



Kent and Medway clinical commissioning groups' (CCGs') schedule of policy statements for health care interventions, and referral and treatment criteria

Issued by: NEL CSU Health Care Intervention Appraisal and Guidance (HCiAG) team

On behalf of: Kent and Medway Clinical Commissioning Groups (NHS Ashford Clinical Commissioning Group [CCG]; NHS Canterbury and Coastal CCG; NHS Dartford, Gravesham and Swanley CCG; NHS Medway CCG; NHS South Kent Coast CCG; NHS Swale CCG; NHS Thanet CCG; NHS West Kent CCG)

Applies from: April 2017

NEL CSU HCiAG team contact details

NEL CSU Health Policy Support Unit (HPSU)

36–38 Friars Walk

Lewes

BN7 2PB

Email: nelcsu.hpsu@nhs.net

Introduction

This schedule of commissioning policy statements sets out Kent and Medway Clinical Commissioning Groups (CCGs) decisions on whether a particular health care intervention is to be made available for persons for whom each CCG has responsibility.

For each health care intervention considered, the policy statement will identify either:

- that it is not routinely funded within the local NHS, or
- the criteria that must be met before it can be funded

The schedule of policy statements is incorporated into all NHS standard contracts agreed by Kent and Medway CCGs. CCGs will not pay for activity unless it meets the criteria set out in this schedule of policy statements or individual approval has been given through the agreed individual funding request (IFR) process.

The schedule of policy statements is also intended to be a guidance document for clinicians and other referrers in primary and secondary care. Its use by GPs is encouraged to help ensure that referrals to secondary care are appropriate, and to manage patient expectations regarding their likely treatment.

There is, however, no blanket ban on the health care interventions covered by policy statements. There is an established mechanism for dealing with individual funding requests (IFRs), in cases where interventions are not routinely funded. A link to 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 the Policy and Operating Procedures for dealing with IFRs) can be found in Appendix A. Patients who fulfil criteria for treatment do not need to be considered by the IFR team.

Procedures covered by local policy statements will be subject to periodic audits to ensure adherence to the criteria. An audit framework is set out in Appendix B.

The schedule of policy statements will be updated regularly to include new policies agreed by all Kent and Medway CCGs, and detail instances where commissioning responsibility has transferred to NHS England.

For High Cost Drugs, please refer to the Kent and Medway Health Economy High Cost Drugs Manual (HCD Manual).

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1 Assisted reproductive technologies

Refer to Kent and Medway CCGs' schedule of policy statements for assisted reproductive technologies (ART) for details of policies and associated eligibility criteria.

2 Dermatology

2.1 Acne scarring

Background

Acne scarring can sometimes develop as a complication of acne. Any type of acne spot can lead to scarring, but it is more common when the most serious types of spots (nodules and cysts) burst and damage nearby skin. Scarring can also occur if acne spots are picked or squeezed.

Policy

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

2.2 Electrolysis for hair removal

Background

Electrolysis treats each hair follicle individually, with a very fine, disposable, sterile probe to permanently destroy the follicle's ability to reproduce, thereby eradicating hair growth on completion of the course of treatment.

Policy

This procedure is not routinely funded.

Where appropriate see separate policy on gender dysphoria.

2.3 Hair transplant/ hair graft/ hair replacement

Background

There are many types of hair loss with different symptoms and causes. In certain circumstances, people may be eligible for free or reduced cost wigs on the NHS. More information on buying wigs and NHS policy is available [here](#).

Policy

Hair replacement/ hair transplant/ grafting is not routinely funded.

2.4 Hirsutism (hair removal procedures for the treatment of)

Background

Hirsutism is the growth of excess terminal hair (which is dark, thick, and coarse as opposed to vellus hair, which is soft, fine, and unpigmented) on the face, chest, linea alba (midline of the abdomen), lower back, buttocks, and anterior thighs in women. Vellus hair does not indicate hirsutism. Some hair growth in androgen dependent areas is normal, and there is no clear cut-off for defining excessive hair growth.

Policy

Hair removal procedures (e.g. electrolysis and laser hair removal) for hirsutism are not routinely funded.

2.5 Hyperhidrosis

Background

Hyperhidrosis can be defined as sweating in excess of the body's homeostatic requirements, and can range from moderate moisture to severe dripping.

Primary hyperhidrosis only affects certain parts of the body, most commonly the armpits, then the feet and hands or more rarely, the face or scalp; some patients exhibit primary hyperhidrosis at more than one location. Symptoms typically start during childhood or adolescence and peak in the third decade. Hyperhidrosis can lead to emotional and physical impairment, affecting professional and social activities and reducing health-related quality of life.

Policy

- Patients with a Hyperhidrosis Disease Severity Scale (HDSS) score of 1–2 should be treated in primary care and not referred to secondary care (see pages 14–16 for treatment algorithm)
- Refer to a dermatologist if there is evidence that treatment (first-line: topical aluminium chloride; second-line: oral systemic anticholinergics [oxybutynin or propantheline; see below regarding glycopyrrolate]) in primary care have been provided and proved unsuccessful (or are contra-indicated) and the patient has an HDSS score of 3–4.
- Prescribing of oral systemic glycopyrrolate is not routinely commissioned (in primary or secondary care) for newly diagnosed patients with hyperhidrosis. Existing patients receiving oral glycopyrrolate should be assessed and switched to oxybutynin or propantheline whenever possible, or referred as appropriate (see below).
- Tap-water iontophoresis is commissioned for palmoplantar and axillary hyperhidrosis provided:
 - Patient has an HDSS score of 3–4 AND there is evidence that treatment in primary care (as outlined above) has been provided and proved unsuccessful

Continued overleaf

Patients receive initial treatment (7 sessions) in the hospital setting. Maintenance therapy varies according to the individual. The addition of anticholinergic drugs (e.g. glycopyrrolate) to water is not routinely funded.

- Botulinum toxin type A (BTX-A) is commissioned for axillary hyperhidrosis provided:
 - Patient has an HDSS score of 3–4 AND there is evidence that treatment in primary care (as outlined above) has been provided and proved unsuccessful

If successful, treatment may be repeated when sweat production is back to 50% of baseline (or HDSS score of 3 or 4), with a minimum treatment interval of 6 months (i.e. maximum of two BTX-A treatments per year).

- BTX-A is not routinely funded for palmar, plantar or craniofacial hyperhidrosis
- Endoscopic Thoracic Sympathectomy (ETS) is not routinely commissioned

Rationale

It is widely recommended by experts that treatment depends on disease severity, focal location and patient preferences, but usually follows a step-by-step approach moving from conservative to more invasive interventions. The level of evidence to support the use of each intervention at different anatomical sites varies considerably.

Topical aluminium chloride

Although the evidence for topical aluminium salts is limited, it is widely recommended by experts for the initial management of primary focal hyperhidrosis.

Oral anticholinergics

Propranolol is the only oral anticholinergic licensed for hyperhidrosis. Oxybutynin hydrochloride is used off-label and oral preparations of glycopyrronium bromide (glycopyrrolate) are not licensed or available in the UK for treating hyperhidrosis – they must be either imported or prepared by ‘specials’ manufacturers.

There is only limited evidence that oral glycopyrrolate reduces sweating in this population, and even less for oral propranolol. Oxybutynin appears to be a reasonable alternative to glycopyrrolate considering the evidence base for oxybutynin is at least as good, and it offers savings on drug costs.

Continued overleaf

Iontophoresis

Clinical opinion and several small studies support tap water iontophoresis in palmoplantar disease. Clinical opinion also suggests iontophoresis for axillary disease may be effective in practice, despite a lack of compelling, published evidence. The evidence for adding glycopyrronium bromide solution is more limited (compared to tap-water iontophoresis), is associated with systemic adverse events and drug costs are high.

BTX-A

BTX-A is only licenced for hyperhidrosis of the axillae. Several large randomised controlled trials have demonstrated the effectiveness of BTX-A for treating axillary disease. BTX-A for palmar and plantar hyperhidrosis is more painful and the evidence base is less robust (especially for plantar disease). Also, higher doses of BTX-A per hand or sole than per axillae are generally required and transient muscle weakness has been reported. There is only limited evidence for BTX-A for craniofacial hyperhidrosis.

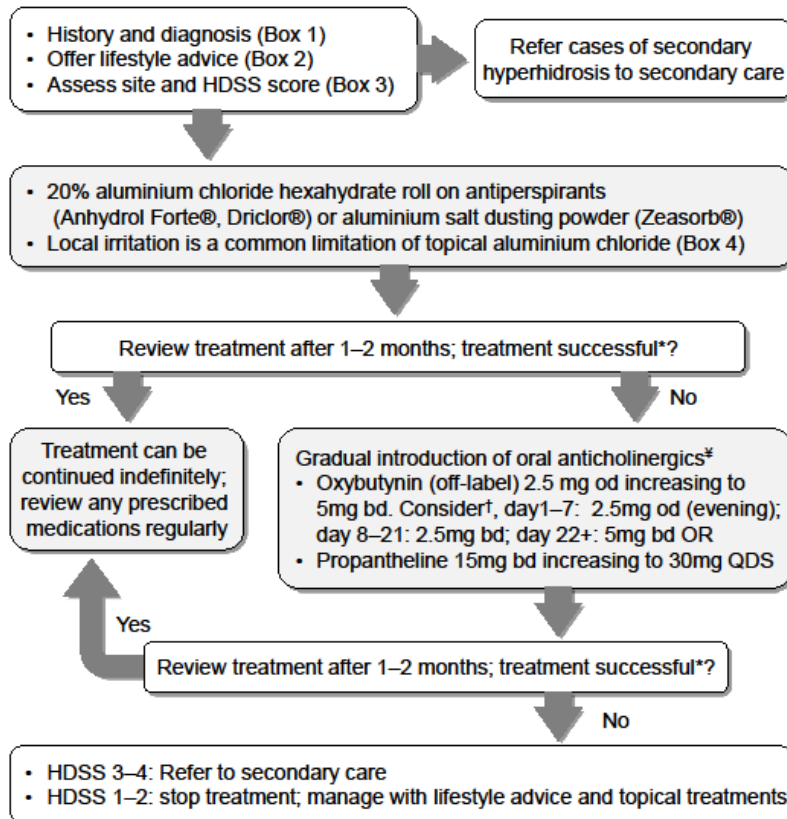
Surgery

Endoscopic Thoracic Sympathectomy (ETS) – the most widely used surgical procedure for hyperhidrosis – is major surgery performed under a general anaesthetic and carries a significant risk of irreversible side effects and complications.

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Treatment algorithm

Primary care

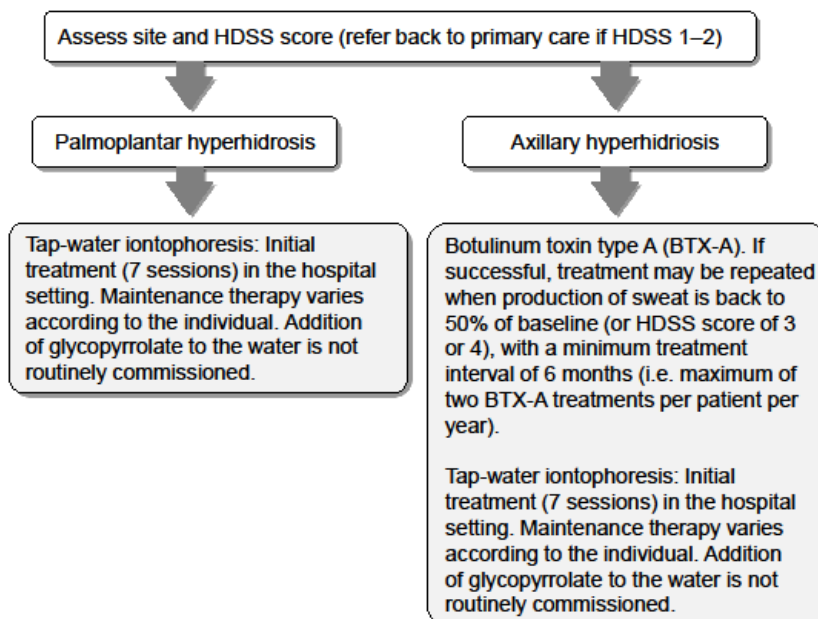


* Successful treatment: Reduction in HDSS score from 3–4 to 1–2. Treatment failure: no change in HDSS or lack of tolerability for treatment.

‡ Glycopyrrolate (unlicensed) is not routinely commissioned. Existing patients should be assessed and switched whenever possible.

† Wolosker N et al. *J Vasc Surg* 2012;55:1696–700.

Secondary care



Continued overleaf

Box 1 – Diagnosis of hyperhidrosis

Primary focal hyperhidrosis can be diagnosed when focal, visible, excessive sweating occurs in at least one of the following sites: axillae, palms, soles, or craniofacial region, and:

- has lasted at least 6 months, and
- has no apparent cause, and
- has at least two of the following characteristics:
 - bilateral and relatively symmetrical
 - impairs daily activities
 - frequency of at least one episode per week
 - onset before 25 years of age
 - positive family history
 - cessation of local sweating during sleep

If symptoms have lasted less than 6 months or onset is at 25 years of age or older, primary focal hyperhidrosis remains a likely diagnosis if other criteria are met, but extra care should be taken to exclude an underlying cause.

If the presentation is characteristic, and there is no evidence of an underlying cause, no laboratory tests are needed.

For people with suspected secondary focal or generalised hyperhidrosis, the history, examination, and investigations should look for an underlying cause. Appropriate management will often include a referral to secondary care.

Box 2 – Lifestyle advice

Managing patient expectations is important. Give links to patients for further information: Hyperhidrosis Support Group (www.hyperhidrosisuk.org/). Patients should be advised:

- to avoid known triggers that make sweating worse, such as spicy foods, crowded rooms alcohol and caffeine
- to use antiperspirant spray frequently, rather than deodorants
- to avoid wearing tight, restrictive clothing and man-made fibres, such as nylon
- that wearing black or white clothing can help to minimise the signs of sweating
- that armpit shields can help to absorb excessive sweat and protect your clothes (these can be obtained via the internet or the Hyperhidrosis Support Group)
- to wear socks that absorb moisture, such as thick, soft socks that are made of natural fibres, or sports socks designed to absorb moisture. Avoid wearing socks that are made out of synthetic materials and change socks at least twice a day.
- to buy shoes that are made of leather, canvas or mesh, rather than synthetic material
- to avoid using soap-based cleansers, especially when using aluminium salts. Use emollient washes and moisturisers instead.

Box 3 – Hyperhidrosis Disease Severity Scale (HDSS) score

Measuring the impact on health-related quality of life may reflect the severity of hyperhidrosis more accurately than isolated quantitative measurements of sweat production, since the level of sweating which causes problems varies between individuals. The easy to use and validated Hyperhidrosis Disease Severity Scale (HDSS) should be used (<http://www.sweathelp.org/pdf/HDSS.pdf>):

How would you rate the severity of your hyperhidrosis?

1	My sweating is never noticeable and never interferes with my daily activities	Mild
2	My sweating is tolerable but sometimes interferes with my daily activities	Moderate
3	My sweating is barely tolerable and frequently interferes with my daily activities	Severe
4	My sweating is intolerable and always interferes with my daily activities	Severe

Continued overleaf

Box 4 – Application of topical treatments

- Anhydrol Forte®, Driclor® should be:
 - applied to dry skin of the axillae, feet, hands, or face (avoiding the eyes). Initially for a few hours, gradually increasing to overnight. Care should be taken to ensure that the area of application is completely dry and that the skin is not shaved for 24hrs before or after application.
 - always washed off at the first sign of significant sweating and in the morning
 - used every 1–2 days, as tolerated, until the condition improves and then as required, which may be up to every 6 weeks
- Consider soaking lotion pads for application to the face
- For plantar hyperhidrosis, Zeasorb® can be used
- Local irritation is a common limitation of topical aluminium chloride. It can be managed by the use of topical emollients and soap substitutes, a reduction in the frequency of application, or giving a short course of 1% hydrocortisone cream for up to 2 weeks.

2.6 Laser therapy/ laser treatment for aesthetic reasons/ tunable dye laser

Background

The refinement of laser technology has created new therapeutic options for issues ranging from insignificant blemishes and tattoos, to extreme and disfiguring birth marks.

Policy

These procedures are not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Post haemangioma involution redness (head and neck area) in children aged ≤18 years, *or*
- Rhinophyma when referred by a consultant

Commissioning responsibility for skin conditions requiring laser therapy is with NHS England under some circumstances (<http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>).

Commissioning responsibility for rhinophyma under some circumstances is with NHS England (<http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

2.7 Refashioning of scar

Background

A scar is a mark that is left on the skin after a wound or an injury to the surface of the skin has healed. Scars are very common.

Policy

Refashioning of scars is not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Documented post-surgical keloid scarring, *or* abnormal post-surgical scarring (i.e. traumatic, poorly designed, poorly healed, or disease-related scar) where consultant confirms scarring is abnormal

Commissioning responsibility for keloid scars under some circumstances is with NHS England (<http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

2.8 Removal of benign skin lesions

Background

This policy statement only applies to removal of the following benign skin lesions: benign melanocytic naevi, cysts (pilar, epidermoid, sebaceous), seborrhoeic keratoses (basal cell papilloma), haemangiomas, lipomata, neurofibromata, dermatofibromata, and fibroepithelial polyp.

Policy

- Kent and Medway CCGs will fund removal of benign skin lesions where the lesion is associated with any one of the following:
 - repeated infection, inflammation or discharge
 - bleeding in the course of normal everyday activity
 - pain
 - obstruction of an orifice to the extent that function is or is likely to become impaired
 - pressure symptoms e.g. on an organ, nerve or tissue
- Or where the lesion:
 - is subject to recurrent trauma, *or*
 - if left untreated, would require a more invasive intervention for removal
- The following are outside the scope of the above policy statement:
 - removal of lesions that are malignant, pre-malignant or have malignant potential
 - removal of lesions other than those listed above
 - removal of lesions under GMS 'additional services'

Continued overleaf

Commissioning responsibility for skin conditions requiring laser therapy is with NHS England under some circumstances (<http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

Rationale

In the absence of evidence from the research literature, the above eligibility criteria were identified by local clinicians participating in a consensus exercise.

2.9

Rhinophyma

Background

Rhinophyma is a swelling of the nose. If the condition progresses, the nose becomes redder, swollen at the end and gains a bumpy surface which changes its shape. The condition is mainly seen in those who have rosacea, a rash that can affect the cheeks, forehead and nose. Rhinophyma usually only develops in rosacea which has been active for many years.

Policy

Treatment for rhinophyma is not routinely funded by Kent and Medway CCGs except where there is evidence of impairment of visual fields in the relaxed, non-compensated state. An initial referral to an ophthalmologist is required to establish this.

Commissioning responsibility for rhinophyma under some circumstances is with NHS England (<http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf>). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

2.10 Skin grafts for scars

Background

A skin graft is a surgical procedure that removes healthy skin from an unaffected area of the body to replace lost or damaged skin.

Policy

This procedure is not routinely funded except in the following circumstances:

- for burns, *or*
- as part of reconstruction following major trauma

2.11 Skin resurfacing techniques

Background

The aim of skin resurfacing techniques is to make the skin look smoother and healthier. All skin resurfacing techniques achieve results by injuring the skin; as the healing process progresses a new, smoother skin usually emerges. Chemical peels involve the application of a caustic solution, dermabrasion uses a rapidly rotating device to sand the outer layers of skin, and laser resurfacing uses a laser beam.

Policy

Skin resurfacing techniques (e.g. chemical peels, dermabrasion and laser therapy) are not routinely funded.

2.12 Tattoo removal

Policy

Tattoo removal is not routinely funded unless the tattoo was applied under duress and where it is a source of continuing allergic phenomena.

Prior approval is required (ifr.secsu@nhs.net).

2.13 Traumatic clefts due to avulsion of body piercing

Policy

Surgical refinement of traumatic clefts due to avulsion of body piercing is not routinely funded.

2.14 Viral warts

Background

Warts are small, rough growths which are caused by certain strains of the human papilloma virus (HPV). They can appear anywhere on the skin but are most commonly seen on the hands and feet. Although warts can be cosmetically unsightly, they are not harmful, usually do not cause symptoms, and most resolve without treatment. Warts can generally be managed in primary care.

Policy

Surgical removal of warts is not routinely funded, except in patients who are immunocompromised. Painful, persistent or extensive warts (particularly in immunocompromised patients) may need specialist assessment by a GP with a Special Interest (GPwSI) or a dermatologist. For a small proportion removal may be appropriate. 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.

3 Endocrinology

3.1 Continuous glucose monitoring (CGM) for adults with type 1 diabetes mellitus (T1DM)

Background

Continuous glucose monitoring (CGM) systems provide real-time measurements of glucose levels 24 hours a day, displayed every few minutes. Users can set alarms to indicate when glucose levels are too high or too low. CGM systems use a tiny sensor inserted under the skin to check glucose levels. This information is sent wirelessly to a remote, portable monitor. CGM systems measure glucose in the interstitial fluid rather than the blood. There is a lag between the blood and interstitial glucose levels, particularly at times of rapid blood glucose change. Consequently, the user will still need to check blood samples with a conventional glucose meter to calibrate the CGM system (typically once or twice per day), before making a change in treatment, and (if a driver) to meet DVLA requirements.

CGM can be used as a stand-alone device by people who are on insulin pump therapy or who use multiple daily injections for insulin delivery. CGM can also be used as part of an integrated sensor-augmented pump therapy system, in which an insulin pump and CGM work together.

Policy

Real-time continuous glucose monitoring (CGM) is not routinely funded by Kent and Medway CCGs for people with type 1 diabetes mellitus (T1DM).

Rationale

NICE guideline [17](#) (2015) on the management of T1DM in adults recommends that CGM is not routinely offered but could be considered when standard management of blood glucose levels has not worked or been difficult (specific criteria apply). It was concluded in NICE NG17 that though there is some evidence of clinical benefit for CGM, this is not compelling and CGM is not currently a cost-effective intervention, even in people who have impaired awareness of hypoglycaemia; more evidence is needed to establish the clinical and cost effectiveness of CGM technologies.

Continued overleaf

According to NICE diagnostics guidance 21 (2016) on integrated sensor-augmented pump therapy systems, the MiniMed Paradigm Veo system is recommended as an option for managing blood glucose levels in people with T1DM who meet specific criteria. The Vibe and G4 PLATINUM CGM system is not recommended. However, it was concluded in DG21 that the overall evidence base to support using these devices is weak; robust data needs to be generated to support the claimed benefits of these technologies and their reimbursement value.

The evidence base for CGM use does not appear compelling at the moment in the context of the resources currently available to Kent and Medway clinical commissioning groups (CCGs). The rapid pace of development of new technologies designed to help with monitoring blood glucose levels has been noted; this topic will therefore be reconsidered in the near future.

3.2 FreeStyle Libre flash glucose monitoring system for adults with diabetes mellitus

Background

The FreeStyle Libre flash glucose monitoring system consists of a sensor disc (similar in size to a £2 coin) attached to the skin of the upper arm and a handset reader. The sensor measures interstitial fluid glucose levels in people with diabetes mellitus. The FreeStyle Libre allows the user to check glucose levels and trends without performing finger-prick testing, but unlike continuous glucose monitoring systems, it does not notify the user of adverse events such as hypoglycaemia as they happen. A finger-prick test using a blood glucose meter is still required during times of rapidly changing glucose levels when interstitial fluid glucose levels may not accurately reflect blood glucose levels, or if hypoglycaemia or impending hypoglycaemia is reported, or the symptoms do not match the system readings. In addition, users will still need to do finger-prick blood tests to meet DVLA requirements.

Policy

The FreeStyle Libre flash glucose monitoring system is not routinely funded on the local NHS for any patient group.

Rationale

The evidence base for the FreeStyle Libre flash glucose monitoring system is not sufficiently compelling in the context of the resources currently available to Kent and Medway CCGs.

4.1 Bone anchored hearing aids

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

4.2 Cochlear implants

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

4.3 Grommets

Background

Grommets, also known as tympanostomy tubes or ventilation tubes, are small tubes that are surgically inserted in the ear drum to aerate the middle ear.

A grommet will help keep the eardrum open for several months. As the eardrum starts to heal, the grommet will slowly be pushed out of the eardrum and will eventually fall out. Most grommets will fall out within 6–12 months of being inserted.

The main indications for grommets are otitis media with effusion (OME), Eustachian tube dysfunction and Ménière's disease. OME is most common during childhood.

Policy

Adults

Grommets for adults are not routinely funded, except 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 6 months (for new referrals) in secondary care before a decision is made to treat, *or*
- Persistent Eustachian tube dysfunction resulting in pain (e.g. flying), *or*
- As treatment for Ménière's disease, *or*
- 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.

Continued overleaf

Children under the age of 18:

Grommets for children are not routinely funded, except in the following circumstances:

- Severe collapse (retraction) of the ear drum, *or*
- Progressive atelectasis of the tympanic membrane, *or*
- Otitis media with effusion (OME) in accordance with recommendations listed in NICE [CG60](#)¹ following formal assessment

Adenoidectomy for otitis media in children is not routinely funded, except when combined with grommets in children who meet the criteria specified in NICE CG60.

¹Although CG60 only pertains to people aged under 12, this policy applies to people aged under 18.

Rationale

The policy on grommets for children with OME is consistent with NICE [CG60](#) and commissioning guidance from the Royal College of Surgeons of England and ENT UK.

Overall there is a lack of evidence for the insertion of grommets in adults. Clinical Commissioning Groups (CCGs) are currently under considerable financial strain and need to prioritise funding of procedures where there is good evidence to suggest they result in health gain. Consequently, watchful waiting is recommended for adults with OME for 6 months.

4.4 Prominent ears (surgical correction of)

Background

Ear prominence is very common. Although there are no functional problems associated with prominent ears, this condition can lead to low self-esteem and psychological morbidity, particularly in childhood and adolescence.

After the age of 6 months, surgical correction (pinnaplasty or otoplasty) is currently the only available method of addressing prominent ears.

It is anticipated that in the majority of cases, GPs will be able to verify whether the patient is suffering from substantial psychological distress that would be relieved by pinnaplasty or otoplasty. If there is any doubt regarding psychological distress the child may benefit from referral for a psychological assessment.

Policy

Surgical correction of prominent ears is not routinely funded except in the following circumstances:

- the person is aged <16 years at the time of surgery *and*
- the child rather than the parents alone, expresses substantial psychological distress.

4.5 Repair of lobe of external ear

Policy

Surgery to repair the lobe of external ear is not routinely funded except for completely split ear lobes as a result of direct trauma.

4.6 Rhinoplasty/ septorhinoplasty

Background

Rhinoplasty is a procedure used to reshape the nose. Septoplasty is a surgical procedure to correct a deviated nasal septum. Septoplasty is sometimes combined with rhinoplasty (septorhinoplasty).

Policy

These procedures are not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Objective nasal deformity caused by trauma, *or*
- Correction of complex congenital conditions, unless the commissioning responsibility of NHS England*

Prior approval is required (ifr.secsu@nhs.net) for complex or severe cases of nasal septal deviation that is not post-traumatic. Applications for septorhinoplasty must demonstrate a clear clinical need for surgery and must be made by a consultant.

*Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

4.7 Tonsillectomies ± adenoidectomies

Background

Tonsillectomy is a very common surgical procedure where each tonsil is removed from a recess in the side of the pharynx called the tonsillar fossa. Tonsils are important lymph tissue that protects the upper airways; they tend to atrophy in early adulthood.

For children, the adenoids are usually removed at the same time as the tonsils, a procedure called adenoidectomy, or adenotonsillectomy when combined.

Policy

Tonsillectomy ± adenoidectomy is not routinely funded except in people who fulfil the criteria outlined below:

- Recurrent tonsillitis: ≥7 well documented, clinically significant, adequately treated sore throats in the preceding year or ≥5 such episodes in each of the preceding two years or ≥3 such episodes in each of the preceding three years. Episodes of sore throat must be due to acute tonsillitis and must be disabling and prevent normal functioning, OR
- Peritonsillar abscesses (PTA): ≥2 episodes resulting in hospital stay or one episode resulting in hospital stay plus a history of recurrent tonsillitis, OR
- Tonsillar hypertrophy causing upper airway obstruction in people aged under 16, OR
- Sleep disordered breathing in people aged under 16 demonstrated by accepted method of diagnosis including sleep study, which impacts on development, behaviour or quality of life, OR
- Malignancy: Suspicion or evidence of malignancy. Patients should be referred and treated as appropriate, OR
- Other: People with specific clinical conditions that require tonsillectomy as part of their on-going management strategy (e.g. psoriasis, nephritis, periodic fever aphthous pharyngitis and cervical adenopathy [PFAPA] syndrome)

Continued overleaf

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

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.

Rationale

The most common indication for tonsillectomy is recurrent sore throat. Whilst the tonsils are considered to play an important role in the causation of chronic/ recurrent acute throat infections, they are probably not the only factor responsible. The indications for tonsillectomy within this patient group are therefore controversial and opinions vary greatly as to whether or not the benefits outweigh the risks. The eligibility criteria detailed in this policy are supported by current SIGN guidance [117](#) on the management of sore throat (2010) and professional society guidance (2013). There is no formal NICE guidance on indications for tonsillectomy. However, NICE have issued interventional procedure guidance (IPG) recommending that current evidence on the safety and efficacy of different tonsillectomy procedures appears adequate to support the use of these techniques.

5 Gender dysphoria

5.1 Gender dysphoria

'Core' procedures for patients with gender dysphoria are funded by NHS England:

- Psychotherapy and counselling
- Hormone therapy
- Speech therapy
- Hair removal
- Genital reassignment surgery
- Mastectomy and hysterectomy (for F to M patients)

For more information, see the NHS England website:

<http://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c05/>

'Non-core' procedures are described by NHS England as being those not exclusive to gender reassignment; these are the commissioning responsibility of CCGs and may include:

- Breast augmentation
- Facial feminisation surgery
- Lipoplasty/ contouring
- Gamete storage

Kent and Medway CCGs do not have a specific policy on funding of procedures for patients with gender dysphoria; funding will be available where the policy relating to the procedure in question indicates that the patient is eligible. Appropriate individual funding requests (IFRs) will always be considered through Kent and Medway CCGs' IFR process.

6 General surgery, urology and vascular

6.1 Bariatric surgery in adults

Bariatric surgery in adults became the commissioning responsibility of CCGs in April 2017. A Kent and Medway wide policy on access to tier 3 and tier 4 obesity services is currently under development. Please contact individual CCGs for their current commissioning policies on bariatric surgery and revision of bariatric surgery.

6.2

Brow-lift

Policy

This procedure is not routinely funded.

6.3

Divarication of rectus abdominis muscles (surgical repair of)

Background

Diastasis recti or divarication of the rectus abdominis muscles describes the separation of the two rectus muscles, usually as a result of the linea alba thinning and stretching. Divarication of rectus muscles is normally considered a cosmetic condition as it does not carry the risks of a true hernia like strangulation of contents.

Surgical correction of rectus divarication can be undertaken in combination with an abdominoplasty to improve appearance. Alternatively the rectus abdominis muscles can be repaired via a simple midline incision.

Policy

- Surgical repair of divarication of rectus abdominis muscles in combination with abdominoplasty is not routinely funded for any patient group
- Surgical repair of divarication of rectus abdominis muscles via midline incision will only be funded:
 - in combination with umbilical hernia repair, where the patient fulfils any relevant criteria for the latter, *and*
 - provided that umbilical hernia repair is coded as the primary procedure

Rationale

There is some evidence to suggest that umbilical hernias are more likely to recur following repair where rectus divarication is present. An abdominoplasty approach would be done only for cosmetic reasons.

6.4 Elective hernia repair in adults (including use of biological meshes)

Background

A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. This policy relates to four types of hernia:

- Inguinal hernias occur in the groin; they are the most common type of hernia and mostly affect men.
- Umbilical hernias occur in the abdomen.
- Incisional hernias are iatrogenic; they occur through a previously made incision in the abdominal wall, normally a scar left from a previous surgical operation.
- Femoral hernias are an uncommon type of hernia; they occur in the groin. Unlike inguinal hernias, femoral hernias occur more frequently in women.

Hernia repair involves replacement and securing of the tissue or bowel back into the abdomen. In some cases a mesh is placed over the hole and fixed using fine stitches to strengthen the area. Meshes can be either synthetic or biological. A synthetic mesh consists of a polymer base but can vary in chemical composition. Biological meshes can be derived from human, porcine or bovine tissue and be composed of dermal, pericardial or intestinal submucosa tissue. The tissue is decellularised to leave a collagen matrix and some are chemically cross-linked.

Policy

Inguinal hernia repair

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic inguinal hernias in adults. Adults 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:
 - A history of incarceration of, or real difficulty reducing, the hernia
 - An inguino-scrotal hernia
 - Increase in size month to month

Continued overleaf

Umbilical hernia repair

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic umbilical hernias in adults. Adults 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:
 - A history of incarceration of, or real difficulty reducing, the hernia
 - Increase in size month to month

Incisional hernia repair

Surgical repair is not routinely funded for asymptomatic or mildly symptomatic incisional hernias in adults. Adults should be referred for surgical assessment if they have:

- Pain/ symptoms interfering with activities of daily living AND conservative management e.g. weight loss, has been tried first where appropriate

Femoral hernia repair

People with femoral hernias should be referred for consultation.

Biological meshes

Biological meshes for hernia repair are not routinely funded by Kent and Medway CCGs for any patient group.

Rationale

There is evidence to suggest that watchful waiting is a reasonable strategy for patients with inguinal and incisional hernia and may lead to avoidance of surgery for a proportion of patients. The Royal College of Surgeons of England (RCSEng), the Association of Surgeons of Great Britain and Ireland and The British Hernia Society have issued a commissioning guide for groin hernia (2013) recommending patients with asymptomatic groin hernias can be managed conservatively. 2014/15 PROMs data indicates that quality of life is likely to worsen or remain unchanged for 17–42% and 20–32% of English patients undergoing surgical repair of groin hernia respectively. Up to 8% of inguinal hernia repair patients may be left with persistent/ chronic pain following surgery.

There is no formal NICE guidance on indications for hernia repair. However, NICE Technology Appraisal (TA) [83](#) recommends laparoscopic surgery as one of the treatment options for repair of inguinal hernia (2004).

Continued overleaf

Femoral hernia repair is almost always recommended straight away because there is a higher risk of complications such as obstruction and strangulation developing in these cases.

The evidence base for the clinical effectiveness of biological meshes for hernia repair is poor and equivocal. Biological meshes (National Tariff exclusions) cost considerably more than synthetic meshes (included within tariff) and there is no evidence that they are cost-effective for the NHS.

6.5 Face lift (rhytidectomy)

Background

A facelift, also known as rhytidectomy, is an operation to lift up the facial skin and underlying muscles, so that the face has a tighter and smoother appearance.

Policy

This procedure is not routinely funded by Kent and Medway CCGs except in the following circumstances:

- Congenital facial abnormalities unless the commissioning responsibility of NHS England*, *or*
- Facial palsy (congenital or acquired paralysis) , *or*
- As part of the treatment of specific conditions affecting the facial skin unless the commissioning responsibility of NHS England*, *or*
- To correct the consequences of trauma, *or*
- To correct deformity following surgery

*Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email:

england.contactus@nhs.net

6.6

Gallstone disease in adults (laparoscopic cholecystectomy for the treatment of)

Background

Cholelithiasis (gallstones) is the term used to describe discrete, hard fatty or mineral deposits (calculus) that are formed in the gallbladder. The presence of one or more gallstones is referred to as gallstone disease. In the UK, around 10-15% of the adult population are thought to have gallstones. Eighty per cent of people with gallstones are asymptomatic; they are normally detected incidentally through imaging such as ultrasound or MRI as part of investigations for other conditions.

Stones may pass from the gallbladder into the common bile duct; these are then referred to as common bile duct (CBD) stones.

Surgery to remove the gallbladder (cholecystectomy) is the most common way to treat symptomatic gallstone disease. Cholecystectomy is normally undertaken laparoscopically as it results in a shorter length of stay, a faster recovery and smaller scars.

Policy

Gallbladder stones

- Patients with an incidental finding of stones in an otherwise normal gallbladder and biliary tree require no further investigation or referral; asymptomatic patients should not be referred to secondary care (see pages 49–50 for care pathway and information on primary care management)
- Surgery for asymptomatic gallstones is not routinely funded
- Laparoscopic cholecystectomy will be funded for people diagnosed with symptomatic gallbladder stones. The decision to operate should be made by the patient with guidance from the surgeon. This will include assessment of the risk of recurrent symptoms and complications of the gallstones and the risks and complication rates of surgery in relation to the individual patient's co-morbidities and preference.

Common bile duct stones

- Bile duct clearance and laparoscopic cholecystectomy will be funded for people with symptomatic or asymptomatic common bile duct stones

Continued overleaf

Rationale

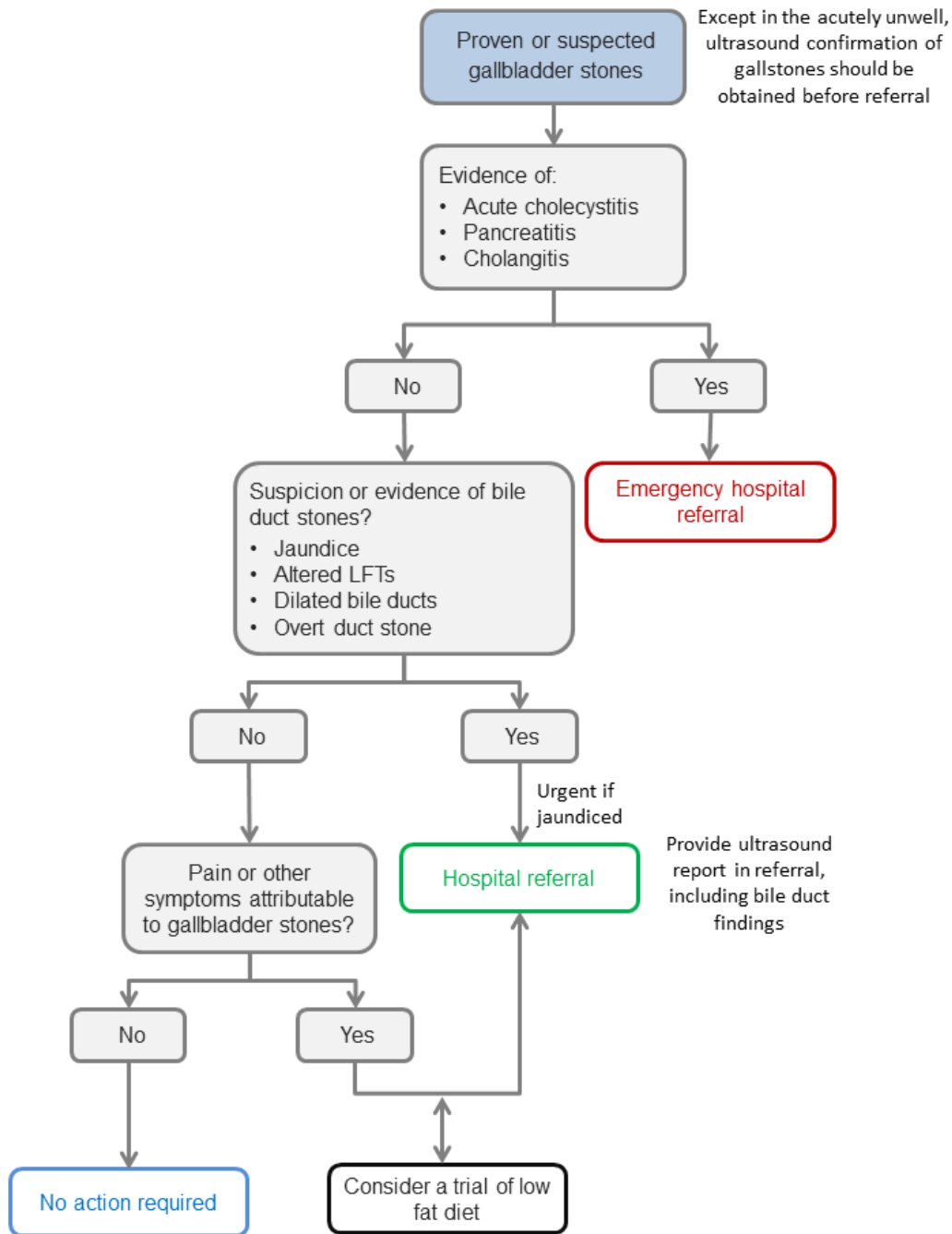
The policy on laparoscopic cholecystectomy for gallstone disease in adults is consistent with NICE Clinical Guideline [188](#) on Gallstone disease (2014) and [commissioning guidance](#) from the Royal College of Surgeons of England and the Association of Upper Gastrointestinal Surgeons of Great Britain (2016).

According to CG188, most people with asymptomatic gallbladder stones will not develop complications and there is currently no way of predicting which ones will. CG188 also noted that prophylactic treatment of asymptomatic gallstones is likely to be associated with higher risks of adverse events than leaving them untreated, and that offering unnecessary treatment to a large number of people would not be the best use of NHS resources.

CG188 recommends bile duct clearance and laparoscopic cholecystectomy should be offered to people with symptomatic or asymptomatic CBD stones because they are at risk of developing severe complications.

Continued overleaf

Treatment algorithm



Source: RCS/ AUGIS commissioning guide (2016) on gallstone disease

Continued overleaf

Box 5 – Primary care management

- Most patients with symptomatic gallstones present with a self-limiting attack of pain that lasts for hours only. This can often be controlled successfully in primary care with appropriate analgesia, avoiding the requirement for emergency admission. When pain cannot be managed or if the patient is otherwise unwell (e.g. sepsis), he or she should be referred to hospital as an emergency.
- Further episodes of biliary pain can be prevented in around 30% of patients by adopting a low fat diet. Fat in the stomach releases cholecystokinin, which precipitates gallbladder contraction and might result in biliary pain.
- Patients with suspicion of acute cholecystitis, cholangitis or acute pancreatitis should be referred to hospital as an emergency
- There is no evidence to support the use of hyoscine or proton pump inhibitors in the management of gallbladder symptoms
- Antibiotics should be reserved for patients with signs of sepsis
- There is no evidence of benefit from the use of non-surgical treatments in the definitive management of gallbladder stones (e.g. gallstone dissolution therapies, ursodeoxycholic acid or extracorporeal lithotripsy)
- Adults with symptomatic gallstone disease who have not had their gallbladder or gallstones removed are advised to avoid food and drink that triggers their symptoms

Source: RCS/ AUGIS commissioning guide (2016) on gallstone disease and NICE [QS104](#) (2015).

6.7 Ganglions (wrist and foot; surgical techniques for the treatment of)

Background

Ganglions are benign fluid-filled lumps. They are generally harmless but can be unsightly and can sometimes be painful, particularly if they lie next to a nerve. The most common site for a ganglion to be found is on the back of the wrist. It can also occur on the other side of the wrist, on the hand, and on the top of the foot. They never spread to other areas of the body.

Policy

Wrist:

Surgical treatments for ganglions of the wrist are not routinely funded except in the following circumstances:

- 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:

Surgical treatments for ganglions of the foot are not routinely funded except in the following circumstances:

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

6.8 Male circumcision

Background

Circumcision is the surgical removal of the foreskin of the penis. The foreskin is the hood of skin covering the end of the penis (glans), which can be gently pulled back.

Policy

This procedure is not routinely funded except in the following circumstances:

- Pathological phimosis, *or*
- Recurrent episodes of balanoposthitis, *or*
- Suspicion or evidence of malignancy, *or*
- For biopsy where disease other than lichen sclerosus cannot be excluded

Rationale

Most healthcare professionals now agree that the risks associated with routine circumcision, such as infection and excessive bleeding, outweigh any potential benefits. According to guidance from the Royal College of Surgeons of England (RCSEng), the only indications for circumcision are pathological phimosis* (the commonest cause is lichen sclerosus; balanitis xerotica obliterans [BXO] is an old fashioned descriptive term) and recurrent episodes of balanoposthitis.

According to RCSEng guidance, referrals from primary care for physiological phimosis account for a significant clinical workload in consultation time that could be avoided. Conservative management of the non-retractile foreskin is often under-recognised and practiced. This is of particular importance in the paediatric population where too many circumcisions are undertaken for physiological phimosis, thereby incurring avoidable morbidity. Whilst major morbidity and mortality following circumcision is very rare, these could be reduced and potentially avoided if surgical indications were more stringently applied. When physiological phimosis is diagnosed in a primary care assessment of foreskin condition, consultation should focus on reassurance and education of parents and child.

According to RCSEng guidance, circumcision in an adult may also be undertaken for premalignant conditions, carcinoma in situ (CIS) and for biopsy where disease other than lichen sclerosus cannot be excluded.

Continued overleaf

*Phimosis is a condition where the foreskin cannot be retracted over the glans penis; it may be physiological or pathological. Physiological phimosis refers to a normal foreskin where non-retractability is due to 'physiological' congenital adherence of the inner foreskin to the glans penis. There is no evidence of scarring. Pathological phimosis is associated with scarring of the foreskin opening leading to symptoms and non-retractability. In children up to and including 18 years of age, pathological phimosis must be distinguished from physiological adherence of the foreskin to the glans, which is normal and can be managed conservatively in most cases. The foreskin is still in the process of developing at birth and hence is often non-retractable up to the age of three years; in a small proportion of boys this natural process continues well into childhood. The proportion of partially or fully retractable foreskin at birth is 4%; 20% at 6 months; 50% at 1 year; 90% at 3–11 years; 95% at 12–13 years and 99% at 14+ years. Non-retractile ballooning of the foreskin and spraying of urine do not routinely need to be referred for circumcision although not all ballooning is related to physiological phimosis and spraying can be due to lichen sclerosus. If there is concern that any pathology is evident, or if there is diagnostic uncertainty, referral is indicated.

6.9 Male sterilisation (vasectomy)

Background

Vasectomy (male sterilisation) is a surgical procedure, whereby the tubes that carry sperm from a man's testicles to the penis are cut, blocked or sealed with heat. This means that when a man ejaculates, the semen has no sperm and a woman's egg cannot be fertilised. A vasectomy has no effect on sex drive or ability to enjoy sex; the only difference is that the semen will not contain sperm.

Policy

This service is provided by primary/ community care, except in the following circumstance (in which case an acute provider will provide the service):

- Primary/ community care is unable to meet the needs of the patient for medical reasons. Prior approval is required (ifr.secsu@nhs.net).

6.10 Penile implants

Policy

Penile implants are not routinely funded.

6.11 Reversal of vasectomy

Background

Vasectomy involves cutting, blocking or sealing the tubes that carry sperm from a man's testicles to the penis. Having a vasectomy should always be viewed as permanent sterilisation. This is because, although reversal is sometimes possible, it may not be successful. A reversal operation requires delicate microsurgery to join the tubes together again. Even with a successful operation, it still may not be possible to father a child.

Policy

Reversal of vasectomy is not routinely funded, where the person consented to sterilisation or where sterilisation was sanctioned in a legal ruling.

Rationale

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. Kent and Medway CCGs consider that it is inappropriate that NHS funds are used in reversing these procedures.

6.12 Upper gastrointestinal endoscopy for the investigations of dyspepsia

Background

Dyspepsia describes a range of symptoms arising from the upper gastrointestinal (GI) tract, but it has no universally accepted definition. The British Society of Gastroenterology (BSG) defines dyspepsia as a group of symptoms that alert doctors to consider disease of the upper GI tract, and states that dyspepsia itself is not a diagnosis. These symptoms, which typically are present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, gastric reflux, nausea or vomiting.

An endoscopy is a procedure, where the inside of the body is examined using a long thin, flexible tube that has a light source and a video camera at one end, called an endoscope. Images of the inside of the body are relayed to a television screen.

For an upper GI endoscopy, also known as a gastroscopy, the endoscope is inserted down the mouth and throat to look inside the oesophagus, stomach and duodenum.

Policy

Criteria for access to upper gastrointestinal (GI) endoscopy for the investigation of dyspepsia should be in line with NICE Clinical Guideline [184](#): *Gastro-oesophageal reflux disease and dyspepsia in adults* and NICE Guideline [12](#): *Suspected cancer: recognition and referral*.

Rationale

For rationale see NICE Clinical Guideline [184](#) and NICE Guideline [12](#).

6.13 Varicose veins – Referral criteria for specialist assessment

Background

Varicose veins are defined as dilated, palpable, subcutaneous veins larger than 4mm caused by valvular incompetence and/or weakness of the vein wall. There are different grades and impact of disease severity.

Policy

Referral for specialist assessment of varicose veins may only be considered for patients with:

- 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

Note that a referral to specialist services does not necessarily imply surgical management.

See Table 1 below for further details.

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

Continued overleaf

Rationale

Local cost impact analysis indicates that referring people with symptomatic* varicose veins as recommended by NICE Clinical Guideline [168](#) would be unaffordable in the context of current Clinical Commissioning Groups (CCGs) resources.

When making resource allocation decisions, Clinical Commissioning Groups (CCGs) need to take into account the needs of their populations. Funding the referral and treatment of people with symptomatic varicose veins would require considerable additional resources and funding. Kent and Medway CCGs have concluded that additional funding for this population of people is not currently a priority.

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

7 Gynaecology

7.1 Dilatation and curettage for heavy menstrual bleeding

Background

Heavy menstrual bleeding is defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms.

Dilatation and curettage (D&C) is a minor surgical procedure to remove tissue from the endometrium (lining of the womb).

Policy

D&C is not funded as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding (HMB).

Rationale

For rationale and guidance on best clinical practice for the management of HMB see NICE [CG44](#).

7.2 Female genital prolapse (primary surgical management of)

Background

Female genital prolapse (FGP), also known as pelvic organ prolapse occurs when pelvic organs (such as the uterus, bladder, bowel) protrude into the vagina due to weakness in the tissues that normally support them. Women with prolapse may have a variety of pelvic floor symptoms. Only some of the symptoms are directly related to the prolapse, including pelvic heaviness, a dragging sensation in the vagina, a bulge, lump or protrusion coming down from the vagina and backache. Symptoms of bladder, bowel or sexual dysfunction are frequently present.

FGP is common, although many are asymptomatic and may only be discovered during an internal examination for another reason such as cervical screening. There are several treatment options available for FGP, depending on severity of symptoms and prolapse, future plans to have children, and individual circumstances. Treatment options include conservative management (e.g. pelvic floor muscle training), mechanical support (such as vaginal pessaries) and surgery.

Policy

Criteria for referral

Asymptomatic patients should not be referred to secondary care. Referral for specialist assessment by a urogynaecologist and treatment in secondary care (see below for indications for surgery), may only be considered for:

- Prolapse combined with urethral sphincter incompetence or faecal incontinence,
or
- Failure of management in primary care*, *or*
- Women with moderate to severe symptoms

*Pessaries are not always available in primary care across Kent and Medway; in such cases, or where pessary has failed or is not clinically appropriate or has been declined after documented discussion with clinician, patients should be referred for specialist assessment by a urogynaecologist.

Continued overleaf

Criteria for surgery

Surgery for female genital prolapse is not routinely funded for asymptomatic patients or those with mild symptoms. Surgery may only be considered for:

- Prolapse combined with urethral sphincter incompetence or faecal incontinence,
or
- Failure of pessary management**, *or*
- Women with moderate to severe symptoms

**Pessary has failed or is not clinically appropriate or has been declined after documented discussion with clinician.

Rationale

There is no NICE guidance on indications for surgery for FGP and no predictive factors that indicate likely response to specific treatments have been identified.

According to local specialists, where people with FGP have symptoms and primary care treatment has failed, they should be referred to secondary care to discuss appropriate options; treatment needs to be tailored to the needs of individuals. Symptoms (and their impact on quality of life) is what is important, not the degree of prolapse. Patients without symptoms do not require intervention and can be reassured in primary care.

7.3 Female sterilisation

Policy

Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena® or a long acting etonogestrel-releasing implant (such as Nexplanon®), 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 period.

The CCGs will fund this procedure:

- 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/ Nexplanon
- 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 counselling¹:

- 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?

Continued overleaf

¹ 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.

- 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.

7.4 Hysterectomy for heavy menstrual bleeding

Background

Heavy menstrual bleeding is defined as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life. It can occur alone or in combination with other symptoms.

A hysterectomy is a surgical procedure to remove the womb (uterus). Pregnancy is no longer possible after having a hysterectomy.

Policy

This procedure is not routinely funded except in the following circumstances:

- 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 ablation¹, thermal balloon ablation, microwave endometrial ablation, endometrial resection, uterine artery embolisation² in selected cases) have failed, are not appropriate or are contraindicated in line with NICE guidelines.

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.

¹Endometrial 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.

²Uterine artery ablation is performed in tertiary centres as defined in NICE guidance.

7.5 Labiaplasty

Background

A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening. Some women feel their vaginal lips should look a certain way, but it's natural for the labia minora to vary widely in appearance.

Policy

This procedure is not routinely funded.

7.6 Reversal of female sterilisation

Background

Female sterilisation is considered a permanent form of contraception. The operation involves cutting, sealing or blocking the fallopian tubes. This prevents the eggs from reaching the uterus (womb) where they could become fertilised, resulting in pregnancy. It may be possible to reverse female sterilisation, but it is a very difficult process that involves removing the blocked part of the fallopian tube and rejoining the ends, and there is no guarantee of success.

Policy

Reversal of female sterilisation is not routinely funded, where the person consented to sterilisation or where sterilisation was sanctioned in a legal ruling.

Rationale

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. Kent and Medway CCGs consider that it is inappropriate that NHS funds are used in reversing these procedures.

7.7 Termination of pregnancy

Policy

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

8 Neurology

8.1 Cerebellar stimulator implants

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

8.2 Chronic fatigue syndrome

Background

Chronic fatigue syndrome causes persistent fatigue (exhaustion) that affects everyday life and does not go away with sleep or rest. Exactly what causes chronic fatigue syndrome is unknown.

Policy

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

8.3 Closure of patent foramen ovale for migraine

Background

The foramen ovale is a hole in the wall that divides the two upper chambers of the heart. The hole is present in the heart of a developing foetus, but normally closes up soon after the baby is born. If it fails to close it is known as a patent foramen ovale (PFO). In most people, this does not cause any problems, but some studies have suggested that there could be a link between having a PFO and recurrent migraines. Closure of PFO involves passing a device through a large vessel in the groin up into the heart and closing/blocking the hole in the wall of the heart.

Policy

This procedure is not routinely funded.

Rationale

According to NICE [IPG370](#), current evidence on the efficacy of percutaneous closure of PFO for recurrent migraine is inadequate in quality and quantity. The evidence on safety shows a small incidence of well-recognised but sometimes serious adverse events, including device embolisation and device prolapse.

8.4 Functional electrical stimulation (FES)

Background

Functional electrical stimulation (FES) involves stimulation of the peripheral nerves that supply the paralysed muscle using electrodes that may be implanted or placed on the surface of the skin. The aim is to restore muscular function. FES is used to treat the effects of upper motor neurone lesions that can result from conditions such as stroke, cerebral palsy, multiple sclerosis or spinal cord injury, but may also occur in other conditions. FES is not normally suitable for patients with lower motor neurone lesions.

Policy

- FES is available for drop foot of central neurological origin. Patient selection for implantable FES for drop foot of central neurological origin should involve a multidisciplinary team specialising in rehabilitation.
- FES is not routinely funded for the treatment of upper limbs

Rationale

NICE have concluded that more research is needed to establish the clinical and cost effectiveness of electrical stimulation to improve hand/ arm function in people after stroke, and to characterise the clinical profiles of people who will benefit. Whereas, according to NICE [IPG278](#), current evidence on the safety and efficacy (in terms of improving gait) of FES for drop foot of central neurological origin appears adequate to support the use of this procedure.

8.5 Hand-held transcutaneous vagus nerve stimulation (tVNS) devices (i.e. Gammacore[®]) for headache in adults

Background

Gammacore[®] – the only hand-held transcutaneous vagus nerve stimulation (tVNS) device currently available – uses low-voltage electrical currents to stimulate the cervical branch of the vagus nerve without the need for implants or surgery. The exact mechanism of pain relief with tVNS is not fully understood but it is thought to inhibit activation of several structures in the brain identified as part of the pain matrix of headache.

Policy

Hand-held tVNS devices (i.e. Gammacore[®]) are not routinely funded on the local NHS for the treatment of headache in adults.

Rationale

According to NICE interventional procedures guidance (IPG) [552](#) on tVNS for migraine and cluster headache (2016), the evidence on the efficacy of tVNS for the treatment of these conditions is limited in quantity and quality. In addition, the cost-effectiveness of tVNS for headache in a UK NHS setting has not been established.

8.6 Single pulse transcranial magnetic stimulation (sTMS) devices (i.e. SpringTMS[®]) for headache in adults

Background

Transcranial magnetic stimulation (TMS) is a non-invasive procedure that aims to treat or prevent migraine episodes. TMS is given using a tabletop or handheld device that delivers a predetermined level of magnetic pulse or pulses to the head. The device is placed on the scalp and either single (sTMS) or repeated (rTMS) magnetic pulses are delivered. SpringTMS is currently the only hand-held sTMS device available.

Policy

Single pulse transcranial magnetic stimulation devices (i.e. SpringTMS[®]) are not routinely funded on the local NHS for the treatment of headache in adults

Rationale

According to NICE interventional procedures guidance (IPG) [477](#) on TMS for migraine (2014), the evidence on the efficacy of sTMS for the treatment of migraine is limited in quantity and for the prevention of migraine is limited in both quantity and quality; there is also uncertainty about the safety of long-term or frequent use of TMS. In addition, the cost-effectiveness of sTMS for headache in a UK NHS setting has not been established.

9.1 Cryotherapy for localised prostate cancer

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

9.2

Cyberknife for cholangiocarcinoma (bile duct cancer)

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

9.3 DaVinci robotic radical prostatectomy for the treatment of prostate cancer

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

9.4

Salvage cryotherapy for recurrent prostate cancer

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

9.5

Stereotactic radiation therapy

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

10 Ophthalmology

10.1 Cataract surgery

Background

Cataract is the opacification of the normally transparent lens of the eye. It occurs as a result of denaturation of lens proteins resulting in cloudiness of vision. Symptoms include glare, blurred vision, progressive decrease in visual function, and blindness. Most people with cataracts, if left untreated, will eventually become visually disabled. Cataracts are very common in the population aged over 65. Surgery becomes an option for patients when vision deteriorates, affecting function.

Policy

Referral for cataract surgery 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
- Willingness to have surgery.

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

Rationale

This policy is consistent with Department of Health guidance.

10.2 Chalazia

Background

A chalazion (plural: chalazia) is a sterile, chronic, inflammatory granuloma on the eyelid caused by a blocked meibomian gland. Chalazia are regarded as the most common cause of lumps on the eyelid. Although they may be considered cosmetically unattractive, chalazia rarely cause serious complications; although there is initial discomfort, this usually settles and pain and tenderness are usually absent.

Chalazia can spontaneously resolve. Conservative treatment might speed up the disappearance of chalazia (Box 6). It is also important to manage risk factors (if present), especially blepharitis, to reduce the risk of future episodes.

Box 6 – Conservative treatment

- Apply a warm compress (e.g. using a clean flannel that has been rinsed with hot water) to the affected eye for 5–10 minutes. Repeat this three to four times daily for up to 4 weeks.
 - This will help to liquefy the lipid content of the chalazion, thus encouraging drainage of the chalazion contents.
 - Avoid excessively hot compresses (to avoid scalding, particularly in children).
- Gently massage the chalazion after application of the warm compress (to aid expression of the chalazion contents).
 - This should be done in the direction of eyelash using clean fingers or cotton buds.
- Clean the affected eyelid twice daily (to clear debris and oily secretions from the eyelid and lashes).
 - This can be performed by rubbing a moistened cotton bud (e.g. using baby shampoo diluted 1:10 with warm water [one part shampoo to nine parts water]) along the lid margin

Policy

Excision of chalazia are not routinely funded, except where all of the following criteria are met:

- The chalazion has been present continuously for more than 6 months, *and*
- Conservative treatment has failed, *and*
- The chalazion is affecting vision *or* it is regularly infected (e.g. two times within a six month time-frame) and in need of medical treatment for infection

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

Continued overleaf

If the chalazion has atypical features or recurs in the same location, biopsy to rule out malignancy.

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

Rationale

Although the evidence for conservative treatment is limited, it is widely recommended by experts for the initial management of chalazia. In small studies, resolution rates were 46–77% with conservative treatment. Mean time to resolution was 2–3 weeks.

A period of 6 months for watchful waiting reflects the results of one small retrospective study, which found that the duration of complaint (from onset of symptoms to symptom resolution) was 5.4 months (range 1.5–12 months) for those chalazia that resolved spontaneously. The spontaneous resolution rate was 25% (or 43% if all patients lost to follow-up were assumed to have chalazia that resolved spontaneously).

Chalazia that are excessively large can cause astigmatism and visual disturbance (by pressing on the cornea). Rarely, a chalazion may become secondarily infected, and the infection can spread or cause preseptal cellulitis.

10.3 Collagen cross linking treatment for corneal ectasias including keratoconus

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

10.4 Ptosis and dermatochalasis

Background

Drooping of the upper eyelid is called 'ptosis' (or 'blepharoptosis').

Dermatochalasis refers to an excess of eyelid skin tissue caused by the loss of elasticity in the connective tissue supporting the structure of the front portion of the eyelid. It can affect the lower and upper eyelids. In severe cases, excess tissue on the upper eyelid can hang down, obstructing vision, in which case a surgical procedure known as blepharoplasty may be considered. Blepharoplasty of the lower eyelid is considered cosmetic because dermatochalasis of the lower eyelid does not obstruct vision. In contrast to dermatochalasis, ptosis refers to an abnormal position of the eyelid margin.

Policy

Surgical repair of ptosis or dermatochalasis is not routinely funded except when both of the following criteria are met:

- Documented complaints of interference with vision or visual field-related activities such as difficulty reading or driving due to upper eyelid skin drooping or eyelid position
- Documented evidence of encroachment of the central 20 degrees of visual field

For cases where combined procedures are requested, the individual must meet the criteria for each procedure.

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

Rationale

There is limited evidence on functional indications for correcting upper eyelid ptosis or dermatochalasis. The requirement for documented evidence of central vision loss is consistent with DVLA guidance on minimum field of vision requirements for safe driving in England.

10.5 Refractive eye surgery

Background

Refractive errors (such as myopia, hyperopia and astigmatism) are usually corrected by wearing spectacles or contact lenses. Photorefractive (laser) surgical treatments have been developed to improve refraction by reshaping the cornea – the transparent layer covering the front of the eye. This is done using a type of laser known as an excimer laser. Different techniques are used to correct short sight (myopia), long sight (hypermetropia) and astigmatism.

Policy

These procedures are not routinely funded.

Rationale

Although current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients, there are alternative methods of correction (i.e. spectacles and contact lenses). Kent and Medway CCGs have concluded that additional funding for this procedure is not currently a priority.

10.6 Xanthelasma

Background

Xanthelasma are yellow flat plaques over the upper or lower eyelids. Once the plaque is established, it tends to remain static in size or grow slowly. The condition itself is harmless, but xanthelasma may indicate high cholesterol.

Policy

Removal of xanthelasma is not routinely funded. Where appropriate, see separate policy on ptosis (and dermatochalasis).

11 Oral Surgery

11.1 Temporomandibular joint replacement

Policy

This procedure is not routinely funded.

12 Orthopaedics

12.1 Arthroscopy of the knee

Background

An arthroscopy is a type of keyhole surgery used both to diagnose and treat problems with joints.

Policy

Arthroscopy should not be the primary investigation for knee pain. 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.

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')

12.2 Carpal tunnel syndrome (surgical techniques for the treatment of)

Background

Carpal tunnel syndrome (CTS) is a relatively common condition that causes a tingling sensation, numbness and sometimes pain in the hand and fingers. It is caused by compression of one of the nerves that controls sensation and movement in the hands (median nerve). In some cases CTS will disappear without treatment, or simple self-care measures will reduce the symptoms. Non-surgical treatments, such as wrist splints and corticosteroid injections, are used to treat mild or moderate symptoms. Surgery may be considered if non-surgical treatments fail to relieve the symptoms; it may also be used if there is a risk of permanent nerve damage.

Policy

Surgery for carpal tunnel syndrome is not routinely funded except in the following circumstances:

- 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

12.3 Dupuytren's contracture

Background

Dupuytren's disease is a benign, slowly progressive condition of unknown origin. It is characterised by a thickening of the connective tissues in the palm, which form nodules and fibrous bands (cords). Dupuytren's disease can cause difficulty in extending the fingers leading to fingers becoming fixed in a bent position which cannot be straightened, in which case it is called Dupuytren's contracture. The contracture typically affects the metacarpophalangeal (MCP) joints (where the phalanges of the finger attach to the metacarpal bones of the hand) and/ or the proximal interphalangeal (PIP) joints (the joints between the proximal and middle phalanges of the finger). Symptoms may include pain and reduced hand function.

Policy

Surgical procedures for this condition are not routinely funded, except in the following circumstances:

- 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

For policy on use of collagenase clostridium histolyticum (Xiapex®) for this indication, refer to the Kent and Medway Health Economy High Cost Drugs Manual (HCD Manual).

Rationale

Contracture of more than 30 degrees at the metacarpophalangeal joint or any contracture at the proximal interphalangeal joint is generally thought to be an indication for surgical intervention, although, there is limited evidence to support this approach. Aggressive disease is more common in people who develop Dupuytren's disease at an early age.

These criteria are consistent with previously published guidelines from the British Society for Surgery for the Hand (BSSH).

12.4

EXOGEN[®] ultrasound bone healing system for long bone fractures

Background

The EXOGEN ultrasound bone healing system delivers low-intensity pulsed ultrasound to help speed up bone healing after fracture. It is thought that EXOGEN promotes healing by increasing both the removal of old bone and the production of new bone. The treatment involves an ultrasound probe being placed on the skin at the site of the fracture for 20 minutes each day.

Policy

- EXOGEN is funded for a maximum of 6 months in adults for the treatment of stable, well aligned non-union¹, long bone² fractures with an inter-fragmental gap <10mm
- EXOGEN is not routinely funded for long bone fractures with delayed healing³
- Where EXOGEN fails to work, the Performance Guarantee Scheme should be pursued and CCGs should subsequently be reimbursed the cost of the device

¹ Non-union fractures: failure to heal after 9 months of trauma occurring

² Limited to femur, tibia, fibula, humerus, ulna and radius

³ Delayed healing: no evidence of healing after 3 months of trauma occurring

Rationale

According to NICE medical technologies guidance (MTG) [12](#), the EXOGEN ultrasound bone healing system shows high rates of fracture healing when it is used to treat non-union fractures of long bones (such as the tibia or femur, long bones in the leg) and it can save money, by avoiding surgery, compared with current treatment for non-union fractures. Non-union means that the fracture hasn't healed after 9 months. According to NICE MTG12, current evidence does not support using EXOGEN to treat long bone fractures with delayed healing. Delayed healing means that there is no evidence of healing after 3 months of trauma occurring.

12.5 Hip and knee replacements (primary total)

Background

Hip or knee replacement surgery involves replacing a damaged joint with an artificial one made of synthetic materials. Joint replacement operations are performed in the vast majority of cases for pain which originates from the joint, limits the patients' ability to perform normal daily activities, disturbs sleep and does not respond to non-surgical measures, most commonly due to osteoarthritis.

Policy

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):
 - Simple analgesia
 - Anti-inflammatory analgesia (where appropriate)
 - Advice on exercise and if appropriate physiotherapy
 - Advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling on the potential risks and benefits of joint replacement surgery
 - Underlying medical conditions should have been investigated and the patient's condition optimised prior to referral

Continued overleaf

- To maximise the long-term functional benefit of joint replacement surgery and reduce the risk of complications during or following surgery, it is strongly advised to reduce BMI¹ to <30 prior to referral
- Patients with BMI ≥ 30 should be encouraged and supported to reduce their BMI both before and after surgery, including referral to weight management services where indicated
- Ideally patients should have had efforts to reduce/eradicate open ulcers, recurrent infections or MRSA colonisation

¹See NICE clinical guideline on obesity ([CG189](#)) for more information on using BMI as a measure.

12.6 Spinal cord stimulation (SCS) for chronic pain

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

12.7

Spinal fusion for non-specific low back pain with or without sciatica

Background

Spinal fusion is an operation performed to achieve solid bone union between spinal vertebrae to prevent movement. The procedure of spinal fusion is commonly carried out as a component part of many types of spinal operation, such as operations to correct deformity, remove tumours and treat spinal fractures. Spinal fusion is sometimes also used to treat severe and constant low back pain that has not resolved despite the use of other more conservative treatments.

Policy

- Spinal fusion is not routinely funded for people aged over 16 years with non-specific low back pain with or without sciatica

Commissioning responsibility for some types of spinal surgery is with NHS England in certain circumstances (<http://www.england.nhs.uk/>). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

Rationale

According to NICE Guideline (NG) [59](#) *Low back pain and sciatica in over 16s: assessment and management* (2016), spinal fusion should not be offered for people with non-specific low back pain unless carried out as part of a randomised controlled trial. NICE noted that there was no consistent benefit of spinal fusion over comparator treatments, and considerable evidence of harm. In addition, health economic evidence indicated that spinal fusion was not a cost effective intervention for the treatment of low back pain.

12.8 Surgical procedures for the treatment of 'first metatarsalphalangeal joint pathology'

Policy

Surgical procedures for the treatment of 'first metatarsalphalangeal joint pathology' are not routinely funded, except in the following circumstances:

- Patient is in pain, *and*
- One or more of the following is present:
 - There is an inter metatarsal angle of greater than 15 degrees, the pain is superficial and the patient cannot wear footwear
 - 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
 - There is Dorsal lipping or other osteophytic enlargement, with joint pain on passive flexion/ extension, and patient feels pain is not manageable

12.9 Trigger finger (surgical techniques for the treatment of)

Background

Trigger finger is a condition that affects the tendons in the hand. When the affected finger or thumb is bent towards the palm, the tendon gets stuck and the finger clicks or locks.

Policy

This procedure is not routinely funded, except in the following circumstances:

- a patient has failed to respond to conservative treatment (including at least two corticosteroid injections), *or*
- has a fixed flexion deformity that cannot be corrected

13 Other

13.1 Acupuncture for non-specific low back pain with or without sciatica

Background

Acupuncture involves treatments with needles, and is most commonly used for pain relief.

Policy

Acupuncture is not routinely funded for managing non-specific low back pain with or without sciatica in people aged over 16 years

Rationale

According to NICE Guideline (NG) [59](#) *Low back pain and sciatica in over 16s: assessment and management* (2016), acupuncture should not be offered for the management of non-specific low back pain with or without sciatica because there is insufficient evidence of a treatment specific effect.

13.2 Complementary and alternative therapies

Policy

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 complementary service for a specific condition where these are commissioned.

*See also separate policy on acupuncture for non-specific low back pain with or without sciatica in over 16s.

13.3 Hyperbaric oxygen therapy

This commissioning responsibility has transferred to NHS England (<http://www.england.nhs.uk/>).

Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

13.4 Minor irregularities of aesthetic significance only

Policy

Procedures to correct minor irregularities of aesthetic significance only are not routinely funded.

13.5 Residential pain management programmes

Policy

Residential pain management programmes are not routinely funded by Kent and Medway CCGs.

Commissioning responsibility for residential pain management programmes under some circumstances is with NHS England (<http://www.england.nhs.uk/>). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

14 Paediatrics

14.1 Polysomnography in the investigation of children with sleep-related disorders

Background

Polysomnography is a test used to diagnose sleep disorders, carried out at a specialist sleep centre. Polysomnography records brain waves, heart rate, breathing patterns, blood oxygen levels and muscle tone. Other tests may also be carried out.

Policy

This procedure is not routinely funded by Kent and Medway CCGs. NHS England has commissioning responsibility for sleep studies as part of specialist respiratory services for children and young people. Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net

15 Plastic surgery

15.1 Body contouring procedures – Abdominoplasty/ apronectomy ('tummy tuck')

Background

Abdominoplasty is a surgical procedure used to remove excess fat and skin from the abdomen and to tighten the abdominal muscles.

An apronectomy is a modified abdominoplasty for patients who have a large excess of skin and fat hanging down over the pubic area. In this procedure only the surplus skin and fat is removed.

Policy

This procedure is not routinely funded.

15.2 Body contouring procedures – Brachioplasty (arm reduction and lift)

Background

Brachioplasty is a surgical procedure used to remove excess skin and fatty tissue from the arm.

Policy

This procedure is not routinely funded.

15.3 Body contouring procedures – Buttock lift

Background

A buttock lift is a surgical procedure used to improve and/or remove excess buttock skin for enhanced firmness.

Policy

This procedure is not routinely funded.

15.4 Body contouring procedures – Neck lift

Background

A neck lift is a set of procedures to enhance the appearance of the neck. Procedures include removing excess skin and fat and removing or altering neck muscles.

Policy

This procedure is not routinely funded.

15.5 Body contouring procedures – Surgery to remove excess skin following profound weight loss

Background

Massive weight loss, either through bariatric surgery or diet and exercise, can lead to significant skin redundancy. The more common plastic surgery procedures carried out to remove excess skin are abdominoplasty/ apronectomy, mastopexy, brachioplasty, thigh lift, and buttock lift.

Policy

- Surgery to remove excess skin following profound weight loss is not routinely funded
- 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 available on the NHS

Where appropriate, this should be part of the consent process.

Rationale

There are considerable uncertainties relating to the clinical need to remove excess skin and the cost-effectiveness of surgery. The complications rates for these procedures appear high. Kent and Medway CCGs have concluded that additional funding for this procedure in this group is not currently a priority.

15.6 Body contouring procedures – Thigh lift

Background

A thigh lift is a surgical procedure to remove skin and fat from the thighs to tighten the skin and improve the contour of the legs.

Policy

This procedure is not routinely funded.

15.7 Breast procedures – Breast augmentation

Background

Breast augmentation (also known as breast implant surgery or breast enlargement) involves the surgical addition of implants to enhance the size and shape of the breast. Some patients may require tissue expansion surgery prior to augmentation.

Breast augmentation may be considered an option for patients with breast asymmetry, amastia (absence of breast tissue, nipples and areola), amazia (absence of breast tissue) or tuberous breasts (herniation of breast tissue through the nipple-areola complex). Breast augmentation may also be requested by patients with gender dysphoria undergoing transition from Male-to-Female and by those who perceive their breasts to be too small.

The life expectancy of breast implants is normally between 10 and 15 years.

Policy

- Breast augmentation is not routinely funded within the local NHS for any patient group

This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer or its prevention.

Rationale

The evidence base relating to the impact of potential indications for breast augmentation on quality of life and the clinical-effectiveness of breast augmentation is poor and equivocal. In addition, there is no evidence that funding breast augmentation is cost-effective for the NHS. In the context of the resources available and the health needs of the population, funding this procedure is not currently a priority for Kent and Medway CCGs.

15.8 Breast procedures – Breast augmentation (revision of)

Background

Due to the life span of breast implants, removal and replacement of implants may be required every 10 to 15 years. Potential indications for revision of breast augmentation include capsular contracture and implant rupture. Revision of breast augmentation involves removal of old breast implants and any surrounding scar tissue, and replacement with new implants.

Policy

- Replacement of breast implants is not routinely 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.

This recommendation does not apply to the following:

- patients undergoing breast reconstruction as part of treatment for breast cancer or its prevention
- patients with PIP implants for whom national guidance applies

Rationale

The Department of Health (2012) has stated that PIP breast implants that were originally fitted on the NHS will be removed and replaced by the NHS at no cost. If the implants were not fitted on the NHS, and the clinic where the implants were originally fitted will not remove them, the implants will be removed free of charge on the NHS for women who are concerned, however in these cases the NHS will not normally fund replacement of the implant.

See also the rationale for the policy on 'Breast procedures – Breast augmentation'.

15.9 Breast procedures – Breast reduction

Background

Breast reduction involves moving the nipple and surrounding tissue to a higher position on the breast, usually while still attached to the blood supply. The lower part of the breast is then removed and the remaining breast tissue reshaped to create a smaller and more elevated breast. If the breasts are extremely large, the nipples may be removed and repositioned as a skin graft where they will develop their own blood supply.

Breast reduction may be considered an option for patients with hypertrophy of the breasts (also known as gigantomastia and macromastia) who commonly complain of neck ache, back ache and shoulder pain. Breast reduction may also be indicated for breast asymmetry and for people with gender dysphoria who are transitioning from Female-to-Male (bi-lateral mastectomy and chest reconstruction for this patient group is the commissioning responsibility of NHS England and is therefore excluded from this policy).

Policy

- Breast reduction should only be considered as an option for patients who fulfil all of the following criteria:
 - Documented evidence of treatment received for physical symptoms of back, neck and/ or shoulder pain due to large breasts;
 - Require more than 500g tissue removed from each breast;
 - BMI of <26kg/m²;
 - Non-smoker

Rationale

There is some evidence to indicate women with hypertrophic breasts have a worse quality of life than the general population. Studies have consistently reported that breast reduction improves quality of life, mood and relieves pain. The eligibility criteria set out in this policy are broadly consistent with indications for breast reduction recommended in a commissioning guide on breast reduction surgery published by The Royal College of Surgeons (RCS) in association with the British Association of Plastic and Reconstructive and Aesthetic Surgeons (BAPRAS) in 2014.

15.10 Breast procedures – Correction of gynaecomastia

Background

Gynaecomastia is defined as the benign glandular proliferation of the male breast, causing enlargement. Gynaecomastia presents as a palpable button of firm or rubbery breast tissue concentric with the nipple-areolar complex. The condition may be attributed to endocrine abnormalities, medications (including drugs used to treat prostate cancer) or drug misuse.

Correction of gynaecomastia normally involves undertaking subcutaneous mastectomy. Mild or moderate gynaecomastia may be corrected using liposuction as an alternative.

Policy

- Correction of gynaecomastia is not routinely funded within the local NHS for any patient group.

Rationale

The evidence base relating to the impact of gynaecomastia on quality of life and the clinical-effectiveness of correction of gynaecomastia is poor and equivocal. In addition, there is no evidence that funding correction of gynaecomastia is cost-effective for the NHS. In the context of the resources available and the health needs of the population, funding this procedure is not currently a priority for Kent and Medway CCGs.

15.11 Breast procedures – Mastopexy

Background

Mastopexy involves lifting of the breast by removing surplus skin from underneath. The breast itself is remodelled into a tighter 'cone' and the nipples are repositioned at a higher level so that they lie at the points of the tightened breasts. Breast size can also be increased during this procedure by introducing breast implants. Mastopexy can also involve reducing the size of the areola.

Mastopexy may be undertaken as part of breast augmentation for conditions such as breast asymmetry and tuberous breasts. Mastopexy may also be undertaken as a standalone procedure for ptosis of the breast. Breast ptosis is common and occurs naturally with age but can be more pronounced after completion of breast feeding or following significant weight loss.

Policy

- Mastopexy is not routinely funded within the local NHS for any patient group. This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer or its prevention.

With respect to breast ptosis due to significant weight loss, see separate policy on body contouring procedures – surgery to remove excess skin following profound weight loss.

Rationale

The evidence base relating to the impact of potential indications for mastopexy on quality of life and the clinical-effectiveness of mastopexy is poor and equivocal. In addition, there is no evidence that funding mastopexy is cost-effective for the NHS. In the context of the resources available and the health needs of the population, funding this procedure is not currently a priority for Kent and Medway CCGs.

15.12 Breast procedures – Nipple eversion

Background

Inverted nipple is a condition where the nipple is retracted into the breast rather than pointing outward. Inverted nipples are normally caused by shortening of the ducts that come from the glandular tissue within the breast. Most women with inverted nipples will be able to breast feed with support from the appropriate professionals.

Protracting inverted nipples may be carried out in several ways depending on the degree of retraction. Non-invasive suction devices may be used by patients to evert nipples; surgery may be considered in more severe cases.

Policy

- Nipple eversion is not routinely funded within the local NHS for any patient group.

This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer or its prevention.

Rationale

No evidence on the impact of inverted nipples on health-related quality of life was identified. In addition, no evidence relating to the safety, clinical- and cost-effectiveness of nipple eversion was identified. In the context of the resources available and the health needs of the population, funding this procedure is not currently a priority for Kent and Medway CCGs.

15.13 Calf implants

Background

Calf implants are a procedure to increase the size and definition of the calf.

Policy

This procedure is not routinely funded.

15.14 Liposuction

Policy

Liposuction is not routinely funded except in the following circumstances:

- management of true lipodystrophies, lymphoedema or lipomas, *or*
- as part of other surgery, e.g. thinning of transplanted flap

15.15 Plastic operations on umbilicus

Policy

Plastic operations on umbilicus are not routinely funded.

16.1 Open MRI scan

Background

Magnetic resonance imaging (MRI) is a relatively safe, non-invasive diagnostic imaging procedure. MRI scans use radio waves, a magnet, and computer software to obtain two and three-dimensional (3D) images of the inside of the body. The basic technology of an open MRI scanner is similar to that of a conventional MRI scanner. The major difference for the patient is that instead of having to go into a cylinder, an open scanner allows more space around the body alleviating feelings of anxiety. Currently, open MRI generally does not produce as good a quality image as closed MRI and the length of time to get an image is longer.

Claustrophobia is the irrational fear of confined spaces. In some cases, people with severe claustrophobia may be referred for open MRI.

Policy

- Open MRI scanning is not routinely available and should be used only where one of the following two criteria are met:
 - Claustrophobia
 - Patient is claustrophobic (see rationale) AND
 - Local sedation pathway followed and not effective OR sedation is not suitable AND
 - other imaging modalities are not appropriate
 - Patient size
 - Patient is too large (see below) to fit comfortably in a conventional MRI scanner AND
 - other imaging modalities are not appropriate

Continued overleaf

- Requests for open MRI should be made to NEL CSU at ifr.secsu@nhs.net. They must come from a radiologist, radiographer, GP or consultant and be supported by appropriate evidence (i.e. sedation pathway has been followed and was not effective/ sedation is not suitable) or an appropriate statement about the issue of size.

The size of a patient and the restriction of the MRI scanner tunnel will vary depending on the patient and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI and can be invited to attend the radiology department to be formally assessed by a radiologist or radiographer for suitability. Normal MRI weight limit is $\leq 250\text{kg}$; and/or diameter $\leq 60\text{cm}$ ($\leq 70\text{cm}$ if wide-bore machine). [Circumference of a circle of 60cm diameter = 188cm = 74 inches; 70cm diameter = 220cm = 86.5 inches].

Rationale

Some people with claustrophobia only react with mild anxiety when in a confined space, while others experience severe anxiety or have a panic attack.

Radiology departments will meet with any claustrophobic patients who have concerns regarding MRI scanning to alleviate any fears. If fears cannot be alleviated or the patient fails an MRI scan, if suitable, the patient may be referred for sedation.

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:

<http://www.ifr.secsu.nhs.uk>

Contact for IFR Manager for Kent & Medway CCGs: 01732 375214

Appendix B – 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.

CCGs may agree an audit schedule with providers in 2017/18 or may agree ad-hoc audits as a follow up to the audits completed in previous years.

Please note it is advised that prior to undertaking audit, CCGs should confirm with individual Trusts the appropriate codes and formatting used.

In the table below, OPCS and ICD10 sub-codes are separated by a decimal point (e.g. M65.3 rather than M653). For ICD10 codes, where a dash follows the decimal point (e.g. H25.-) all the subsequent sub-codes are relevant.

Procedure	OPCS (procedures) Codes	ICD10 (diagnosis) Code	Specialty for audit	Comments
Acne scarring	S60.1-2 S09.1-3,8-9 S10.3 S11.3		Dermatology	
Arthroscopy of the knee	W87.1,8-9		Orthopaedics	
Body contouring procedures:				
· Abdominoplasty/ apronectomy	S02.1-2,8-9		General Surgery	
· Brachioplasty / upper arm lift	S03.3,8-9		General Surgery	
· Buttock lift	S03.1		General Surgery	
· Calf implants			General Surgery	
· Liposuction	S62.1-2		General Surgery	
· Neck lift	S01.3		General Surgery	
· Thigh lift	S03.2		General Surgery	
· Upper arm reduction	S03.3		General Surgery	
Breast procedures				
· Breast augmentation	B31.2 B30.1			
· Revision of breast augmentation	B29.5 B30.2-4,8-9 B31.4 B33.2 B37.4	T85.4,7-9		
· Breast reduction	B31.1, 8-9			
· Nipple eversion	B35.6		General Surgery	
· Gynaecomastia	B31.1	N62 N/2X (See comment)	General Surgery	Male only. All activity with diagnosis codes N62 or N62X (Hypertrophy of Breast) should also be included
· Mastopexy	B31.2-3		General Surgery	
Carpal tunnel syndrome	A65.1,8-9 W02.1-4, 8-9	G56.0	Orthopaedics	
Cataract surgery	C75.1-4,8-9 C71.1-3,8-9	H25.- H26.-	Ophthalmology	

Procedure	OPCS (procedures) Codes	ICD10 (diagnosis) Code	Specialty for audit	Comments
	C72.1-3,8-9 C73.1-4,8-9 C74.1-3,8-9	H28.-		
Chalazia	C12.1-6,8-9	H00.1	Ophthalmology	
Chronic fatigue syndrome		G93.3 R53		
Circumcision	N30.3 Z42.6	N48.1 C60.- N47/N47X	General Surgery	
Closure of patent foramen ovale for migraine	K16.5 Y53.1-9	Q21.1 G43.-		
Complementary and alternative therapies				
· Acupuncture	X61.8-9	M545.-		
· Aromatherapy	X61.8-9			
· Chinese medicines				
· Chiropractic therapy	X61.8-9			
· Clinical ecology				
· Herbal remedies				
· Homeopathy				
· Hypnotherapy	X61.8-9			
· Massage	X61.3			
· Osteopathy	X61.8-9			
· Reflexology	X61.8-9			
Continuous glucose monitoring (CGM) for adults with type-1 diabetes mellitus (T1DM)				
Collagen cross linking	C51.8 Y37.1	H18.6,7,9 Q13.4 Q90.-	Ophthalmology	
Dilation and curettage	Q10.1-3,8-9 Q18.1,8-9		Gynaecology	
Divarication of rectus abdominus (surgical repair of)	No code	M62.08 M62.09		
Dupuytren's contracture	T52.1-2, 5-6, 8-9 T54.1,8-9	M72.0	Orthopaedics	
Elective hernia repair in adults	T20.1-4,8-9 T21.1-4,8-9 T22.1-3,8-9 T23.1-3,8-9 T24.1-4,8-9 T25.1-3,8-9 T26.1-3,8-9 T27.1-4,8-9	K40.- K41.- K42.- K43.-		Note, NHS Digital states that Hernia repair with biological mesh codes have been remapped directly to new HRG root FZ87 Complex Hernia Procedures to reflect the additional resource implications of using these meshes.
Electrolysis	S60.6			
Excimer laser surgery for short sight	C44.2 C44.4 C44.5 C46.1	H52.1		
Excision of redundant skin or fat	S03.3, 8-9			

Procedure	OPCS (procedures) Codes	ICD10 (diagnosis) Code	Specialty for audit	Comments
Exogen ultrasound bone healing system for long bone fractures		M84.1		
Facial procedures				
· Blepharoplasty	C13.1-4,8-9		Ophthalmology	
· Brow lift	S01.4-6,8-9			
· Face lift	S01.1-2,8-9			
· Ptosis of eyelid	C15.1-2,4-5 C18.1-6,8-9		Ophthalmology	
· Pinnaplasty	D03.3	Q17.5	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Repair of lobe of external ear	D03.1-2,4,8-9 D06.2		ENT	
· Rhinophyma	E01.8-9 S60.1 E07.8-9	L71.1	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Rhinoplasty/ septorhinoplasty	E02.1-6,8-9 E03.6 E07.3		ENT	
Female genital prolapse	M35.8-9 M53.1 P22.1-3,8-9 P23.1-4,8-9 P24.1-4,8-9	N81.-	Gynaecology	
Female sterilisation	Q27.1-2,8-9 Q28.1-4,8-9		Gynaecology	
FreeStyle Libre flash glucose monitoring system for adults with diabetes mellitus				
Functional Electrical Stimulation (FES) for drop foot of central neurological origin	A70.1 A70.7 Plus site code from chapter Z according to which nerve inserted	M21.3	Neurology	
Ganglia (wrist and foot: surgical techniques for the treatment of)	T59.1-4,8-9 T60.1-4,8-9	M67.4	Orthopaedics	
Gender dysphoria (non-core procedures, commissioning responsibility of the CCG) - Breast augmentation - Facial feminisation surgery - Lipoplasty/contouring - Gamete storage		F64.8 F64.9		Male only
Grommets	D15.1,8-9 D20.2-3,8-9, D28.8-9	18 and under: H65.0-1 F80 Q90 Q35 Over 18: H65.4,9 H68.- H91.9 H81.0	ENT	All procedure codes should be included for audit.
Hair transplant /hair graft/hair replacement	S21.1-2,8-9 S33.1-3,8-9 S34.1-2,8-9			
Hand-held transcutaneous vagus nerve stimulation (tVNS) devices (i.e.	A70.7 with Z04.4	G44.0 G43.-		

Procedure	OPCS (procedures) Codes	ICD10 (diagnosis) Code	Specialty for audit	Comments
Gammacore®) for headache in adults				
Hip & knee replacements				
· Hip	W37.0-3,8-9 W38.0-3,8-9 W39.0-4,8-9		Orthopaedics	
· Knee	W40.0-3,8-9 W41.0-3,8-9 W42.0-4,8-9		Orthopaedics	
Hirsutism treatment	S60.6 -7	L68.0	Dermatology	
Hyperbaric oxygen therapy	X52.1			
Hyperhidrosis	S04.1-3	R61.-		
Hysterectomy for heavy menstrual bleeding	Q07.1-5,7-8 Q08.1-3,8-9		Gynaecology	
Labioplasty	P05.5-7			
Laparoscopic cholecystectomy	J18.1-9 with Y75.2			
Laser therapy/ laser treatment for aesthetic reasons/ tunable dye laser				
Male sterilisation	N17.1-2,8-9		General Surgery	
Minor irregularities of aesthetic significance				
Open MRI scan				
Penile implants	N29.1-2, 8-9			
Plastic operations on umbilicus	T29.6			
Polysomnography in the investigation of children with sleep-related disorders				
Refashioning of scar	S60.4		General Surgery	
Removal of benign skin lesions	S03.8-9 S04.1-3,8-9 S05.1-5,8-9 S06.1-5,8-9 S07.2 S08.1-3,8-9 S09.1-5,8-9 S10.1-5,8-9 S11.1-5,8-9		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				
Reversal of vasectomy / reversal of sterilisation	Q29.1-2,8-9 N18.1		General Surgery	
Skin grafts for scars	S60.4			
Skin resurfacing techniques				
· Chemical peels	S10.3 S11.3		Dermatology	
· Dermabrasion	S60.1-2		Dermatology	
· Laser resurfacing	S09.1-3,8-9		Dermatology	
Spinal Cord Stimulation (SCS) for ischaemic pain	No code			
Spinal fusion for the treatment of lower back pain	V38.2-6 V38.8 V39.3-7 V40.4 With V55 code for level	M545.-	Orthopaedics	

Procedure	OPCS (procedures) Codes	ICD10 (diagnosis) Code	Specialty for audit	Comments
Surgical procedures for the treatment of 'First metatarsalphalangeal joint pathology	W79.1-2,8-9			
Tattoo removal	S60.1-2			
Temporomandibular joint replacement	V20.1-2			
Termination of pregnancy	Q14.1-6, 8-9	O04.5-9	Gynaecology	
Tonsillectomies (±adenoidectomy)	F34.1-9 F36.1,8-9 E20.1	J35.0 G47.3 J36.- L04.0 C02.4 C09.- D10.4 L40.-	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
Transcranial magnetic stimulation (ie SpringTMS) for migraine	A09.8	G43.-		
Traumatic clefts due to avulsion of body piercing				
Trigger finger	T70.5,8-9 T71.1,8-9 T72.8-9 T74.8-9 T65.2,8-9 T69.1,8-9	M65.3	Orthopaedics	All procedure codes should be included for audit. Diagnosis codes are for information only.
Upper gastrointestinal endoscopy for the investigation of dyspepsia	G45.1-4,8-9	K30		
Varicose veins	L84.1-6,8-9 L85.1-3,8-9 L86.1-3,8-9 L87.1-7,8-9 L88.1-3,8-9	I83.- I86.-	Vascular Surgery	
Viral warts		B07/B07X B08.1 B08.8 B09		
Xanthelasma		H02.6		

