Value Based Clinical Commissioning Policies

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Value Based Clinical Commissioning Policies

Introduction

Across the country most, if not all, PCTs have a set of policies and procedures for limiting the number of low clinical value interventions as part of their QIPP plans. The Audit Commission recently published a report ‘Reducing expenditure on low clinical value treatments’\(^1\) that analyses how PCTs are approaching this. The report is supported by an online tool\(^2\) that looks at PCT expenditure on treatments of limited clinical value. The tool is based on the ‘Save to Invest’ programme developed by the London Health Observatory\(^3\) incorporating the ‘Croydon List’ of 34 low priority treatments.

The PCTs in the North East have a similar set of policies developed in 2010. Since then the policies have not been reviewed, and each PCT has made some changes to these policies reflecting local views, resulting in differences in the interpretation and application of the policies. The need for a consistent set of policies came from the North East Advisory Group looking into the transition arrangements for the NHS. In response, this document has been produced by a group of specialists in public health medicine from each of the four PCT clusters. We have taken the advice of consultants in different clinical specialties for specific policies (names and contact details of the members of the group can be found in Appendix 1).

While reviewing the original 2010 set of policies, we have removed any intervention covered by a NICE Technology Appraisal or Clinical Guideline where there is an obligation for NHS bodies to implement their recommendation. A list of relevant recommendations from NICE can be found in Appendix 2. Not included in this document is any procedure that is included in the remit of NHS Specialist Services Commissioning. A list of these services is included in Appendix 3. There are other bodies, whose treatment recommendations NHS organisations in the North East also agree to support, such as the North East Cancer Drugs Advisory Group and the North East Treatment Advisory Group. These interventions are not included in this document, as the guidance and mandate is already clear.

There are other national and regional guidelines, and reviews of the effectiveness and cost-effectiveness of treatments, where the mandate for the NHS is less clear cut. These include Intervventional Procedure Guidance produced by NICE, technology assessments by bodies other than NICE, and guidance from professional bodies. These therefore need some clarification about what procedures NHS funding will routinely be available for, and under what circumstances.

The following document lists the interventions that the NHS commissioners in the North East have agreed to adopt as policies for limiting low clinical value interventions. The list includes procedures where there is evidence that they are not clinically effective, procedures where there is a lack of evidence for their effectiveness, and procedures that

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are effective for some patients and not others. We have included the funding policies for infertility and pre-implantation genetic diagnosis. The reason for their inclusion here is that PCTs have agreed to limit funding for these interventions to those who will gain the most benefit and not about their value as a clinical intervention.

The content of the document will be subject to a quarterly update and a full review in January 2013. If you have any comments on any of the policies then contact one of the members of the policy review group (contact details in Appendix 1)

The purpose of this document is to support a consistent approach to decommissioning treatments of low clinical value across the North East. The aim is to make it easier for GPs and consultants to use in clinical practice, and to ensure that the policies are applied consistently across all PCTs. These policies will be included in contracts between commissioners and providers and will be regularly monitored by the contracting teams.

The policies are written in such a way that it should be clear if a patient fulfils the criteria for funding. Each PCT will continue to run its own Individual Funding Request process and will use the policies in this document to support local decision making.

The mechanisms available for supporting local implementation of these policies include audit, monitoring within the Quality Schedules of contracts with NHS Trusts, service specifications, contract review meetings, incentive schemes, and service reform initiatives. The application of these tools will be at the discretion of each PCT. There is further information about the decision making process in the Q&A section in Appendix 4. If you would like a copy of the Exceptional Treatment Policy for the PCT in your area then contact the IFR Manager (contact details in Appendix 1).

Acknowledgements:

We are indebted to colleagues in other parts of the country for advice and information. In particularly we are grateful to the Health Commission Wales for permission to base our work on published National Public Health Service of Wales guidance. We would like to thank the following colleagues for their suggestions and comments on specific policies:

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Value Based Clinical Commissioning Policies

Carpal Tunnel Syndrome (OPCS Code: A65.1 A65.8)

**Background:** Evidence from observational studies shows that symptoms resolve spontaneously in some people: good prognostic indicators are short duration of symptoms, a young age, and carpal tunnel syndrome due to pregnancy.

There is good evidence that surgical treatment relieves the symptoms of carpal tunnel syndrome (CTS) more effectively than splinting. However splinting is effective in about 50% of people in the short term.

Carpal tunnel surgery is a low priority procedure for patients with intermittent or mild to moderate symptoms. The exception to this are patients who have not responded to 3 months of conservative management, including:

- At least 8 weeks of night-time use of wrist splints and/or
- Corticosteroid injection in appropriate patients

**Referral guidance:** Consider referral for electromyography and nerve conduction studies if the diagnosis is uncertain.

**Policy:** Carpal tunnel surgery will be funded if the following criteria are met:

- Symptoms persist or recur after conservative therapy with either local corticosteroid injections and/or nocturnal splinting
  OR
- There is neurological deficit, for example sensory blunting, thenar muscle wasting or motor weakness
  OR
- There are severe symptoms that significantly interfere with daily activities.

**References:**

1. NHS Clinical Knowledge Summaries [http://www.cks.nhs.uk/carpal_tunnel_syndrome#337731001](http://www.cks.nhs.uk/carpal_tunnel_syndrome#337731001)

Breast augmentation (Breast enlargement) (OPCS Code: B31.2)

**Background:** Breast augmentation/enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape. It should not be carried out for “small” but normal breasts or for breast tissue involution (including post partum changes). Breast implants should have a life span and any approval granted is for one course of treatment and any complications.
Referral guidance:
- Include the cup size of each breast in your referral letter

Policy: Breast augmentation will only be funded in accordance with the criteria specified below.

For women:
- with a complete absence of breast tissue unilaterally or bilaterally;
OR
- with of a significant degree of asymmetry of breast shape of two or more cup sizes.

Breast prosthesis removal or replacement (OPCS Code: B30.-)

Background: breast prosthesis may have to be removed after some complications such as leakage of silicone gel or physical intolerance or social unacceptability by the individual. It may have to be replaced after the given age of the implant is over.

Policy: Breast prosthesis removal or replacement will only be funded in accordance with the criteria specified below.

- Revision surgery will only be considered if the NHS commissioned the original surgery. If revision surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the criteria for augmentation at the time of revision.
- For patients who had original surgery carried out privately, removal to make safe only will be provided. Further treatment will only be commissioned in light of appropriate evidence being provided to prove that the patient meets the criteria for breast augmentation at the time of application based on their original breast size before private implants were inserted.

Breast reduction (OPCS Code: B31.1)

Background: excessively large breasts can cause physical and psychological problems. Breast reduction procedure involves removing excess breast tissue to reduce size and improve shape.

Policy: Breast reduction will only be funded in accordance with the criteria specified below.

For women:
- suffering from neck ache or, backache or intertrigo;
AND
- wearing a professionally fitted brassiere has not relieved the symptoms;
AND
- has a preoperative body mass index (BMI) of less than 27 kg/m².

At least 500gms of tissue will be removed from each breast (see below for guidance on assessment).

<table>
<thead>
<tr>
<th>Chest measurement (in)</th>
<th>Minimum cup size</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 / 34</td>
<td>&gt;= E</td>
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</tbody>
</table>
Once women have reached this size, they are likely to have a significant weight problem which should be addressed prior to surgery.

**Gynaecomastia (OPCS Code: B31.1)**

**Background:** Gynaecomastia (ICD-10 Code: N62X) is benign enlargement of the male breast. Most cases are idiopathic. For others endocrinological disorders and certain drugs such as oestrogens, gonadotrophins, digoxin, spironolactone, cimetidine and proton pump inhibitors could be the primary cause. Obesity can also give the appearance of breast development as part of the wide distribution of excess adipose tissue.

**Referral guidance:** Ensure that appropriate screening for endocrinological and drug related causes and/or psychological distress occurs prior to consultation with a plastic surgeon.

**Policy:** Surgery to correct gynaecomastia will only be funded in accordance with the criteria specified below.

- Post pubertal
- BMI less than 27 Kg/m².

**Exclusions:** Body builders and sportsmen desiring reduction of perceived excess prepectoral tissue to enhance appearance at the gymnasium will not be funded.

**Inverted nipple correction (OPCS Code: B35.6)**

**Background:** The term inverted nipple (ICD-10 Code: N64.5) refers to a nipple that is tucked into the breast instead of sticking out or being flat. It can be unilateral or bilateral. It may cause functional and psychological disturbance. Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded.

**Policy:** Surgery for the correction of inverted nipple for cosmetic reasons will not be funded.

**Mastopexy (OPCS Code: B31.3)**

**Background:** Breasts begin to sag and droop with age as a natural process. Pregnancy, lactation and substantial weight loss may escalate this process. This is sometimes complicated by the presence of a prosthesis which becomes separated from the main breast tissue leading to “double bubble” appearance.

**Policy:** Mastopexy will only be funded in accordance with the criteria specified below.

- Whilst this is routinely part of treating breast asymmetry and reduction it is not available for purely cosmetic/aesthetic purposes, such as postlactational ptosis. The presence of a prosthesis does not change eligibility for mastopexy.
- Criteria for asymmetry and breast reduction should be met to qualify for mastopexy.
Revision mammoplasty (OPCS Codes: B31.4, B30.2)

**Background:** The term mammoplasty refers to breast reduction or augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or as a result of problem with implants.

**Policy:** Revision mammoplasty will only be funded in accordance with the criteria specified below.

- Revisional surgery will only be considered if the NHS commissioned the original surgery. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them should be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.

Autologous Serum Eye Drops

**Background:** Autologous serum eye drops treat severe keratoconjunctivitis sicca (dry eye). Dry eyes can be helped with intensive treatment with artificial teardrops however for some patients the symptoms are not completely relieved. The National Blood Service has developed an alternative to these artificial drops. Autologous serum eye drops are a last resort measure where all other conservative interventions have failed.

**Policy:** Autologous serum eye drops will only be funded in accordance with the criteria specified below.

- Patients have been treated with maximal tolerated artificial tear therapy (preservative free).
- Indefinite NHS funding will be subject to the submission of a progress report following a 5 month trial.

Collagen cross-linking for corneal irregularities including keratoconus

**Background:** These are highly variable conditions. This treatment is the only one with the potential to delay the need for corneal transplant.

**Policy:** Collagen cross-linking will only be funded in accordance with the criteria specified below.

For those cases where there is documented progression of disease, but before the disease has progressed to spectacle or contact lens intolerance, the PCT will consider these on an individual basis.

Excimer laser for cases with poor refraction after corneal transplant or cataract surgery (OPCS Codes: C46.1.)

**Background:** This is a last resort measure where all other conservative and surgical interventions have failed.

**Policy:** This procedure will only be funded if all other conservative and surgical interventions have failed.
**Excimer laser for corneal erosions**  
(OPCS Codes: C45.3)

**Background:** This is a last resort measure where all other conservative and surgical interventions have failed.

For these cases, we will normally expect a recognised expert in corneal disorders to assess and endorse the request.

**Policy:** This procedure will only be funded if all other conservative and surgical interventions have failed.

**Excimer laser for refractive error**  
(OPCS Code: C46.1)

**Background:** Photorefractive (laser) surgery for the correction of refractive errors is safe and effective in appropriately selected patients. Photorefractive surgery should be considered against the alternative methods of correction: spectacles and contact lenses.

**Policy:** Laser surgery for the correction of refractive error will only be funded for patients in the range of refractive error from +6 dioptres (D) of hyperopia to –10 D of myopia, with up to 4 cylinders of astigmatism.

**References**

**Blepharoplasty**  
(OPCS Code: C13.)

**Background:** blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision. It is usually done for cosmetic reasons. Consideration should be given to whether blepharoplasty or brow lift is the more appropriate procedure, particularly in the case of obscured visual fields.

**Policy:** Blepharoplasty will only be funded in accordance with the criteria specified below.

- Impairment of visual fields in the relaxed, non-compensated state;
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow.

**Pinnaplasty**  
(OPCS Code: D03.3)

**Background:** pinnaplasty is performed for the correction of prominent ears or bat ears (ICD-10 Code: Q17.5). Prominent ears are a condition where one's ears stick out more than normal. This condition does not cause any physical problems but may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy.

This policy does not cover congenital abnormalities of the external ear. These should be managed by plastic surgeons and do not need prior approval through the IFR process.
Policy: Pinnaplasty will only be funded in accordance with the criteria specified below.
- The patient must be under the age of 19 years at the time of referral.
- Patients under 5 years of age will not be considered for this procedure.

Repair of lobe of external ear (OPCS Code: D06.2)

Background: the external ear lobe can split partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.

Policy: Repair of lobe of external ear will only be funded in accordance with the criteria specified below.
- If the totally split ear lobes is a result of direct trauma and the treatment is required at the time of or soon after the acute episode.

Rhinoplasty (OPCS Codes: E02.3, E02.4, E02.5, E02.6)

Background: rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self image.

Policy: Rhinoplasty will only be funded in accordance with the criteria specified below.
- Problems caused by obstruction of the nasal airway;
  OR
- Objective nasal deformity caused by trauma;
  OR
- Correction of complex congenital conditions e.g. cleft lip and palate.

Tonsillectomy (OPCS Code: F34.-)

Background: Tonsillectomy is one of the most frequently performed surgical procedures in the UK. There is no high quality evidence in adults for the effectiveness of tonsillectomy. In children who are not severely affected by tonsillitis, any benefits from tonsillectomy may be outweighed by the morbidity associated with surgery.

Policy: Tonsillectomy will only be funded in accordance with the criteria specified below.

For recurrent **acute sore throat in adults and children** in the following circumstances:

- The sore throats are due to tonsillitis;
  AND
- The episodes of sore throat are disabling and prevent normal functioning
  AND
- Seven or more well documented, clinically significant, adequately treated episodes of sore throat in the previous year;
  OR
  - Five or more such episodes have occurred in each of the preceding two years
  OR
  - Three or more such episodes have occurred in each of the preceding three years.
In addition there is no restriction on funding for the following conditions:

- Quinsy
  OR
- Tonsil bleeding
  OR
- Severe neck infection
  OR
- To exclude possible malignancy e.g. lymphoma
  OR
- Adult obstructive sleep apnoea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful).
  OR
- Sleep disordered breathing (apnoea) in children

References:
4. National Specialist Advisory Group (NSAG) of ENT Surgeons of Wales. (e-mail communication)

Apicectomy (OPCS Code: F12.1)

**Background:** Apicectomy is a surgical procedure involving the removal of infected tip of the root of a tooth and a small amount of surrounding bone and tissue. The success rate of apical surgery on molar teeth is low and should not be routinely undertaken. It is also sufficiently destructive that it may also compromise the chances of a subsequent dental prosthesis.

**Policy:** Apicectomy will only be funded in exceptional clinical circumstances based on the following criteria.

- presence of periradicular disease, with or without symptoms in a root filled tooth, where non surgical root canal re-treatment cannot be undertaken or has failed, or
where conventional re-treatment may be detrimental to the retention of the tooth. For example, obliterated root canals, small teeth with full coverage restorations where conventional access may jeopardise the underlying core. It is recognised that non-surgical root canal treatment is the treatment of choice in most cases;

OR

• presence of periradicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken;

OR

• where a biopsy of periradicular tissue is required;

OR

• where visualisation of the periradicular tissues and tooth root is required when perforation, root crack or fracture is suspected;

OR

• where procedures are required that require either tooth sectioning or root amputation;

OR

• where it may not be expedient to undertake prolonged non surgical root canal re-treatment because of patient considerations.

References


Dental implants (OPCS Code: F11.5)

**Background:** An endosseous dental implant is a surgically implanted device which replaces the lost roots of a tooth and which can offer the possibility of a stable prosthesis for individuals who have suffered extensive loss of oral tissue. Osseointegrated dental implants have been shown to be a successful and predictable treatment for replacing missing teeth by providing support for fixed bridge prostheses, individual crowns, and overdentures. They are also useful to provide support for maxillofacial prostheses providing a functional dentition for patients with the severe disfiguring oral and dental pathology that may result from developmental conditions, major trauma or following the resection of malignancies.

The technique relies on the principle of osseointegration. The titanium implants become integrated within the jaw bone giving the implant stability and permitting the attachment of prostheses to the implant(s).

**Policy:** Dental implants will only be funded in accordance to the criteria specified below.

Implants should be considered for NHS funding in the following groups, where there is no practical alternative and other alternatives have been demonstrably explored and excluded:

• Patients with maxillofacial and cranial defects.

OR

• Individuals with considerable amounts of missing hard tissue and/or teeth, which may result from developmental disorders or tumours. These include:
  - Clefts of the hard and / or soft palate
Major maxillary / mandibular resections
Extensive alveolar ridge deformities

- Patients with anodontia (congenital absence of all teeth), or oligodontia (≥6 congenitally missing teeth).

OR
- Patients who have suffered major trauma

OR
- Dental implants would not normally be considered where there is significant risk of failure because of: tobacco smoking, misuse of drugs or alcohol, severe psychiatric problems, or medical conditions of the bone or bleeding disorders, poor oral hygiene, uncontrolled dental caries, untreated periodontal disease, bruxism or other parafunctional habits, participation in contact sports.

OR
- Dental implants are not suitable for those who are still growing.

References
2. The guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS. Faculty of Dental Surgery, National Clinical Guidelines, Royal College of Surgeons of England, 1997.

Orthodontic treatments for essentially cosmetic nature (OPCS Codes: F14.-, F15.-)

Background: Orthodontic dentistry specialises in aligning crooked teeth. The treatment involves wearing braces. Quite often this treatment is undertaken for cosmetic reasons.

Policy: Orthodontic treatments for cosmetic reasons will only be funded in accordance with the criteria specified below.
- Orthodontic treatment is offered to people with a score of greater than 5 on the Index of Orthodontic Treatment Need (IOTN).

References

Cholecystectomy (for asymptomatic gall stones) (OPCS Code: J18.-)

Background: Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones (Code: K80.2). Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy.

Policy: Cholecystectomy (for asymptomatic gall stones) will only be funded in exceptional clinical circumstances through an Individual Funding Request.
Varicose veins  

**OPCS Codes: L84.-, L85.-, L86.-, L87.-, L88.-**

**Background:** In general varicose veins do not require surgical intervention. However, some are sufficiently troublesome to require treatment. The most common complaint about varicose veins is their appearance. Patients report symptoms such as aches, pains, restless legs, cramps, itchiness, heaviness and oedema. However, a link between symptoms and varicose veins can be difficult to establish. When indicated, endovenous surgical treatment should be given in an outpatient setting.

**Referral guidance:**
- Bleeding from a varicosity that has eroded the skin
- History of bleeding from a varicosity and are at risk of bleeding again
- Ulceration which is progressive and/or painful despite treatment
- Active or healed ulceration and/or progressive skin changes that may benefit from surgery
- Recurrent superficial thrombophlebitis
- Discomfort attributable to varicose veins having a severe impact on quality of life.

**Policy:** Surgical treatment for varicose veins will only be funded in accordance with the criteria specified below.

- Persistent ulceration that is painful or progressive (ICD-10 Codes: I83.0, I83.2)  
  OR
- Recurrent superficial thrombophlebitis (ICD-10 Codes: I83.1, I83.2) where there is significant pain and disability following an unsuccessful 6 month trial of conservative management (compression stockings, exercise and daily elevation 2-3 times a day)  
  OR
- Significant haemorrhage from a ruptured superficial varicosity  
  OR
- Patients with significant discomfort likely to be due to varicose veins  
  AND
- Have not responded to at least 6 months of conservative management (compression stockings, exercise and daily elevation 2-3 times a day)

**Uncomplicated varicose veins**
- Patients whose primary concern is cosmetic will not be funded for surgical treatment.

**References:**
1. NHS Clinical Knowledge Summaries [http://www.cks.nhs.uk/varicose_veins#337903004](http://www.cks.nhs.uk/varicose_veins#337903004)

Reversal of male sterilisation  

**OPCS Codes: N18.1**

**Background:** Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the vas deferens.
Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

Policy: Reversal of sterilisation will only be funded in exceptional clinical circumstances through an Individual Funding Request.

Reversal of female sterilisation (OPCS Codes: Q29.-, Q27.-)

Background: Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Sterilisation procedure is available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

Policy: Reversal of sterilisation will only be funded in exceptional clinical circumstances through an Individual Funding Request.

Circumcision (OPCS Code: N30.3)

Background: Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications.

Policy: Circumcision will only be funded for specific medical reasons in accordance with the criteria specified below.

Medical reasons for funding circumcision include:

- Phimosis in children with spraying, ballooning and/or recurrent infection;
- Adult Phimosis;
- recurrent balanitis;
- Balanitis xerotica obliterans;
- Paraphimosis;
- Suspected malignancy;
- Dermatological disorders unresponsive to treatment;
- Congenital urological abnormalities when skin is required for grafting;
- Interference with normal sexual activity in adult males.

References:
Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty (OPCS Codes: P21.3)

Surgery for Vaginoplasty, Labial Vulvoplasty and Vulvar lipoplasty are all cosmetic procedures. This policy does not cover the immediate vaginal repair following delivery and is part of obstetric care.

Policy: Vaginoplasty will only be funded in exceptional clinical circumstances through an Individual Funding Request.

Hirsutism (OPCS Codes: S09.2.1, S60.6)

Background: Laser treatment is increasingly being used as a cosmetic intervention to remove body hair. Patients with excessive body hair are described as having hirsutism. Hair depilation (for the management of hypertrichosis – code L68) involves permanent removal/reduction of hair from face, neck, legs, armpits and other areas of body usually for cosmetic reasons. Hair depilation is most effectively achieved by laser treatment. This policy does not cover individuals undergoing gender reassignment. These individuals are covered under the policy “Gender Reassignment Surgery in Adults”.

Policy: Hair depilation will only be funded in accordance with the criteria specified below.

One course of treatment will be funded for those patients:

- Who are undergoing treatment for pilonidal sinuses to reduce recurrence, OR
- For patients with excessive hair who have undergone reconstructive surgery leading to abnormally located hair-bearing skin.

Applications in other exceptional circumstances will need to demonstrate that:

- Normal means of dealing with hair growth such as shaving, dyeing, depilatory creams have been tried.

AND

- in the opinion of the patient’s GP/specialist consultant, the amount of body hair is excessive and beyond normal limits.

Removal of tattoos (OPCS Codes: S60.1, S60.2, S60.3)

Background: A tattoo (ICD-10 Code: L81.8) is a mark made by inserting pigment into the skin. People choose to be tattooed for various cosmetic, social, and religious reasons. It carries certain health risks such as infection and allergic reaction. A tattoo can be removed by laser, surgical excision, or dermabrasion.

Policy: Tattoo removal will only be funded in accordance with the criteria specified below.

- Where the tattoo is the result of trauma, inflicted against the patient’s will (“rape tattoo”); OR
- The patient was not Gillick competent, and therefore not responsible for their actions, at the time of the tattooing.
Resurfacing procedures: Dermabrasion, chemical peels and laser treatment  
(OPCS Codes: S60.1, S60.2, S09.-, S10.3, S11.3)

**Background:** Dermabrasion, involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications.

**Policy:** Resurfacing procedures including dermabrasion, chemical peels and laser treatment will only be funded in accordance with the criteria specified below.

For those with post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

**Capillary Haemangiomas (Port Wine Stains):** Laser treatment of capillary haemangiomas on the face and neck will be supported. Applications for treatment of capillary haemangiomas on other parts of the body, will be considered, but will be considered on a case by case basis.

Laser is not an appropriate treatment option for cavernous haemangiomas (Strawberry Naevi) and will not be considered.

**Acne Scarring:** Consideration will be given to severe facial or neck scarring which has resulted in significant withdrawal from social, educational or work environments. One course of treatment only will be funded. Laser is not an effective treatment for milder forms of post acne scarring or generalised poor skin texture following burnt out acne.

**Telangiectasia:** Treatment of benign, acquired lesions such as spider naevi is not authorised. Treatment of other lesions on the face is considered, if there is evidence of significant withdrawal from social, educational or work environments.

Treatment of facial telangiectasia following rosacea will be supported, but only after confirmation of the diagnosis by an experienced dermatologist. Treatment for facial telangiectasia and vascular complications following other conditions will not be supported.

Abdominoplasty or Apronectomy  
(OPCS Codes: S02.1, S02.2)

**Background:** Abdominoplasty (also known as tummy tuck) is a surgical procedure performed to remove excess fat and skin from mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss. However, surgery is not part of the usual response to these normal, physiological processes.

**Policy:** Abdominoplasty or Apronectomy will only be funded in accordance with the criteria specified below.

- Stable BMI between 18 and less than 27 Kg/m2
- be suffering from severe functional problems that interfere with activities of daily living.

**IN ADDITION** the patient must fulfil ONE of the following criteria:
- Scarring following trauma or previous abdominal surgery;
- Required as part of abdominal hernia correction or other abdominal wall surgery.
- Correction of problems associated with poorly fitting stoma bags:
Those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds. To fulfil this criteria the patient must also:
  - Have achieved a loss of 10 points in BMI scale
AND
  - Have maintained their weight loss for at least 2 years from the date they have achieved the 10 point BMI loss.

**Face lift or brow lift**  
*(OPCS Code: S01.-)*

**Background:** These surgical procedures are performed to lift the loose skin of face and forehead to get firm and smoother appearance of the face. These procedures will not be funded to treat the natural processes of ageing.

**Policy:** Face lift or brow lift will only be funded in accordance with the criteria specified below.

These procedures will be considered for treatment of:

- Congenital facial abnormalities (Code: Q18);
- Facial palsy (congenital or acquired paralysis) (Code: G51.0);
- As part of the treatment of specific conditions affecting the facial skin eg. Cutis laxa, pseudoxanthoma elasticum, neurofibromatosis;
- To correct the consequences of trauma;
- To correct deformity following surgery;
- In some cases of impaired visual fields, where it may be a more appropriate primary procedure than blepharoplasty

**Liposuction**  
*(OPCS Codes: S62.1, S62.2)*

**Background:** Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures.

**Policy:** Liposuction simply to correct the distribution of fat will not be funded.

**Removal of benign skin lesions** *(OPCS Codes: S04.-, S05.-, S06.-, S09.-, S10.-, S11.-)*

**Background:** Benign skin lesions include wide range of skin disorders such as sebaceous cyst, dermoid cyst, skin tags, hirsutism, milia, molluscum contagiosum, seborrhoeic keratoses (basal cell papillomata), spider naevus (telangiectasia), warts, sebaceous cysts, xanthelasma, dermatofibromas, benign pigmented moles, comedones and corn/callous. Mostly these are removed on purely cosmetic grounds. Patients with moderate to large lesions that cause actual facial disfigurement may benefit from surgical excision. The risks of scarring must be balanced against the appearance of the lesion.

**Policy:** Removal of benign skin lesions will only be funded in accordance with the criteria specified below.

These lesions should only be removed when they interfere with the physical functioning of the body, specifically:

- when the benign lesion becomes infected;
OR
- if located on a site where they are subjected to recurrent trauma.

This guidance covers benign skin lesions only. If there is any suspicion of malignancy then any surgical removal of a skin lesion is included in the diagnostic process.

Where the lump is rapidly growing or abnormally located, specialist assessment should be sought.

**Removal of lipomata**

**Background:** Lipomata (ICD-10 Codes: D17, E882) are benign tumours commonly found on the trunk and shoulder. These are removed mostly on cosmetic grounds. Patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis.

**Policy:** Removal of lipomata will only be funded accordance with criteria specified below.
- the lipoma (-ta) is / are symptomatic;
- there is functional impairment.
- for diagnostic purposes to exclude the possibility of malignancy

**Thigh lift, buttock lift and arm lift, excision of redundant skin or fat**

**(OPCS Code: S03.-)**

**Background:** These surgical procedures are performed to remove loose skin or excess fat to reshape body contours. As the patient groups seeking such procedures are similar to those seeking abdominoplasty (see above), the functional disturbance of skin excess in these sites tends to be less and so surgery is less likely to be indicated except for appearance, in which case it should not be available on the NHS.

**Policy:** These procedures will only be funded accordance with criteria specified below.

If there is documented evidence of:
- significant interference with normal daily activities
- intractable intertrigo.

**References for plastic surgery:**
Hair grafting - Male pattern baldness  

**Background:** male pattern baldness (ICD-10 Codes: L64.8, L64.9) is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Hair grafting is mostly done for aesthetic reasons.

**Policy:** Hair grafting for male pattern baldness will not be funded.

Hyperhidrosis treatment with Botulinum Toxin  

**Background:** Hyperhidrosis (ICD-10 Code: R61) is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people.

BTX-A is only licensed for the treatment of severe axillary hyperhidrosis and it’s cost effectiveness compared to other treatment options is yet to be established.

**Policy:** Botulinum Toxin will only be funded in management severe axillary hyperhidrosis provided the first line treatment has failed or is contraindicated.

Ganglia  

**Background:** Ganglia are benign fluid filled, firm and rubbery lumps attached to the adjacent underlying joint capsule, ligament, tendon or tendon sheath. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%). Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates up to 40% have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.

**Referral guidance**
- Include reference to the degree of pain and restriction of normal activities caused by the ganglion.

**Policy:** Surgical treatment for ganglia will only be funded in accordance with the criteria specified below.
- The ganglia are symptomatic;
OR
- There is functional impairment.
OR
- For diagnostic purposes to exclude the possibility of malignancy

References:
2. FD Burke; Melikyan EY; Bradley MJ et al. Primary care referral protocol for wrist ganglia. Postgraduate Medical Journal 2003 79:329-331

Gender Reassignment Surgery in Adults  (OPCS Code: X15.1, X15.2)

Gender reassignment surgery is considered not medically necessary when one or more of the referral criteria for Gender Dysphoria Services have not been met. These criteria are laid out in a separate document (Northumberland Tyne and Wear NHS Trust Gender Dysphoria Draft Service Specification).

Policy:

Core Surgical Procedures
For patients who meet the referral criteria, only the core procedures defined below will be funded.

Core surgical procedures for Trans Women (Male to Female)
- Clitoroplasty
- Labiaplasty
- Donor site hair removal
- Orchidectomy
- Penectomy
- Vaginoplasty

Core surgical procedures for Trans Men (Female to Male)
- Hysterectomy
- Mastectomy
- Metoidoplasty or Phalloplasty
- Salpingo-oophorectomy
- Scrotoplasty and placement of testicular prostheses
- Urethroplasty
- Vaginectomy

Non Core Surgical Procedures
The following procedures are not funded as part of the Gender Reassignment Surgery package and will only be considered for funding in exceptional circumstances.
- Blepharoplasty
- Breast augmentation
- Chest reconstruction
- Facial feminisation
- Facial hair removal
- Rhinoplasty
- Speech and language therapy
- Thyroid chondroplast
- Voice modification surgery

Reversal of Gender Reassignment Surgery
The commissioner will not routinely provide funding for reversal of Gender Reassignment Surgery.

Co-Funding
The commissioner will not co-fund procedures in gender dysphoria patients nor will it support private non-core procedures being carried out at the same time as core NHS funded procedures. This ensures there is a clear separation with regard to funding and liability.

**Infertility Treatment**

The eligibility criteria for infertility treatment laid out in this document cover the following procedures:
- In vitro fertilisation;
- Intracytoplasmic sperm injection;
- Intra-uterine insemination;
- Donor insemination;
- Follicle Stimulating Hormone.
- Ovulation induction using gonadotrophins

**Background:** The Clinical Guideline on fertility assessment and treatment was published by NICE in February 2004 (NICE CG11, 2004). A single consistent infertility policy for the NHS in the North East has been produced to ensure consistency in the application of the guideline across the region.

**Definition:** “Infertility should be defined as a failure to conceive after regular unprotected sexual intercourse (every 2-3 days) for 2 years in the absence of known reproductive pathology (NICE CG11, 2004).”

Around 84% of couples attempting to conceive are successful after trying for one year. After two years this figure rises to 92%. Female fertility declines with age and for women aged 38 only about 77 out of every 100 who have regular unprotected sexual intercourse will get pregnant after 3 years.

At any point in time, the estimated prevalence of infertility is one in seven couples in the UK. A typical Primary Care Trust can expect about 230 new consultant referrals (couples) per 250,000 head of population per year (NICE CG11, 2004).

All couples are eligible for consultation and advice from the specialist service.

**Policy:** Infertility treatment will be funded accordance within the criteria specified below.

<table>
<thead>
<tr>
<th>Eligibility criteria for treatment</th>
<th>Definition</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female Age</strong></td>
<td>Female Partner must be between 23 years of age or older and before her 40th birthday at the start of treatment (except frozen/thaw treatment within one year of unsuccessful fresh treatment)</td>
<td>Previous good responders who are not pregnant after fresh and frozen treatment may be considered for a further treatment within 6 months of their 40th birthday.</td>
</tr>
<tr>
<td><strong>Male Age</strong></td>
<td>Male partner must be 23 years of age or older at the start of treatment.</td>
<td>A lower age limit will be considered in exceptional circumstances if the female partner has bilateral tubal blockage or the man has severe male factors and</td>
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<tr>
<td>Eligibility criteria for treatment</td>
<td>Definition</td>
<td>Additional Notes</td>
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<tr>
<td><strong>Female Body Mass Index (BMI)</strong></td>
<td>BMI greater than 19 and lower than or equal to 30 at the start of treatment.</td>
<td>This criterion reflects the increased efficacy of infertility treatment in this weight range.</td>
</tr>
<tr>
<td><strong>Minimum length of unexplained infertility</strong></td>
<td>2 years of unexplained infertility at time of treatment.</td>
<td>People who have not conceived after 1 year of regular unprotected sexual intercourse should be offered further clinical investigation including semen analysis and/or assessment of ovulation. Where there is a history of predisposing factors (such as amenorrhoea, oligomenorrhoea, pelvic inflammatory disease or undescended testes), or where a woman is aged 35 years or over, earlier investigation should be offered. Should a couple know that they are unable to conceive naturally (e.g. both tubes are blocked) there is no need for them to wait 2 years.</td>
</tr>
<tr>
<td><strong>Existing children</strong></td>
<td>Treatment will only be offered to couples where neither partner has any living children from current or previous relationships.</td>
<td>This criterion includes adopted children, but excludes fostered children.</td>
</tr>
<tr>
<td><strong>Same sex couples</strong></td>
<td>Treatment is offered irrespective of sexual orientation. Treatment will only be offered where the partner wishing to become pregnant is sub-fertile.</td>
<td>Over a period of 2 years, same sex couples must have completed a routine donor programme, as private patients.</td>
</tr>
<tr>
<td><strong>Previous Sterilisation</strong></td>
<td>No previous sterilisation history in either partner.</td>
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</tr>
<tr>
<td><strong>Number of treatments</strong></td>
<td>3 completed treatments (including associated frozen/thaw transfers) will be offered, provided that the above criteria are met and that the outcome of previous treatments indicates that further treatment is clinically appropriate.</td>
<td>This does not promise everyone 3 treatments. Treatment must be medically indicated at the start of each treatment.</td>
</tr>
<tr>
<td>Eligibility criteria for treatment</td>
<td>Definition</td>
<td>Additional Notes</td>
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</tr>
<tr>
<td>Length of time resident in catchment area</td>
<td>Both partners should be patients registered for one year within the PCT area at time of referral.</td>
<td>This excludes short term students who are not otherwise eligible for NHS treatment.</td>
</tr>
<tr>
<td>Residence in UK</td>
<td>Must be eligible for free hospital treatment in line with the Overseas Visitors Charging Regulations.</td>
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</tbody>
</table>

**Additional guidance notes**

The notes below do not relate specifically to the patients eligibility for infertility treatment, but provide additional information about the overall functioning of the treatments.

**Gametes**
- Commissioners will not fund the cost of gametes from private sources.

**Nature of Relationship**
- The Human Fertilisation and Embryology Authority (HFEA) recommend that the couple must have a stable union of at least 3 years.
- The General Practitioner and referring consultant must be satisfied that a caring environment can be offered to the child.

**Freezing**
- Freezing and thawing will be provided consistent with the protocols of the treatment centre.
- Ongoing storage is not funded after one year if there is a subsequent pregnancy.

**Smoking**
- All smokers are to be given written information about the smoking cessation programmes.
- Clinical notes are to be documented accordingly.

**Clinical judgement**
- Any variation from the criteria above must be after discussion between the consultant and commissioner and will only be agreed under exceptional circumstances.

**Waiting Times**
- The time from referral by the GP to being given a date to start treatment (as clinically appropriate) should be no more than 18 weeks.

**HFEA**
- There will be full compliance with the HFEA Code of Practice.

**NICE**
- Clinical practice will be guided by the NICE guidance, February 2004 (Fertility Assessment and Treatment for people with Fertility Problems) and subsequent published evidence.

**Abbreviations**
Pre-implantation Genetic Diagnosis (PGD)

Pre-Implantation Genetic Diagnosis (PGD) uses in vitro fertilisation (IVF) to create embryos, from which one or two cells can be removed by biopsy and tested for a specific genetic abnormality. It enables the identification of unaffected embryos for transfer to the uterus. PGD assists couples at significant risk of having a child with an inherited disorder to have a healthy baby. For some couples, selection of an unaffected embryo is preferable to termination of pregnancy following prenatal testing.

Policy: All PGD treatment will need individual funding approval. Funding for PGD will be assessed by the criteria specified below.

- The PGD centre must be licensed by the HFEA to carry out a test for the relevant condition and the test must be included in the list of UKGTN approved tests.
- The laboratory where the test is being carried out should be Clinical Pathology Accredited. (Any future equivalents to CP accreditation would need to be assessed against CP accreditation criteria in order to ensure quality and standards are maintained).
- A couple considering PGD must have been seen by the Regional genetics centre first.
- Consideration must be given to the welfare of the child, in accordance with the HFE Act 2008.

<table>
<thead>
<tr>
<th>Eligibility criteria for treatment</th>
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<tbody>
<tr>
<td>Inherited chromosomal abnormality</td>
<td>Couples who have a history of repeated miscarriages (as a result of an inherited chromosome abnormality) or of children born with genetic abnormalities or history of a genetic disease in one of them or a member(s) of their family.</td>
<td></td>
</tr>
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<td>Female Age</td>
<td>Female Partner must be older than 23 years of age and before her 40th birthday at the start of treatment.</td>
<td>Previous good responders who are not pregnant after fresh and frozen treatment may be considered for a further treatment within 6 months of their 40th birthday.</td>
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<td>This criterion reflects the increased efficacy of infertility treatment in this weight range.</td>
</tr>
<tr>
<td>Existing children</td>
<td>Treatment will be offered to couples where neither partner has any living children from current or previous relationships.</td>
<td>This criterion includes adopted children, but excludes fostered children. An exception to this criteria is a couple with an existing child severely affected by the genetic condition.</td>
</tr>
<tr>
<td>Same sex couples</td>
<td>Treatment is offered irrespective of sexual orientation.</td>
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</tr>
<tr>
<td>Previous Sterilisation</td>
<td>No previous sterilisation history in either partner.</td>
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</tr>
<tr>
<td>Number of treatments</td>
<td>This policy supports a maximum of 6 embryo transfers within a maximum of 3 fresh cycles (including associated frozen/thaw transfers), and is such that the outcome of previous treatments should indicate that further treatment is clinically appropriate.</td>
<td>This does not promise everyone 3 treatments. Treatment must be medically indicated at the start of each treatment.</td>
</tr>
<tr>
<td>Length of time resident in catchment area</td>
<td>Both partners should be patients registered for one year within the PCT area at time of referral.</td>
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**Additional guidance notes**

The notes below do not relate specifically to the patients eligibility for PGD, but provide additional information about the overall functioning of the treatments.

**Nature of Relationship**
- The Human Fertilisation and Embryology Association (HFEA) recommend that the couple must have a stable union of at least 3 years.
• The General Practitioner and referring consultant must be satisfied that a caring environment can be offered to the child.

**Freezing**
- Freezing and thawing will be provided consistent with the protocols of the treatment centre.
- Ongoing storage is not funded after one year if there is a subsequent pregnancy.

**Smoking**
- All smokers are to be given written information about the smoking cessation programmes.
- Clinical notes are to be documented accordingly.

**Clinical judgement**
- Any variation from the criteria above must be after discussion with the consultant and will only be agreed under exceptional circumstances.

**REFERENCE**
1. DH (2002) Preimplantation Genetic Diagnosis (PGD) – Guiding Principles for Commissioners of NHS services
# Appendix 1. Contact details for the policy review group

<table>
<thead>
<tr>
<th>NHS North of Tyne</th>
<th>Individual Funding Requests:</th>
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</thead>
<tbody>
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<td>Tina Raw</td>
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<tr>
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<tr>
<td>Newcastle upon Tyne</td>
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<td>NE13 9BA</td>
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<td>Telephone: 0191 217 2850</td>
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<td>Email: <a href="mailto:sue.gordon@northoftyne.nhs.uk">sue.gordon@northoftyne.nhs.uk</a></td>
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<thead>
<tr>
<th>NHS South of Tyne</th>
<th>Individual Funding Requests:</th>
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<tbody>
<tr>
<td>Dr Mark F Lambert</td>
<td>Lisa Hunter</td>
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<td>Colima Ave</td>
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<td>Sunderland</td>
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<td>SR5 3XB</td>
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<td>Telephone: 0191 5297129</td>
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<tr>
<th>NHS County Durham and Darlington</th>
<th>Individual Funding Requests:</th>
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<tbody>
<tr>
<td>Dr Mike Lavender</td>
<td>Judith Hunter</td>
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<td>Appleton House</td>
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<td>Durham</td>
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<tr>
<td>DH1 5XZ</td>
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<td>Telephone: 0191 3713667</td>
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<tr>
<td>Email: <a href="mailto:mike.lavender@nhs.net">mike.lavender@nhs.net</a></td>
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<th>NHS Tees</th>
<th>Individual Funding Requests:</th>
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<tbody>
<tr>
<td>Dr Toks Sangowawa</td>
<td>Katie Speck</td>
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<tr>
<td>Redheugh House</td>
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<td>Teesdale South</td>
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<td>Thornaby Place</td>
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<td>Thornaby</td>
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<td>Stockton on Tees</td>
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<td>TS17 6SG</td>
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<td>Telephone: 01642 745194</td>
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<td>Email: <a href="mailto:Toks.Sangowawa@tees.nhs.uk">Toks.Sangowawa@tees.nhs.uk</a></td>
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</tr>
</tbody>
</table>
Appendix 2. NICE Technology Appraisals and Clinical Guidelines
As at 10 October 2011

*In the alphabetical order that they appear:*

**Included:**
- Elective interventions or procedures
- Surgical interventions or devices

**Excluded:**
- Pharmacological interventions
- Guidance on management of chronic conditions in primary and secondary care (e.g., diabetes foot care or retinopathy)
- Treatments for cancer or pre-malignant disease
- Choice or timing of interventions or technologies by specialist teams (e.g., implantable cardiac defibrillators, ECT, stapled haemorrhoidopexy) this criterion probably applies to ALL TAs

**Technology assessments**
- TA167 Abdominal aortic aneurysm - endovascular stent-grafts
- TA73 Angina and myocardial infarction - myocardial perfusion scintigraphy
- TA166 Hearing impairment - cochlear implants
- TA44 Hip disease - metal on metal hip resurfacing
- TA2 Hip disease - replacement prostheses
- TA71 Ischaemic heart disease - coronary artery stents
- TA78 Menstrual bleeding - fluid-filled thermal balloon and microwave endometrial ablation
- TA159 Pain (chronic neuropathic or ischaemic) - spinal cord stimulation
- TA139 Sleep apnoea - continuous positive airway pressure (CPAP)
- TA1 Wisdom teeth - removal

**Clinical guidelines**
- CG13 Caesarean section
- CG85 Glaucoma
- CG44 Heavy menstrual bleeding
- CG30 Long-acting reversible contraception
- CG88 Low back pain
- CG97 Lower urinary tract symptoms
- CG43 Obesity
- CG31 Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD)
- CG59 Osteoarthritis
- CG126 Stable angina
- CG60 Surgical management of otitis media with effusion OME
- CG40 Urinary incontinence
Appendix 3. Specialised Services Commissioning

Specialised cancer services (adult)
Specialised services for blood and marrow transplantation (all ages)
Specialised services for haemophilia and other related bleeding disorders (all ages)
Specialised services for women's health
Assessment and provision of equipment for people with complex physical disability
Specialised spinal services (all ages)
Specialised rehabilitation services for brain injury and complex disability (adult)
Specialised neurosciences services (adult)
Specialised burn care services (all ages)
Cystic fibrosis services (all ages)
Specialised renal services (adult)
Specialised intestinal failure and home parenteral nutrition services (adult)
Specialised cardiology and cardiac surgery services (adult)
Cleft lip and palate services (all ages)
Specialised immunology services (all ages)
Specialised allergy services (all ages)
Specialised services for infectious diseases (all ages)
Specialised services for liver, biliary and pancreatic medicine and surgery (adult)
Medical genetic services (all ages)
Specialised mental health services (all ages)
Specialised services for children
Specialised dermatology services (all ages)
Specialised rheumatology services (all ages)
Specialised endocrinology services (adult)
Specialised respiratory services (adult)
Specialised vascular services (adult)
Specialised pain management services (adult)
Specialised ear services (all ages)
Specialised colorectal services (adult)
Specialised orthopaedic services (adult)
Specialised morbid obesity services (all ages)
Specialised services for metabolic disorders (all ages)
Specialised ophthalmology services (adult)
Specialised haemoglobinopathy services (all ages)
Appendix 4. Value Based Clinical Commissioning Policies -
Guide for making referrals

This guide has been developed to assist clinicians answer questions in relation to individual funding requests (IFRs). At the end of this guide you will find quick links to qualifying criteria of individual policies contained within the Value based clinical commissioning Treatment Policies document.

FAQs (hyperlink to responses)
1. Why do we need policies?
2. What do these policies cover?
3. Who are they for?
4. How has the list been compiled?
5. How have they been developed?
6. Do I need approval before referring for plastic surgery?
7. Can you give any general guidance about what is in the policies?
8. Is securing funding a guarantee of treatment?
9. What if funding is declined?
10. Who tells the patient if funding is declined?
11. What about treatments that have already started under private arrangements?
12. What if I have a patient whose needs are exceptional?
13. What about psychological considerations?
14. Are photographs helpful?
15. What if GPs make referrals outside the criteria outlined these policies?
16. What if surgeons undertake procedures outside the indications in these policies?
17. Where can I find out more?

1. Why do we need policies?

NHS resources come under ever greater pressures each year. Ensuring that treatment and care is focused where it can make the biggest difference is a key part of making best use of these resources. This is a key challenge for all NHS organisations, and a prime focus for commissioning among CCGs. These policies help clinicians identify interventions with limited benefit, thereby providing potential for reinvesting elsewhere, where potential benefits are greater.

The alternative to having policies of this kind is to leave each decision to individual GPs, to manage individual dilemmas without guidance and without the context of the health needs of the wider population.

2. What do these policies cover?

These cover interventions where there is significant risk that patients undergoing them will gain little health benefit.

The procedures have low rather than no clinical value. Some may be effective, but may have low value because other (medical) treatments could be tried first. Other effective procedures may provide large benefits for some patients but less to those with few symptoms, where risks and benefits are closely balanced. There are interventions which are effective in some but give no clinical value in others. Finally, there are those interventions that whilst effective, are undertaken for primarily cosmetic reasons, which commissioners often consider as providing low clinical value.
3. Who are they for?

They are to assist GPs in making referral decisions, where the principal reason for referral is for surgical intervention.

They are also to assist providers of surgical services - a statement about what the NHS will pay for.

4. How has the list been compiled?

The list of procedures is a historical one, starting with declarations about plastic surgery and IVF, and have grown with greater understanding about health benefits from surgical intervention, publication of authoritative national guidelines and unexplained variations in clinical practice.

5. How have they been developed?

Every effort has been made to get an up to date view of practice. However, some will contain contentious criteria - for example among eligibility for plastic surgery and IVF.

We aim to take account of the most up to date clinical evidence, legal precedent and gain consensus before publication. A full review of these policies is currently underway, led by PCT public health staff across the North East. And keeping these up to date will require significant ongoing efforts.

6. Do I need approval before referring for plastic surgery?

Where your patient meets the criteria in the policy, you can assume that NHS funding is available; authorisation is NOT required before referral is made. Some providers may still ask for confirmation of funding.

7. Can you give any general guidance about what is in the policies?

Here is some general advice about those policies which are most commonly referred to.

For procedures that are often carried out for cosmetic reasons: breast surgery (reduction or augmentation), benign skin lesions or lipomata, you should consider extent to which the individual deviates from the normal range, and the impact of any anomaly on activities of daily living.

Unhappiness is common experience among people wanting plastic surgery who do not receive NHS funding. This unhappiness is not, on its own, sufficient to make an individual exceptional.

Much varicose vein surgery undertaken in England is for cosmetic reasons, so you should also consider the impact on activities of daily living before referring.

For IVF - there is an age limit for starting treatment that is based on the probability of success. Treatment must start by the patient’s 40th birthday. Please alert couples about the lead time to establish infertility (two years) and to undertake relevant investigation and medical treatment. Age and lack of understanding of the pathway are not exceptional reasons for access to IVF.

For most discretionary surgery - a normal BMI (18-27) is required- and important for safe surgery.
8. Is securing funding a guarantee of treatment?

Approval for NHS funding is NOT the same as a guarantee of treatment. Funding (the role of the commissioner for a whole population) is often requested before specialist assessment. However, the ultimate decision about safety and appropriateness of treatment is clinical one, which must be done with the patient.

9. What if funding is declined?

If there are individual circumstances to be considered, and the decision is to decline funding, you will be sent details of how to appeal.

10. Who tells the patient if funding is declined?

We will tell the referring clinician, who remains responsible for ongoing treatment and care. The correspondence lays out this responsibility, and any time scales for action.

11. What about treatments that have already started under private arrangements?

If treatments have already been started under private arrangements, the assumption is that a whole package of care has been purchased and its potential complications taken account of. Therefore, it would be unreasonable to expect the NHS to pick up the costs associated with private treatment unless there is a medical emergency, or some other exceptional circumstance. Running out of funds, whilst unfortunate, is not exceptional.

12. What if I have a patient whose needs are exceptional?

We welcome Individual Funding Requests- either for patients who are clearly different from the group of patients covered by the policy- or for those with very unusual conditions or clinical presentations. Please:

- check the policies (see list below),
- use the referral forms and guidance that are available on the PCT’s website to indicate how your patient is exceptional.

13. What about psychological considerations?

Some PCTs have taken account of psychological factors in arriving at a decision about eligibility for NHS funding. But this is hard to do in a clear and fair way. These considerations have been removed from the current draft of these policies.

NICE guidance indicates that clinicians should consider the possibility of Body Dysmorphic Syndrome when making referral for plastic surgery (NICE Clinical Guideline 31).

14. Are photographs helpful?

Photographs are not used in consideration of exceptionality- and handling them presents significant risks of compromising confidentiality. Please do NOT submit photographs. Any photographs received will be returned to sender upon receipt.

15. What if GPs make referrals outside the criteria outlined these policies?

The implication is that there is no guarantee of payment, although the level of detail in these policies is not fully reflected in financial agreements with hospital providers.

16. What if surgeons undertake procedures outside the indications in these policies?
The implication is that there is no guarantee of payment, although legally binding contracts govern financial transactions.

17. Where can I find out more?

The National Prescribing Centre provide further guidance on this topic: http://www.npc.co.uk/faqs_ldm.php

If you have any questions or comments about these policies then contact one of the working group members. Contact details are in Appendix 1.