



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

Issued by: SE 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)

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Introduction

This schedule of commissioning policy statements sets out Kent and Medway Clinical Commissioning Groups (CCGs) decision 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 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). 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

Propantheline bromide 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 propantheline. 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.

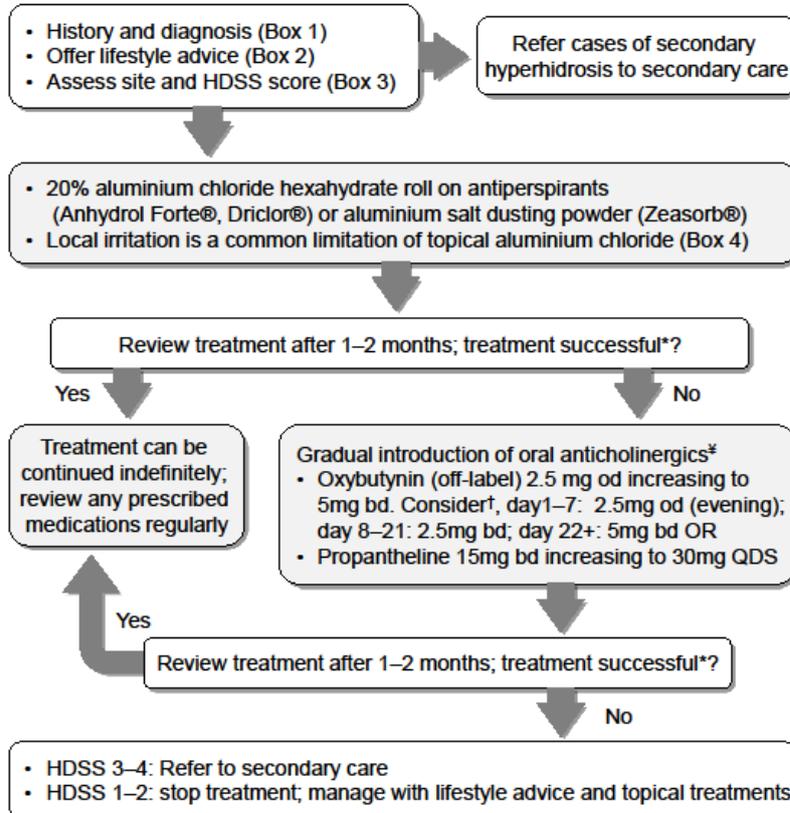
Surgery

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

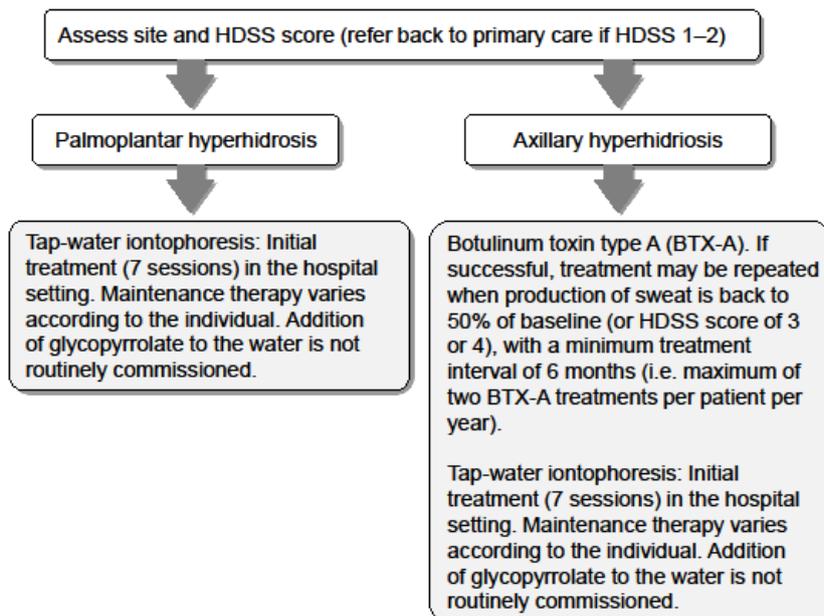


* Successful treatment: Reduction in HDSS score from 3–4 to 1–2. Treatment failure: no change in HDSS or lack of tolerability for treatment.

‡ 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 ENT

3.1 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

3.2 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

3.3 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.

3.4

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.

3.5 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.

3.6 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

3.7 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.

4 Gender dysphoria

4.1 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.

5 General surgery, urology and vascular

5.1 Bariatric surgery in adults

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

5.2 Brow-lift

Policy

This procedure is not routinely funded.

5.3 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.

5.4 Elective hernia repair in adults

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.

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

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

Continued overleaf

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.

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).

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.

5.5 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

5.6 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

5.7 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.

5.8 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).

5.9 Penile implants

Policy

Penile implants are not routinely funded.

5.10 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.

5.11 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](#).

5.12 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).

6.1 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](#).

6.2 Female genital prolapse (primary surgical management of)

Background

The organs within a woman's pelvis (uterus, bladder and rectum) are normally held in place by ligaments and muscles known as the pelvic floor. If these support structures are weakened, the pelvic organs can bulge (prolapse) from their natural position into the vagina. When this happens it is known as pelvic organ prolapse. Mild prolapse often causes no symptoms. More severe prolapse can cause bladder and bowel problems, and sexual activity may also be affected. There are different types of prolapse depending on which organ is bulging into the vagina.

Policy

This procedure is not routinely funded for asymptomatic or mild pelvic organ prolapse. Referral for specialist assessment may only be considered for:

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

6.3 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.

6.4 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.

6.5

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.

6.6 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.

6.7 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

7 Neurology

7.1 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

7.2 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.

7.3 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.

7.4 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 Oncology

8.1 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

8.2

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

8.3 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

8.4

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

8.5 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

9 Ophthalmology

9.1 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.

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 5). It is also important to manage risk factors (if present), especially blepharitis, to reduce the risk of future episodes.

Box 5 – 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.

9.3

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

9.4 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.

9.5 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.

9.6

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).

10 Oral Surgery

10.1 Temporomandibular joint replacement

Policy

This procedure is not routinely funded.

11 Orthopaedics

11.1 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')

11.2 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

11.3 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).

11.4 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 recommended 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 recommended 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 distal femur, femur, tibia, ulna and radius

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

Rationale

According to NICE medical technology 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.

11.5 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.

11.6 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

11.7 Spinal fusion for the treatment of lower back pain

Background

Spinal fusion is a surgical procedure where two or more vertebrae are joined together with a section of bone to stabilise the spine and reduce pain.

Policy

Patients should be managed in line with [NICE CG88](#). Referral for an opinion on spinal fusion should only be considered for patients who:

- have completed an optimal package of care, including a combined physical and psychological treatment programme, *and*
- still have severe non-specific low back pain for which they would consider surgery.

Commissioning responsibility for some types of spinal surgery 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

11.8 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

11.9 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

12 Other

12.1 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.

12.2 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

12.3 Minor irregularities of aesthetic significance only

Policy

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

12.4 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

13 Paediatrics

13.1 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

14 Plastic surgery

14.1 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.

14.2 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.

14.3 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.

14.4 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.

14.5 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 a currently a priority.

14.6 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.

14.7 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. Common indications for breast augmentation include amastia, tuberous breasts and breast asymmetry.

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

Policy

- Breast augmentation is not 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 patients undergoing gender reassignment surgery.

Rationale

The impact of living with indications for breast augmentation is not well documented. Poor quality evidence suggests that patients are generally satisfied with the outcome of surgery, however complication rates are high. The impact of surgery on clinically meaningful outcomes such as quality of life, psychosocial factors and daily function have not been robustly demonstrated.

14.8 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. Revision of breast augmentation is most commonly undertaken to treat capsular contracture. 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 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.
- The above statement applies both to patients who underwent their original breast augmentation surgery privately and those who received it on the NHS.

These recommendations do not apply to the following:

- patients undergoing breast reconstruction as part of treatment for breast cancer
- patients undergoing gender reassignment surgery
- patients with PIP implants for whom national guidance applies

Rationale

In 2012, the Chief Medical Officer stated that the NHS will fund the removal of PIP implants inserted by the NHS or at private practices free of charge for women who are concerned. In addition, the NHS will fund implant replacements for women who received PIP implants on the NHS.

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

14.9 Breast procedures – Breast reduction

Background

Hypertrophy of the breasts, gigantomastia and macromastia are terms commonly used to describe large breasts. Patients with hypertrophy of the breasts commonly complain of breast discomfort, neck ache, back ache, shoulder pain and discomfort exercising. Because of these problems, individuals with hypertrophy of the breast may present for breast reduction.

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 $<26\text{kg/m}^2$;
 - Non-smoker

Rationale

Studies reported breast reduction led to improvements in breast-related symptoms, health-related quality of life, mental health, sexual function and postural stability. Although reports of complications and post-operative pain were common, patients were generally satisfied with surgery.

14.10 Breast procedures – Correction of gynaecomastia

Background

Gynaecomastia is defined as the benign glandular proliferation of the male breast, causing enlargement. It is often attributed to hormonal imbalance, medications, or drug misuse. In addition, the condition may be caused by cancer or endocrine abnormalities. There are three peak incidences for gynaecomastia: neonatal, puberty and the sixth to ninth decades. Pseudogynaecomastia describes male breasts composed of adipose tissue. Correction of gynaecomastia normally involves subcutaneous mastectomy. Mild or moderate gynaecomastia may be corrected using liposuction as an alternative.

Policy

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

This recommendation does not apply to prostate cancer patients.

Rationale

The impact of living with gynaecomastia is not well documented.

Poor quality evidence suggests patients are generally satisfied with the results of their surgery. Complications were fairly common but in general were mild to moderate in severity. The impact of surgery on clinically meaningful outcomes such as quality of life, psychosocial factors and daily function have not been robustly demonstrated.

14.11 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.

Indications for mastopexy include ptosis of the breasts, which is characterised by a loss in volume and the presence of redundant skin. This condition occurs naturally with age but can be more pronounced following significant weight loss or after completion of breast-feeding.

Policy

- Mastopexy is not 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.

Rationale

The impact of living with ptosis of the breasts is not well documented.

Poor quality evidence suggests that patients are generally satisfied with the outcome of surgery, however complication rates are high. The impact of surgery on clinically meaningful outcomes such as quality of life, psychosocial factors and daily function have not been robustly demonstrated.

14.12 Breast procedures – Nipple eversion

Background

Inverted nipple is a common congenital 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.

Correction of inverted nipples may be carried out in several ways depending on the degree of retraction; surgery is only appropriate for the more severe cases.

Policy

- Nipple eversion is not 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.

Rationale

The impact of living with inverted nipples is not well documented.

Poor quality evidence suggests patients are generally satisfied with the results of surgery, however the impact of this intervention on quality of life and psychosocial factors has not been robustly demonstrated. Complications reported were generally mild in severity.

14.13 Calf implants

Background

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

Policy

This procedure is not routinely funded.

14.14 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

14.15 Plastic operations on umbilicus

Policy

Plastic operations on umbilicus are not routinely funded.

15.1 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 the South East Commissioning Support Unit (SE 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 2015/16 or may agree ad-hoc audits as a follow up to the audits completed in previous years.

Procedure	ACT to identify and challenge	CCG to Audit	OPCS Codes	Diagnosis Code	Specialty for audit	Comments
Acne scarring	X		S601-2 S091-3,8-9 S103 S113 S601-2		Dermatology	
Arthroscopy of the knee		X	W871-879		Orthopaedics	
Body contouring procedures:	X					
· Abdominoplasty/ apronectomy	X		S021-2,8-9		General Surgery	
· Brachioplasty / upper arm lift	X		S033,8-9		General Surgery	
· Buttock lift	X		S031,8-9		General Surgery	
· Calf implants	X				General Surgery	
· Liposuction	X		S621-2		General Surgery	
· Neck lift	X				General Surgery	
· Thigh lift	X		S032-3,8-9		General Surgery	
· Upper arm reduction	X		S033,8-9		General Surgery	
Breast procedures	X					
· Breast augmentation	X		B312			
· Revision of breast augmentation			B295,B302,B314, B332, B374			
· Breast reduction	X		B311			
· Nipple eversion	X		B356		General Surgery	
· Gynaecomastia	X		B311	N62 N62X (See comment)	General Surgery	Male only. All activity with diagnosis codes N62 or N62X (Hypertrophy of Breast) should also be included
· Mastopexy	X		B312-3		General Surgery	
Carpal tunnel syndrome		X	A651,8-9		Orthopaedics	
Cataract surgery		X	C751		Ophthalmology	
Chalazia	X		C121-6,8-9		Ophthalmology	
Chronic fatigue syndrome	X					
Circumcision		X	N303, Z426		General Surgery	
Closure of patent foramen ovale for migraine						
Complementary and alternative therapies						
· Acupuncture						
· Aromatherapy						
· Chinese medicines						

Procedure	ACT to identify and challenge	CCG to Audit	OPCS Codes	Diagnosis Code	Specialty for audit	Comments
· Chiropractic therapy						
· Clinical ecology						
· Herbal remedies						
· Homeopathy						
· Hypnotherapy						
· Massage						
· Osteopathy						
· Reflexology						
Collagen cross linking					Ophthalmology	
Dilation and curettage	X	X	Q101-3,8-9 Q181,8-9		Gynaecology	
Dupuytren's contracture	X	X	T521-2,8-9 T541,8-9		Orthopaedics	
Electrolysis			S606			
Excimer laser surgery for short sight	X		C461			
Excision of redundant skin or fat	X		S031-3			
Facial procedures						
· Blepharoplasty	X	X	C131-4,8-9		Ophthalmology	
· Brow lift	X		S014-6,8-9			
· Face lift	X		S011-3,8-9			
· Ptosis of eyelid	X	X	C151-2, C181-6,8-9		Ophthalmology	
· Pinnaplasty	X	X	D033	Q175	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Repair of lobe of external ear	X		D031-2,4,8-9 D062		ENT	
· Rhinophyma	X		E011,8-9	L711	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
· Rhinoplasty/ septorhinoplasty	X		E021-6,8-9, E036 E073		ENT	
· Submental lipectomy						
Female genital prolapse		X	M358-9 M531 P221-3,8-9 P231-4,8-9 P241-4,8-9		Gynaecology	
Female sterilisation	X	X	Q271-2,8-9 Q281-4,8-9		Gynaecology	
Functional Electrical Stimulation (FES) for drop foot of central neurological origin					Neurology	
Ganglia (wrist and foot: surgical techniques for the treatment of)	X	X	T591-4,8-9 T601-4,8-9		Orthopaedics	
Grommets		X	D151, 8-9 D202-3,8-9, D288-9	18 and under H650, H651, F80, Q90, Q35 Over 18 H654, H659,	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.

Procedure	ACT to identify and challenge	CCG to Audit	OPCS Codes	Diagnosis Code	Specialty for audit	Comments
				H919, H810, H68		
Hair transplant /hair graft/hair replacement			S331-4,8-9 S341-2,8-9			
Hip & knee replacements						
· Hip		X	W370-3,8-9 W380-3,8-9 W390-4,8-9		Orthopaedics	
· Knee		X	W400-3,8-9 W410-3,8-9 W420-4,8-9		Orthopaedics	
Hirsutism treatment	X		S606	L680	Dermatology	
Hyperbaric oxygen therapy	X		X521			
Hyperhidrosis	X					
Hysterectomy for heavy menstrual bleeding		X	Q071-5,7-8 Q081-3,8-9		Gynaecology	
Inguinal hernia in adults		X			General Surgery	
Intra-uterine insemination (IUI), in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) - Assisted conception treatments for sub-fertility			Q134-Q137-Y96 inc Y961-Y969			
Labiaplasty						
Laser therapy/ laser treatment for aesthetic reasons/ tunable dye laser	X		ICD Q825			
Male sterilisation	X				General Surgery	
Minor irregularities of aesthetic significance						
Open MRI scan						
Penile implants	X		N29			
Plastic operations on umbilicus						
Polysomnography in the investigation of children with sleep-related disorders						
Refashioning of scar			S604		General Surgery	
Removal of benign skin lesions		X	S038-9 S041-3,8-9 S051-5,8-9 S061-5,8-9 S081-3,8-9 S091-3,8-9 S101-4,8-9 S111-4,8-9		Dermatology (See comment)	Assessment must be completed by a Dermatologist. Activity that is assigned to another specialty must be included in audit.
Residential pain management programmes						
Reversal of vasectomy / reversal of sterilisation	X		Q291-2,8-9 N181		General Surgery	
Skin grafts for scars	X		S604			
Skin resurfacing techniques	X		S601-2 S091-3,8-9 S103 S113			
· Chemical peels	X				Dermatology	
· Dermabrasion	X				Dermatology	
Spinal Cord Stimulation (SCS) for ischaemic pain			S483			

Procedure	ACT to identify and challenge	CCG to Audit	OPCS Codes	Diagnosis Code	Specialty for audit	Comments
Spinal fusion for the treatment of lower back pain	X	X			Orthopaedics	
Surgical procedures for the treatment of 'First metatarsalphalangeal joint pathology						
Tattoo removal	X		S601-3			
Temporomandibular joint replacement						
Termination of pregnancy		X			Gynaecology	
Tonsillectomies		X	F341-9	J350, G473, J36, L040	ENT	All procedure codes should be included for audit. Diagnosis codes are for information only.
Traumatic clefts due to avulsion of body piercing						
Trigger finger	X		T705,8-9 T711,8-9 T728-9 T748-9 T652,8-9 T691,8-9	M200 M653	Orthopaedics	All procedure codes should be included for audit. Diagnosis codes are for information only.
Upper gastrointestinal endoscopy for the investigation of dyspepsia						
Varicose veins	X	X	L841-6,8-9 L851-3,8-9 L861-2,8-9 L871-6,8-9 L881-3,8-9		Vascular Surgery	
Ventral/ incisional hernias (surgical repair of)			T251-3, T258-9, T261-4, T268-9, T271-4, T278-9			
Viral warts	X			B081		
Xanthelasma	X			H026		

