine insemination (IUI), In vitro fertilisation (IVF) and Intracytoplasmic sperm injection (ICSI) - Assisted Conception Treatments for Sub-Fertility			Q134-Q137-Y96 inc Y961-Y969			
Labioplasty						
Laser Therapy / Laser Treatment for Aesthetic Reasons / Tunable Dye Laser	X		ICD Q825			
Male Sterilisation	X				General Surgery	
Minor Irregularities of Aesthetic Significance						
Open MRI Scan						
Penile Implants	X		N29			
Plastic Operations on Umbilicus						
Polysomnography in the Investigation of Children with Sleep-Related Disorders						
Private Treatment Available on the NHS						
Refashioning of Scar			S604		General Surgery	
Removal of Benign Skin Lesions		X	S038-9 S041-3,8-9 S051-5,8-9 S061-5,8-9 S081-3,8-9 S091-3,8-9 S101-4,8-9 S111-4,8-9		Dermatology (See comment)	Assessment must be completed by a Dermatologist. Activity that is assigned to another specialty must be included in audit.
Residential Pain Management Programmes						
Retractile Penis Surgery						
Reversal of Vasectomy / Reversal of Sterilisation	X		Q291-2,8-9 N181		General Surgery	
Salvage Cryotherapy for Recurrent Prostate Cancer						
Skin Grafts for Scars	X		S604			
Skin Resurfacing Techniques	X		S601-2 S091-3,8-9 S103 S113			
· Chemical Peels	X				Dermatology	
· Dermabrasion	X				Dermatology	
Spinal Cord Stimulation (SCS) for Ischaemic Pain			S483			
Spinal Fusion for the Treatment of Lower Back Pain	X	X			Orthopaedics	
Stereotactic Radiation Therapy						
Surgical procedures for the treatment of 'First Metatarsalphalangeal Joint pathology						
Tattoo Removal	X		S601-3			
Temporomandibular Joint Replacement						
Termination of Pregnancy		X			Gynaecology	
Tonsillectomies		X	F341-9	J350, G473, J36, L040	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
Traumatic Clefts due to Avulsion of Body Piercing						
Trigger finger	X		T705,8-9 T711,8-9 T728-9 T748-9 T652,8-9 T691,8-9	M200 M653	Orthopaedics	All procedure codes should be included for audit. Diagnosis codes are for information only.
Upper GI Endoscopy for the Investigation of Dyspepsia						
Varicose Veins	X	X	L841-6,8-9 L851-3,8-9 L861-2,8-9 L871-6,8-9 L881-3,8-9		Vascular Surgery	
Ventral/Incisional Hernias (Surgical repair of)			T251-3,T258-9,T261-4, T268-9,T271-4,T278-9			
Viral Warts	X			B081		
Xanthelasma	X			H026		

APPENDIX G
LISTING BY ACUTE SPECIALITY

Dermatology

- Acne Scarring
- Electrolysis
- Hair Transplant / Hair Graft/ Hair Replacement
- Hirsutism Treatment
- Hyperhidrosis
- Laser Therapy / Laser Treatment for Aesthetic Reasons /Tunable Dye Laser
- Removal of Benign Skin Lesions
- Skin Grafts for Scars
- Skin Resurfacing Techniques
 - Chemical Peels
 - Dermabrasion
- Tattoo Removal
- Traumatic Clefts due to Avulsion of Body Piercing
- Viral Warts

ENT

- Pinnaplasty
- Repair of Lobe of external ear
- Rhinophyma
- Rhinoplasty/Septorhinoplasty
- Submental Lipectomy
- Grommets
- Tonsillectomies

Gender Dysphoria

- Gender Dysphoria

General Surgery, Urology & Vascular

- Bariatric Surgery
- Breast Procedures
 - Breast Augmentation
 - Breast Reduction
 - Correction of Inverted Nipple
 - Gynaecomastia
 - Mastopexy
- Circumcision
- Brow Lift
- Face Lift
- Ganglia (Wrist and Foot: Surgical Techniques for the Treatment Of)
- Inguinal hernia in adults
- Male Sterilisation
- Minor Irregularities of Aesthetic Significance
- Penile Implants
- Retractable Penis Surgery
- Refashioning of Scar
- Reversal of Vasectomy / Reversal of Sterilisation

- Upper GI Endoscopy for the Investigations of Dyspepsia
- Ventral/Incisional Hernias (Surgical repair of)
- Varicose Veins

Gynaecology

- Dilation and Curettage
- Female genital prolapse
- Female Sterilisation
- Hysterectomy for Heavy Menstrual Bleeding
- Labiaplasty
- Reversal of Vasectomy/Reversal of Sterilisation
- Termination of Pregnancy

Neurology

- Cerebellar Stimulator Implants
- Chronic Fatigue Syndrome
- Closure of Patent Foramen Ovale for Migraine
- Functional Electrical Stimulation (FES)

Oncology

- Cryotherapy for Localised Prostate Cancer
- Cyberknife for Cholangiocarcinoma
- DaVinci Robotic Radical Prostatectomy for the Treatment of Prostate Cancer
- Salvage Cryotherapy for Recurrent Prostate Cancer
- Stereotactic Radiation Therapy

Ophthalmology

- Cataract surgery
- Chalazia
- Collagen Cross Linking
- Refractive eye surgery
- Blepharoplasty
- Ptosis of eyelid
- Xanthelasma

Oral Surgery

- Dental Procedures
 - Asymptomatic Impacted Third Molars
 - Dental extraction of Non-Impacted Teeth
 - Dental extraction of wisdom teeth in children under general anaesthetic
 - Dental Implants
 - Orthodontics
- Temporomandibular Joint Replacement

Other

- Complimentary and Alternative Therapies
- Hyperbaric Oxygen Therapy for Wound Healing
- Intra-uterine insemination (IUI), In vitro fertilisation (IVF) and Intracytoplasmic sperm injection (ICSI) - Assisted Conception Treatments for Sub-Fertility

- Private Treatment Available on the NHS
- Residential Pain Management Programmes

Orthopaedics

- Arthroscopy of the knee
- Carpal Tunnel Syndrome
- Dupuytren's contracture
- Hip & Knee replacements
- Spinal Cord Stimulation (SCS) for Ischaemic Pain
- Spinal Fusion for the Treatment of Lower Back Pain
- Surgical procedures for the treatment of 'First Metatarsalphalangeal Joint pathology'
- Trigger finger

Paediatrics

- Polysomnography in the Investigation of Children with Sleep-Related Disorders

Plastic Surgery

- Body Contouring Procedures:
 - Abdominoplasty/Apronectomy
 - Brachioplasty / Upper Arm Lift
 - Buttock Lift
 - Calf Implants
 - Liposuction
 - Neck Lift
 - Thigh Lift
 - Upper Arm Reduction
- Excision of Redundant Skin or Fat
- Plastic Operations on Umbilicus

Radiology

- Open MRI Scan