Individual policies have been revised at different times in 2008 & 2009.

April 2010
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Acknowledgements for Low Priority Procedures & Other Procedures with Restrictions

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- Agreed by the West Sussex Joint Forum for Service Improvement, Priorities and Clinical Effectiveness (SPACE) on 6th December 2006.
- Ratified by the Professional Executive Committee (PEC) on 7th December 2006.
- Considered by the Practice Based Commissioning Clinical Leads Group on the 12th July 2007.
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- Approved by the PCT’s Professional Executive Committee on 16th August 2007.
- Ratified by the West Sussex PCT Board on 27th September 2007.
- Noted by the West Sussex Health and Overview Scrutiny Committee on 22nd October 2007.
- Individual policies have been revised at different times as necessary in 2008 & 2009.
- Individual Policies in this document will continue to be reviewed as necessary in future.
Introduction and Background

The agreed list will form part of the Service Level Agreements with the providers.

There is no blanket ban on any of the procedures. There is an established PCT mechanism for dealing with individual cases / exceptions.

This document applies to treatments outside of the primary care GMS contract.

This list does not apply to treatments which are part of a total package of reconstruction following major trauma or following surgery for cancer or where cancer is suspected, e.g. head and neck cancer surgery, mastectomy and breast reconstruction, burns and trauma post operative care.

Exceptionality

The IFR Panel shall determine, based upon the evidence provided to the panel, whether the patient has demonstrated exceptional clinical circumstances. The evidence to show that, for the individual patient, the proposed treatment is likely to be clinically effective may be part of the case that the patient's clinical circumstances are asserted to be exceptional. However, in determining whether a patient is able to demonstrate exceptional clinical circumstances, the IFR Panel shall compare the patient to other patients with the same presenting medical condition at the same stage of progression.

Whether a patient can demonstrate “exceptional clinical circumstances” depends on the precise clinical facts of each individual case and whether those can genuinely be described as exceptional. However, an IFR Panel may consider that a named patient who has clinical circumstances which, taken as a whole are outside the range of clinical circumstances presented by at least 95% of patients with the same medical condition at the same stage of progression as the named patient, could show that their clinical circumstances were sufficiently unusual that they could properly be described as being exceptional.

The fact that a patient has exhausted all NHS treatment options available for a particular condition is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances. Equally, the fact that the patient is refractory to existing treatments where a recognised proportion of patients with the same presenting medical condition at the same stage are, to a greater or lesser extent, refractory to existing treatments is unlikely, of itself, to be sufficient to demonstrate exceptional circumstances.

Rationale for Designating Procedures as Low Priority

West Sussex PCT has designated a number of procedures as low priority for NHS funding. The PCT is under significant financial pressure to provide funds for all treatments (or preventative measures) for all patients in West Sussex. The PCT does not have the resources to meet all of these demands. Therefore it has to make difficult choices about which treatments/services represent the best use of its finite resources.

The rationale for tightening restrictions on low priority procedures is as follows:

1. To allow funding to be concentrated on treatments which result in the most health gain and hence make the best use of limited resources for our
population.

2. To offer better treatment access to patients with a high clinical priority by reducing referrals/admissions to the waiting lists.

3. In seeking to make appropriate use of limited resources the PCT has taken into account the following factors:
   a) The extent to which the problem in question is an illness, disease, injury or impairment.
   b) Whether the proposed treatment represents the appropriate clinical strategy to address the problem.
   c) Whether the service to address the problem can and should be subject to NHS funding.
   d) The evidence of clinical and cost effectiveness of the treatments.

In this document is a list of procedures that West Sussex PCT has designated low priority for NHS funding and will not be routinely funded. This is not a blanket ban, the PCT recognises there will be exceptional, individual or clinical circumstances when funding for these treatments will be appropriate. In such cases, funding applications should be made to the West Sussex PCT Review Panel for Individual Funding Requests (IFR). West Sussex PCT will not pay for these procedures unless prior authorisation is obtained. **This document also lists procedures which are funded by the PCT but where restrictions or a threshold for treatment applies.**

**West Sussex PCT Review Panel for Individual Funding Requests (IFR)**

The West Sussex PCT Review Panel for Individual Funding Requests has a very clear and explicit process for making decisions on treatments that are not routinely commissioned by the PCT. These include drugs, low priority procedures and treatments that have not yet been reviewed by NICE. The Review Panel will consider the following factors when making decisions:

- Resources
- Cost Effectiveness
- Scientific / Clinical Evidence of Effectiveness
- Guidance such as NICE Guidance and any other relevant guidance
- Specialist Advice where appropriate
- Alternative Treatments
- The Law
- Equity

The document has been checked by Capsticks, the PCT solicitors.

**All Review & Appeal Panel Members are trained in the following:**

- How to evaluate clinical evidence
- Legal considerations including the Human Rights Legislation etc.
- PCT accountability for public funds
- SEC Framework

The Review Panel terms of reference and appeal process guidance is available to clinicians and patients.
Part 1 - Low Priority Procedures and Other Procedures with Restrictions

The PCT has considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision in order to formulate the following recommendations

1. **Abdominoplasty / Apronectomy**
   
   This procedure is not routinely funded.

2. **Acne Scarring**
   
   Procedures for acne scarring are not routinely funded.

3. **Acupuncture**
   
   This procedure is not routinely funded by the PCT but may be available in some cases as part of a defined package of care.

4. **Aromatherapy**
   
   This procedure not routinely funded by the PCT. It is only available occasionally in hospices and hospitals as part of palliative care packages.

5. **Asymptomatic Impacted Third Molars**
   
   Surgical extraction of asymptomatic impacted third molars is not routinely funded by the PCT save the circumstances recommended by NICE as set out below. In exceptional circumstances, funding may be approved on an individual basis, via the agreed PCT mechanism.

   NICE have issued the following guidance:

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

6. **Basal Cell Papillomas**
   
   Please see “Removal of Benign Skin Lesions”.

7. **Blepharoplasty**
   
   This procedure is not routinely funded.

Please note that the PCT supports the correction of ectropion and entropion.

8. **Body Contouring**
   
   This procedure is not routinely funded.

9. **Botulinum Toxin Injections**
   
   The PCT supports the use of botulinum toxin injections for the treatment of the following conditions: **blepharospasm, cervical dystonia and hemifacial spasm**.

   Botulinum toxin injections for other conditions will not be routinely funded. In exceptional cases, funding may be approved on an individual basis, via the agreed PCT mechanism.
Blepharospasm is an idiopathic condition, a focal dystonia. It can result in intermittent and closure of the lids resulting in functional blindness. Treatment is either botox chemo denervation or surgical myectomy.

Hemi-facial spasm may be due to compression of the cranial nerve root and can also result in closure of the lids. Treatment is either chemo denervation or neurosurgical decompression.

**Evidence**

A Cochrane review (2004) concluded that there is good evidence that botulinum toxin type A (BTX-A) is an effective treatment for blephorospasm [1]:

“There are no high quality randomised, controlled efficacy data to support the use of BTX-A for blepharospasm. Despite this, other studies suggest that BTX-A is highly effective and safe for treating blephorospasm and support its use. The effect size (90% of patients benefit) seen in open studies makes it very difficult and probably unethical to perform new placebo-controlled trials of efficacy of BTX-A for blephorospasm”.

A Cochrane review (2005) concluded that BTX-A is an effective treatment for cervical dystonia [2]:

“A single injection of BTX-A is effective and safe for treating cervical dystonia. Enriched trials (using patients previously treated with BTX-A) suggest that further injection cycles continue to work for most patients”.

A Cochrane review (2005) concluded that there is evidence that BTX-A is an effective treatment for hemifacial spasm [3]:

“The findings of this single eligible trial support the results of large, open, case-control studies showing a benefit rate between 70 and 100%. This effect size probably makes it very difficult to perform new large placebo controlled trials for hemifacial spasm. Despite the paucity of good quality controlled data, all the studies available suggest that BTX-A is effective and safe for treating hemifacial spasm”.

An evidence review on botulinum toxin for a number of indications was conducted by Public Health in March 2009

10. **Brachioplasty / Upper Arm Lift**

This procedure is not routinely funded the PCT.

11. **Breast Augmentation**

Breast augmentation is not routinely funded by the PCT.

It is **only** funded when it is required following surgery for cancer.

12. **Breast Reduction**

This procedure is not routinely funded.

13. **Brow Lift**

This procedure is not routinely funded by the PCT.
14. **Buttock Lift**
This procedure is not routinely funded.

15. **Calf Implants**
This procedure is not routinely funded.

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

The PCT will fund excision of chalazia when all of the following criteria are met:
- The chalazia has been present for more than 6 months
- Where it is situated on the upper eyelid
- Where it is causing blurring of vision

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

These criteria also apply to eyelid papillomas

17. **Chemical Peels**
This procedure is not routinely funded.

18. **Chinese Medicines**
These therapies are not routinely funded.

19. **Chiropractic Therapy**
This procedure is not routinely funded by the PCT but may be available in some cases as part of a defined package of care.

20. **Circumcision**
The PCT will fund circumcision when the procedure is for:
- Patients with severe phimosis
- Severe recurrent balanitis
- Where cancer is suspected

21. **Clinical ecology**
Clinical ecology procedures are not routinely funded by the PCT.

22. **Co-careldopa intestinal gel (Duodopa ®) for the treatment of advanced Parkinson's disease**
The South East Coast Policy Recommendation Committee (PRC) has considered evidence of clinical effectiveness and experience, and available information on current activity, resources and costs, with regard to whether or not co-careldopa intestinal gel should be used for advanced Parkinson's disease. The Policy Recommendation Committee recommends that:-
1. Co-careldopa intestinal gel is not used for the treatment of advanced Parkinson’s disease in the South East Coast NHS unless it is being used as part of good quality research. Research and excess treatment costs must be agreed in advance with PCT commissioners and the Acute Trusts.

2. Patients currently receiving NHS funded Duodopa® for the treatment of advanced Parkinson’s disease should have the option to continue therapy until they and their clinicians consider it appropriate to stop.

This policy recommendation will be reviewed in light of new evidence or guidance from NICE.

23. **Correction of Inverted Nipple**

This procedure is not routinely funded.

24. **Dental Extraction of Non-Impacted Teeth**

Extraction of non-impacted teeth will not be routinely funded in secondary care. The PCT has established a process for triaging dental referrals into secondary care.

25. **Dental Implants**

Dental implants are not routinely funded.

26. **Dermabrasion of Skin**

This procedure is not routinely funded.

27. **Dilation and Curettage**

The Department of Health uses a basket of five procedures as an indicator or excess surgical activity. Dilation and curettage is one of these procedures.

The PCT will fund dilation and curettage for diagnostic purposes and for evacuation of retained products of conception.

The procedure will not be routinely funded for other reasons.

28. **Electrolysis**

This procedure is not routinely funded.

29. **Excimir Laser Surgery for Short Sight**

This procedure is not routinely funded.

30. **Excision of Redundant Skin or Fat**

This procedure is not routinely funded.

31. **Eyelid Surgery**

See Blepharoplasty

32. **Face Lift**

This procedure is not routinely funded.
33.   Female Sterilisation

Sterilisation will not be available on non medical grounds unless the woman has had at least 12 months’ trial using Mirena or Implanon and found it unsuitable.

Exceptions to this policy include the following:-
- Where sterilisation is to take place at the time of another procedure such as caesarean section.
- Where there is a clinical contraindication to the use of a Mirena/Implanon.
- Where there is an absolute clinical contraindication to pregnancy. These are:-
  - young women (under 45 years of age) undergoing endometrial ablation for heavy periods
  - women with severe diabetes
  - women with severe heart disease

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.

34.   Gender Reassignment

GPs should refer patients to a local psychiatric unit for assessment. Patients should then be referred to the West London Mental Health NHS Trust (Charing Cross Gender Identity Clinic) who have developed expertise in the field and have protocols for eligibility to progress to further assessment/surgery.

The management includes long periods of out-patient work and living in the opposite gender role for 2 years. Where the PCT has funded the assessment process to be carried out and the patient has fulfilled the Gender Identity Clinic’s management care pathway it will pay for the Core Gender Reassignment Surgery.

Core Gender Reassignment Surgery refers to Genital Surgical Procedures. Core Procedures for Female to Male Reassignment may consist of the following:
- Mastectomy
- Hysterectomy
- Oophorectomy
- Salpingectomy
- Vaginectomy
- Phalloplasty/Metoidioplasty
- Urethroplasty
- Testicular Prostheses and Penile Prosthesis.

Core Procedures for Male to Female Reassignment may consist of:
- Orchidectomy
- Penectomy
- Vaginoplasty
- Clitiroplasty
- Labiaplasty

Non-Core gender reassignment procedures are not routinely funded by the PCT. Procedures such as Breast Augmentation, Thyroid Cartilage Reduction, Rhinoplasty, Electrolysis, Laser Treatment for Hair Removal, Jaw Reduction, Waist Liposuction and Wigs are not considered as a core part of Gender Reassignment Surgery.

The reversal of Gender Reassignment will not be funded by the PCT.
35. **Glucosamine**

Glucosamine is classified as a food supplement in the UK. It is not a licensed medicinal product. Patients who wish to take glucosamine should be encouraged to purchase it ‘over the counter’ or via mail order.

36. **Grommets**

The Department of Health uses a basket of five procedures as an indicator of excess surgical activity. Inserting grommets is one of these procedures. The policy statement on funding this procedure was developed with ENT consultant.

There is only limited evidence that grommets are an effective treatment in children with otitis media with effusions. Therefore, they are not routinely funded by the PCT. However the PCT will fund this procedure in children who are likely to benefit as follows:-

**Grommets for Children**

Grommets will not be routinely funded except for children who fulfil the criteria outlined below. These will be audited to ensure adherence to the criteria. If the trends and numbers go up significantly the policy will be revisited.

**Eligibility Criteria**

1. Children with demonstrable conductive hearing loss for at least 6 months, in the presence of middle ear fluid and one of:-
   - Speech delay
   - Difficulties at school related to hearing
   - Behavioural difficulties related to hearing
2. Recurrent infections
3. Sensory neural hearing loss with supra-imposed either fluctuating or persistent conductive loss
4. Severe tympanic membrane retraction
5. A second disability such as Down’s Syndrome

**Grommets for Adults**

Grommets will be funded for adults who fulfil the criteria below. However, an application for funding must be submitted to the PCT for approval to ensure that these criteria are met.

**Eligibility criteria**

- A middle ear effusion causing measured conductive hearing loss, persisting for at least 6 months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician
- Persistent Eustachian tube dysfunction resulting in pain (e.g. flying)
- As one possible treatment for Meniere's disease.
- Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma.
37. Gynaecomastia
Procedures to treat gynaecomastia in men are not routinely funded.

38. Hair Transplant / Hair Graft
Hair transplant/grafting is not routinely funded.

39. Herbal Remedies
There is little evidence that herbal remedies are clinically effective. Therefore they are not routinely funded.

40. Hirsuitism Treatment
Laser treatment for hirsuitism is not routinely funded.

41. Homoeopathy
There is no strong evidence that homeopathy is clinically effective. Therefore, West Sussex PCT does not fund homeopathy as standard treatment.

42. Hyperbaric Oxygen Therapy for Wound Healing
There is insufficient evidence for the clinical effectiveness of Hyperbaric Oxygen Therapy (HBOT) for wound healing. Therefore it is not routinely funded.

43. Hypnotherapy
There is little evidence that hypnotherapy is clinically effective. Therefore it is not routinely funded.

44. Labiaplasty
This procedure is not routinely funded.

45. Laser Therapy / Laser Treatment for Aesthetic Reasons / Tunable Dye Laser
The PCT will not routinely fund this procedure for cosmetic problems.

46. Limb prosthesis
These are available on the NHS and will therefore not be funded privately.

47. Liposuction
The PCT will not routinely fund cosmetic liposuction. However, liposuction may be used as part of other surgery, e.g. thinning of transplanted flap.

48. Massage
This procedure is not routinely funded by the PCT. The procedure is sometimes available in hospices as part of a palliative care package.

49. Mastopexy
This procedure is not routinely funded.
50. **Minor Irregularities of Aesthetic Significance**

The PCT does not routinely fund aesthetic procedures.

51. **Neck Lift**

This procedure is not routinely funded.

52. **Osteopathy**

This procedure is not routinely funded by the PCT but may be available in some cases as part of a defined package of care.

53. **Penile Implants**

This procedure is not routinely funded.

54. **Periapical Surgery**

The PCT will not routinely fund periapical surgery. However the PCT will consider funding for patients who fulfil the criteria in the PCTs dental guidelines. All cases will be considered by the PCT Panel. See Appendix 4

55. **Pinnaplasty**

This procedure is not routinely funded.

56. **Plastic Operations on Umbilicus**

Plastic operations on the umbilicus are not routinely funded.

57. **Private Treatment Available on the NHS**

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

58. **Probiotics**

The South East Coast Policy Recommendation Committee (PRC) has considered evidence of clinical and cost-effectiveness, available information on current activity, resources and costs, and opinion of key stakeholders with regard to whether or not probiotics should be made available for the treatment of lactose intolerance, Irritable Bowel Syndrome and Inflammatory Bowel Disease. Taking these into account the Policy Recommendation Committee recommends that:-

1. VSL#3 (but not other probiotics) may be considered as a treatment for chronic pouchitis in adults provided these criteria are met:
   - Pouchitis has been diagnosed by a gastrointestinal specialist.
   - All other standard pharmalogical treatments have been tried.
   - The patient is not severely immunosuppressed.
   - Treatment is initiated in secondary care. Assessment of effectiveness is undertaken in secondary care. Ongoing prescribing can be undertaken in primary care.
2. VSL#3 and other probiotics are not available for the treatment or maintenance of remission in lactose intolerance, irritable bowel syndrome or inflammatory bowel disease.
3. Clinicians advising patients on the benefits and risks of self funded treatment with probiotics in lactose intolerance, irritable bowel syndrome or inflammatory bowel disease are likely to find the HPSU report helpful as there is preliminary positive evidence and definite negative evidence for individual probiotics and indications. The evidence base in the review suggests that each individual probiotic and disease indication is a unique combination and no class effect of probiotics is demonstrated.

This policy recommendation will be reviewed in light of new evidence or guidance from NICE.

Primary Care Trusts in NHS South East Coast will always consider exceptional cases according to individual need.

59.  Ptosis of Eyelid

Procedures to correct ptosis will only be funded in cases where formal visual field testing has demonstrated a visual field defect. The referral will not be accepted unless it is accompanied by documentary evidence of a visual field defect.

60.  Refashioning of Scar

This procedure is not routinely funded.

61.  Reflexology

This procedure is not routinely funded by the PCT.

62.  Removal of Benign Skin Lesions

Rationale

- Approach supported by national guidelines on cosmetic surgery.
- Limited evidence that surgery on these lesions for aesthetic reasons offers benefit to patients.
- Where there is no suspicion of malignancy or complications, benign skin lesions may be self-limiting, respond to conservative measures and have no long-term health consequences for patients.
- The policy acknowledges the potential for uncertainty of diagnosis, and, where there is concern over risk of malignancy, a secondary care opinion should be sought.
- There is a wide clinical consensus on the list of lesions included.

Excision of benign skin lesions for purely aesthetic reasons will not be routinely funded in primary or secondary care except in exceptional circumstances via the appropriate PCT mechanism.

This does not apply to lesions where there is suspicion of malignancy or serious complications

The lesions and the indications listed below are covered under the primary care DES minor surgery services and primary care dermatology services and can be undertaken in primary care. These procedures for the indications below will not be routinely funded in secondary care except in exceptional circumstances through the agreed PCT mechanisms. Regular audits will be undertaken in relation to these procedures undertaken in primary care

Lipomata
Lipomata are by definition not skin lesions, they are subcutaneous and their diagnosis depends on their not being attached to the skin. It is quite reasonable and clinically good practice to remove any subcutaneous lump if there is any doubt whatsoever about its diagnosis. Thus the DES will pay for removal of lipomata where there is any doubt about diagnosis or where they are symptomatic.

**Sebaceous Cysts**
These are benign skin lesions in the sense of being non-malignant however they are not benign in the sense of not doing harm. They can become badly infected, smell badly, cause difficulty with rubbing with clothing.

The DES will pay for removal of sebaceous cysts in any of the following circumstances:-
- Cyst has become infected
- Cyst causes pain, discomfort, smell or is discharging
- Cyst is situated where it interferes with activities of normal daily living, such as hair combing, buttoning a collar, sitting in a chair, tightening a belt and similar
- Cyst is exceptionally large and a severe embarrassment to patient

**Chalazion**
Chalazia (meibomian cysts) are benign, granulomatous lesions that will normally resolve within 6 months. Treatment consists of regular (four times daily) application of heatpacks. Chalazia are not infected, and generally cause no harm.

The DES will fund excision of chalazia when all of the following criteria are met:
- The chalazia has been present for more than 6 months
- Where it is situated on the upper eyelid
- Where it is causing blurring of vision

**These criteria also apply to eyelid papillomas**

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

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

63. **Repair of Lobe of External Ear**
This procedure is not routinely funded.

64. **Residential Pain Management Programmes**
These are not routinely funded as there is insufficient evidence for their clinical effectiveness.

65. **Retractile Penis Surgery**
This procedure is not routinely funded.

66. **Reversal of Vasectomy / Reversal of Sterilisation**
West Sussex PCT will not routinely fund reversal of vasectomy and female sterilisation reversals.
Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.

67. **Rhinophyma**

Treatment for this condition is not routinely funded.

68. **Rhinoplasty / Septorhinoplasty**

The PCT will not routinely fund these procedures.

The PCT will only fund these procedures as a package of reconstructive surgery to restore function as part of a total package of surgery following major trauma [at the time that the reconstructive surgery takes place] or to repair cleft palate.

69. **Skin Grafts for Scars**

This procedure is not routinely funded however the PCT will fund this treatment for burns and as part of reconstruction following major trauma.

70. **Snoring Devices**

This procedure is not routinely funded.

These devices can now be bought over the counter

71. **Submental Lipectomy**

This procedure is not routinely funded.

72. **Tattooing of Skin**

This procedure is not routinely funded.

73. **Tattoo Removal**

This procedure is not routinely funded.

74. **Terbinafine for Fungal Nail Infections**

West Sussex PCT considers the treatment of onychomycosis (fungal nail infection) with terbinafine, to be a low priority and recommend that it is not normally prescribed, with the exception of patients who are immunocompromised, have peripheral vascular disease or diabetes. In these patients, mycological confirmation should always be sought prior to treatment. When treatment is indicated, only oral terbinafine should be prescribed as topical terbinafine has inferior efficacy.

1. Terbinafine is an antifungal drug that is indicated in dermatophyte infections of the nails, and ringworm infections, where oral therapy is appropriate.

2. Fungal nail infection can be unsightly, causing thickening and slight discolouration of the nail, but often cause no other symptoms. In a few cases, especially in patients who are immunocompromised, have peripheral vascular disease or diabetes; fungal nail infections can lead to cellulites. Differential diagnoses include: trauma, lichen planus and psoriasis.
3. A firm diagnosis should always be sought prior to initiating drug treatment. Sub-ungal scrapings or nail clippings should be sent to microbiology for assessment and drug therapy only initiated where the laboratory confirms infection.

4. Topical treatment is inferior to systematic treatment. Systemic terbinafine is the most effective agent in dermatophyte onychomycosis, but there is still a 20 – 30% failure rate. Treatment with oral antifungals should only be prescribed when absolutely necessary as they all have the potential to cause serious side effects, for example liver failure, and are costly. Patients taking oral antifungals should be aware that a six-week course of treatment is needed for fingernail disease and three months for toenail disease. Patients should be reassured that their nail infection might still respond even after the treatment course is completed. The importance of good nail hygiene should be emphasized.

This statement will be reviewed in the light of new evidence or further guidance from NICE.

75. **Thigh Lift**
This procedure is not routinely funded.

76. **Tonsillectomies**

**Tonsillectomy for Adults and Children**

PCTs will not routinely fund tonsillectomy except in children and adults who fulfil the criteria outlined below. Patients who fulfil the criteria below do not need to be considered by the Review Panel. However these will be audited to ensure adherence to the criteria. If the trends and numbers go up significantly the policy will be revisited.

**Eligibility Criteria**
- Cases of suspected malignancy
- Sore throats must be due to tonsillitis and must be “disabling and prevent normal functioning”; the symptoms must have been present for at least a year and there must have been five or more episodes a year, two or more weeks absence from work/school/college/duties as a carer.
- Tonsillitis or quinsy requiring two or more hospital admissions
- Tonsillar enlargement causing upper airways obstruction.

77. **Traumatic Clefts due to Avulsion of Body Piercing**
This procedure is not routinely funded.

78. **Upper Arm Reduction**
This procedure is not routinely funded.

79. **Varicose Veins**

The PCT will not routinely fund varicose veins except in patients who fulfil the eligibility criteria outlined below. Patients who meet the eligibility criteria do not need to be considered by the Individual Funding Requests (IFR) Panel. However these will be audited to ensure they only treat patients who meet the eligibility criteria. **Trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria.**
Eligibility Criteria

1. Venous Bleeding or above knee thrombophlebitis
2. Where patients have failed a trial of class I/II compression stockings for 4 months and any 2 of the following are present:-
   - Ulcer (active/healed)
   - Lipodermatosclerosis
   - Venous eczema

For patients who do not meet the eligibility criteria and there are exceptional individual clinical circumstances an application for funding can be made to the West Sussex Individual Funding Requests (IFR) Panel.

Check List for GP Referral:--
- Confirmation that compression has been tried
- Document presence of ulceration
- Details of previous surgery/injections
- History of previous limb or pelvic trauma
- History of previous long illness with bed rest
- History of abnormal clotting/anticoagulation
- Family history of clotting disorders
- Drug history especially oral contraception or HRT

See Appendix 3 for the Patient Referral Pathway

Reviewed 2008

80. Vertebroplasty

This procedure is not routinely funded by the PCT. There is good evidence to show that vertebroplasty is no more effective than a sham procedure.

81. Viral Warts

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

There are no restrictions on treatment of genital warts.

82. Xanthelasma

This procedure is not routinely funded.

PART 2 – Commissioning for Clinical Effectiveness

83. Carpal Tunnel Syndrome

Rationale

- Conservative treatment offers short-term benefit (1-3 months) similar to surgery and many patients with mild symptoms may get relief for at least a year after conservative treatment. After corticosteroid injection, up to 50% of these patients may report minor or no symptoms at one year.
- The benefits of conservative therapy are short lived in moderate or advanced cases while the benefits of surgery take longer to be fully realised.
- Corticosteroid injections and nocturnal splinting can be effective conservative therapies.
- In the longer term (3-18 months), surgery is better than conservative therapy with up to 90% of patients reporting complete or much improvement at 18 months.
- A trial of conservative therapy offers the opportunity to avoid surgery in mild cases.

**Evidence**

- Local corticosteroid injection is effective in relieving symptoms but effectiveness beyond one month is uncertain. Local injection is more effective than oral steroids (Cochrane Review, Search Date May 2002).
- Some studies suggest up to 80% effectiveness (no or minor symptoms) at one month which decreases to 50% at one year for corticosteroid injection (Dammers et al) compared with placebo.
- Non-surgical treatment, including oral steroids, splinting, ultrasound, yoga and carpal bone mobilisation show short-term benefit compared with placebo or other non-surgical control interventions (Cochrane Review, Search Date March 2002).
- Surgery is better than splinting at relieving symptoms at three months and one year (Cochrane Review, Search Date October 2002).
- Two recent randomised controlled trials compared surgery to injected steroids. One (n=50) showed greater symptomatic improvement with surgery at 20 weeks. The other (n=163) showed greater improvement in the steroid group for nocturnal paraesthesiae at three months but equivalence at six and twelve months. In the second study, most patients needed two steroid injections and referral to surgery was counted as treatment failure in the intention to treat analysis (Hui 2005, Ly-Pen 2005).
- One recent randomised controlled trial compared splinting to surgery. This study, included in the Cochrane review, showed improved outcomes with surgery at three months and 18 months (Gerritsen 2002). By 18 months, 41% of the splinting group had undergone surgery.
- Two randomised controlled trials have compared steroid injections with splinting. In one study in mild to moderate carpal tunnel syndrome, at one year, splinting was effective for both symptoms and nerve conduction when worn every night. Steroid injection was not effective at one year (Sevim 2004). The other study (Celiker 2002) compared non-steroidal anti-inflammatory agents and splinting to steroid injection. Both groups showed similar improvement at eight weeks.

**Policy Statement**

**Carpal Tunnel Syndrome**

Carpal Tunnel surgery for intermittent symptoms is a low priority procedure and will not be routinely funded.

Referral for mild Carpal Tunnel syndrome should only be made if conservative treatment has been tried in patients with intermittent symptoms.

Conservative treatment should include:
1. Adjustment of posture, with night splintage in neutral wrist position.
2. Consideration of steroid injections in uncomplicated cases

Patients typically present with nocturnal dyseaesthesia in the hands wearing off with activity. The presence of a positive Phalen’s (wrist flexion test) confirms. Nerve conduction studies are NOT generally needed to confirm the diagnosis. In elderly patients the condition may develop insidiously.

Advanced Carpal Tunnel syndrome indicated by constant pins and needles,
numbness and muscle wasting is unlikely to respond to non-operative treatment. In many cases it will indicate progressive permanent nerve damage. These patients should be referred.

84. Dupuytren’s contracture

**Rationale**

This intervention has been assessed by the South West Thames Public health Observatory as an effective procedure but with a close benefit/risk balance in mild cases.

**Evidence**

Most patients with Dupuytren's disease do not need treatment and can be managed expectantly. Intervention is exclusively surgical and should be considered when function is impeded or deformity is disabling. In general, surgery should be performed on an affected PIP joint if the contracture is 25° or greater as such contractures are less likely to lead to a good outcome if allowed to progress. MCP joint contracture should be surgically corrected if they cause functional disability.

**Policy Statement**

**Dupuytren’s contracture**

Surgery for Dupytren’s contracture is a low priority procedure and will not be routinely funded except via the appropriate PCT mechanism. The Panel will consider patients who have fulfilled the criteria below:

Simple nodules in the palm are not an indication for surgery. Referral for Dupuytren’s contracture should only be made if defined criteria have been met:

Referral indicated if:
1. Fixed flexion in one or more joints exceeding 25 degrees.
2. Young patients (under 45 years) with disease affecting 2 or more digits and fixed flexion exceeding 10 degrees.

85. Ganglion of the Wrist

**Rationale**

Asymptomatic ganglions are considered low priority for treatment and will not be funded. These should not normally be referred to secondary care. Ganglions arising at the level of the wrist rarely cause significant disability and will usually resolve.
Policy Statement

Ganglion of the wrist

Surgery for ganglion of the wrist is a low priority procedure and will not be routinely funded by the PCT.

- Ganglion due to inflammatory or degenerative joint disease do not benefit from surgery but should be referred the underlying condition as appropriate.
- If ganglion suddenly increases in size and raises suspicion of an alternative diagnosis please refer.
- Neurological loss or weakness of the wrist and muscle wasting of the hand should be considered for referral.

In the absence of the above conditions patients can be reassured and told to seek assistance if the situation changes. There is a reasonable chance that ganglia will disappear spontaneously and even if they persist they do not cause adverse long term effects.

Conservative management is largely a matter of reassurance. Sometimes support and rest to the wrist can cause ganglions to disappear. Rest and splinting can also cause symptomatic ganglions to resolve.

86. Trigger Finger

Rationale

Trigger finger causes snapping of the fingers as they are extended from a fully flexed posture and is sometimes associated with a tender nodule in flexor tendon at base of finger or thumb.

Policy Statement

Trigger Finger

Surgery for trigger finger is a low priority procedure and will not be routinely funded, except via the appropriate PCT mechanism. The Panel will consider patients who fulfill the criteria below:

- Where the patient has failed to respond to conservative measures. Up to 2 hydrocortisone injections into the tendon sheath will often settle early cases.

  OR

- Where the patient has a fixed deformity that cannot be corrected.

87. Arthroscopy of the knee (Osteoarthritis)

Rationale

Evidence suggests that arthroscopic surgery is not effective for osteoarthritis.
When knee surgery (open or arthroscopic) is under consideration, investigation by MRI has been shown to result in fewer interventions and overall reduced costs.

The West Sussex Public Health Observatory has undertaken some work to benchmark the number of operations in West Sussex against the national average and have age standardised these as follows:

**Data Source**
Hospital activity data for the year 2005/2006 has been used to calculate age standardised activity ratios (SARs) for arthroscopy of the knee. The calculation is based on finished consultant episodes (FCEs) and national data has been used as the standard (England = 100). Three-digit OPCS procedure codes have been used to identify the relevant procedures. To help in the interpretation, the SARs for the diagnosis are also presented.

<table>
<thead>
<tr>
<th>Main Operations – 3 Digit Codes</th>
<th>Observed</th>
<th>Expected</th>
<th>SAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>W82 Therapeutic endoscopic operations on semilunar cartilage</td>
<td>903</td>
<td>674</td>
<td>134</td>
</tr>
<tr>
<td>W83 Therapeutic endoscopic operations on other articular cartilage</td>
<td>314</td>
<td>115</td>
<td>274</td>
</tr>
<tr>
<td>W84 Therapeutic endoscopic operations on other joint structure</td>
<td>611</td>
<td>379</td>
<td>161</td>
</tr>
<tr>
<td>W85 Therapeutic endoscopic operations on cavity of knee joint</td>
<td>350</td>
<td>306</td>
<td>114</td>
</tr>
<tr>
<td>W86 Therapeutic endoscopic operations on cavity of other joint</td>
<td>42</td>
<td>40</td>
<td>106</td>
</tr>
<tr>
<td>W87 Diagnostic endoscopic examination of knee joint</td>
<td>314</td>
<td>270</td>
<td>116</td>
</tr>
<tr>
<td>W88 Diagnostic endoscopic examination of other joint</td>
<td>93</td>
<td>48</td>
<td>195</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2627</strong></td>
<td><strong>1832</strong></td>
<td><strong>183</strong></td>
</tr>
</tbody>
</table>

Both diagnostic endoscope examinations and therapeutic endoscope operations of the knee joint is well above the national average. The calculation suggests that the observed number of procedures exceed the expected number by 795. That is, if the national rate of intervention applied in West Sussex there would by 795 fewer arthroscopies. This suggests that appropriate guidelines need to be developed with clinicians.

A randomised controlled trial assessed by the Health Technology Assessment programme found that nearly half the surgery undertaken for knee injuries might be avoided if MRI investigation were used, without adverse impact on patient outcome or cost.

**Policy Statement**

**Arthroscopy of the knee**

Referrals for arthroscopic surgery for osteoarthritis will not normally be funded except in exceptional circumstances via the agreed PCT mechanism. If weight bearing X-ray shows complete loss of joint space arthroscopy is of little benefit.

**88. Hysterectomy for Dysfunctional Uterine Bleeding**

**Rationale**

- The Mirena® device has been shown to be effective in the treatment of heavy menstrual bleeding.
- The levonorgestrel intrauterine system is considerably cheaper than performing a hysterectomy, even if required for many years.
A number of effective conservative treatments are available as second line treatment after failure of Mirena or where it is contra-indicated.

**Evidence**

NICE published Clinical Guidelines on heavy menstrual bleeding in January 2007. Regarding hysterectomy for heavy menstrual bleeding this guidance states: Hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. Hysterectomy should be considered only when:
- other treatment options have failed, are contraindicated or are declined by the woman
- there is a wish for amenorrhoea
- the woman no longer wishes to retain her uterus and fertility.

A Cochrane systemic review concluded that levonorgestrel intrauterine system/Mirena coil improved the quality of life of women with menorrhagia as effectively as hysterectomy.

**Policy Statement**

**Hysterectomy for Dysfunctional Uterine Bleeding**

Prior to referral to secondary care treatment with non-steroidal anti-inflammatory agents and/or tranexamic acid should have been tried unless contraindicated.

West Sussex Primary Care Trust will not routinely fund hysterectomy for dysfunctional uterine bleeding except where:
- There has been a prior trial with a levonorgestrel intrauterine system (Mirena®) (unless contraindicated) and/or endometrial resection/ablation which has not successfully relieved symptoms.

Contraindications to the levonorgestrel intrauterine system are:
- Severe anaemia, unresponsive to transfusion or other treatment, whilst a levonorgestrel intrauterine system trial is in progress.
- Distorted or small uterine cavity (with proven ultrasound measurements).
- Genital malignancy
- Active trophoblastic disease
- Pelvic inflammatory disease
- Established or marked immunosuppression
- Submucous fibroid

89. Female Genital Prolapse

**Rationale**
- Prolapse is often asymptomatic and an incidental finding, and clinical examination may not necessarily correlate with symptoms
- Surgical intervention has been assessed as effective but with a close benefit/risk balance in mild cases.

**Evidence**

**Prevention**

Few large prospective trials have assessed the prevention of prolapse:
- The role of obstetric risk factors is unclear - reduced duration of the second stage of labour, decreased use of instrumental deliveries, and episiotomies may help prevent prolapse in the long term
- Treatment of conditions that increase intra-abdominal pressure such as constipation, obstructive airway disease, chronic cough, and obesity are primary and secondary prevention strategies
- The role of hormone replacement therapy in preventing prolapse is uncertain
Pelvic floor exercises after childbirth may help, though this has not been proved. Conservative treatment should always be offered before referral to hospital.

**Pelvic floor exercises**

Pelvic floor exercises may limit the progression of mild prolapse and alleviate mild prolapse symptoms such as low backache and pelvic pressure. However, they are not useful if the prolapse extends to or beyond the vaginal introitus.

**Policy Statement**

**Female Genital Prolapse**

West Sussex PCT will not normally fund surgery for asymptomatic or mild pelvic organ prolapse.

The indications for surgery are:

- Failure of pessary
- Prolapse combined with urethral sphincter incompetence or faecal incontinence – referral to a specialist urogynaecologist should be considered.

Reassurance, self help information such as weight loss and avoidance of constipation should be provided together with physiotherapy for pelvic floor muscle training or trial of ring pessary where symptoms are mild.

90. **Orthodontics for Mild Malocclusions (IOTN1,2,3) in Secondary Care**

**West Sussex PCT Policy Statement**

Orthodontic treatment in secondary care will only be funded for patients who score 4 or 5 on the Index of Orthodontic Treatment Need (IOTN).

Patients aged under 18 years at the time of the case assessment will be eligible for treatment if they have treatment needs assessed as IOTN Grades 4 or 5.

Patients over the age of 18 with complex occlusal and skeletal problems requiring multi-disciplinary treatment will be eligible for treatment.

The PCT recognises there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate. In such cases, funding applications should be made to the West Sussex PCT Review Panel for Patients with Individual Needs (PIN) outlining the individual exceptional circumstances. West Sussex PCT will not pay for these procedures unless prior authorisation is obtained.

It is up to the requesting clinician to demonstrate why the patient should be considered as an exception. Orthodontic treatment is not available for aesthetic reasons alone.

Patients requesting treatment in primary care and assessed as below 3.6 IOTN and feel that they have exceptional circumstances can also appeal to the West Sussex PCT Review Panel for Patients with Individual Needs.

The PCT will set up a mechanism in primary care to assess eligibility criteria for treatment in secondary care (IOTN 4 and 5).
Appendix 1 - IFR Decision Making Process (Formerly PIN)

**Request from General Practitioner / other practitioners**

**Request from Consultant**

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**Proposal for treatment**
Case presented addressing questions on form PF4 or Drug questionnaire or letter outlining why a case should be treated as an exception to the Clinical Policy/Low Priority Procedures etc.

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**IFR Panel**

Review Panel Membership:-
- Clinicians (GPs and hospital consultants)
- Dentist
- Consultant in Public Health Medicine
- PCT Finance/Commissioners
- Lay Person/Member (s)
- Public Health Specialist who prepares case papers and Evidence Reviews

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**Clinical Evidence Review & Position of the Clinical Networks**
Independent Expert Specialist Input for all Specialities as appropriate

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**Advise the PCT on commissioning issues which need to be addressed / clinical policies which need to be reviewed or developed as a result of the individual case reviews**

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**FUND**

- Uphold Decision

**DO NOT FUND**

- Appeal

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**Appeals Panel**

Appeal Panel Membership:-
- GP(s)/Consultant(s)
- Consultant in Public Health Medicine
- Commissioners
- Lay Member(s)

Public Health Specialist (not a member of the Panel) to prepare papers for the Appeal Panel and record the deliberations of the Panel

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**Accept Decision**

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**Overturn Decision**
Case returned to IFR Panel
What is a chalazia?

A chalazion is an enlargement of an oil-producing gland in the eyelid (the meibomian gland). It forms when the gland opening becomes clogged with oil secretions. It is not caused by an infection from bacteria, and it is not cancerous.

A chalazion is sometimes confused with a stye, which also appears as a lump on the eyelid. A stye is a red, sore lump near the edge of the eyelid caused by an infected eyelash follicle.

Initially, a chalazion may resemble a stye, but it usually grows larger, sometimes as large as a pea. Chalazia also tend to develop farther from the edge of the eyelid than styes.

About 25% of chalazia have no symptoms and will disappear without any treatment. Sometimes, however, a chalazion may become red, swollen and tender. A larger usually upper lid chalazion may also cause blurred vision by distorting the shape of the eye. Occasionally, a chalazion can cause the entire eyelid to swell suddenly.

How should chalazia be treated?

Symptoms are treated with one or more of the following methods:

Warm compresses help to clear the clogged gland. Soak a clean washcloth in hot water and apply the cloth to the lid for 10 - 15 minutes, three or four times a day until the chalazion is gone. You should repeatedly soak the cloth in hot water to maintain adequate heat.

Antibiotic ointment may be prescribed if bacteria infect the chalazion.

If a large chalazion does not respond to other treatments and affects vision, it may require incision and curettage. The procedure is usually performed under local anaesthesia in outpatients but children will require a general anaesthetic.

A chalazion usually responds well to treatment, although some people are prone to recurrences. If a chalazion recurs in the same place, a biopsy to rule out sebaceous gland carcinoma may be indicated.
APPENDIX 3 NHS West Sussex Varicose Vein Referral Guidelines and Management

Patient presents to GP with Varicose Veins

Route 1
- Venous Bleeding Or Above Knee Thrombophlebitis
  - Treatment in Secondary care
    - YES
    - Secondary Care referral inappropriate
  - NO

Route 2
- Trial of class I/II stockings¹
  - Failed Compression
    - Are any 2 of the following present?
      1. Ulcer³ (active/healed)
      2. Lipodermatosclerosis
      3. Venous Eczema
    - CEAP grades² 4b, 5 & 6
    - Are there any exceptional circumstances?
      - YES
      - IFR

Route 3
- Exceptional circumstances
  - YES

1. 1. Trial of class I/II compression stocking for 4 months
2. 2. CEAP classification of venous disease
3. 3. Ulcers without other skin changes may not be venous

Check List for GP Referral:
- Confirmation that compression has been tried
- Document presence of ulceration or other skin changes
- Details of previous surgery/injections
- History of possible/definite DVT
- History of previous limb or pelvic trauma
- History of previous long illness with bed rest
- History of abnormal clotting/anticoagulation
- Family history of clotting disorder
- Drug history especially oral contraception or HRT

- Patients who meet the eligibility criteria are to be treated without applying to the IFR panel
- Referrals which do not meet the eligibility criteria are to be returned to GP
- Hospital trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria
- Trusts will be audited to ensure that they treat patients who meet the eligibility criteria only.
Dental Referral Guidelines

1) Dental Extractions of Non-impacted Teeth
2) Apicectomy
3) Dental Implants
4) Asymptomatic Impacted Third Molars
5) Orthodontics for Mild Malocclusions (ITON 1,2,3)

April 2010
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West Sussex Primary Care Trust

LOW PRIORITY PROCEDURES DENTAL REFERRAL GUIDELINES

The referral guidelines below relate to the dental procedures which the PCT has designated as Low Priority Procedures (LPPs) i.e. procedures which will not be routinely funded in secondary care. The PCT commissions services from a variety of providers in primary and secondary care to ensure best use of finite resources. The PCT is setting up minor oral surgery services in primary care, therefore some referrals will be directed to these providers in the primary care setting as appropriate.

You will have received a copy of the document along with a patient leaflet explaining the rationale for the LPPs.

There is no blanket ban on any of the procedures. The West Sussex PCT Review Panel for Individual Needs (PIN) is the mechanism for dealing with individual cases/exceptions. Applications for funding low priority procedures in secondary care will be handled through the PCT Prior Approvals mechanism, which is the PIN process. The PIN Team will work very closely/jointly with the dental referral management service to ensure that referrals are processed in a timely manner without causing any undue delays to patient treatment.

All dental referrals will be processed through the new Dental Referral Management Service.

The referral guidelines have been developed to help dentists make appropriate referrals. The guidelines have been written by consultants with input from the Local Dental Committee and the Oral Health Advisory Group (OHAG).

Inappropriate referrals if received by the Dental Referral Management Service will be returned to the referring dentist for appropriate management in primary care.

The referral guidelines relate to the following procedures:-

1. Extraction of non-impacted teeth
2. Apicectomy
3. Dental Implants
4. Asymptomatic Impacted Third Molars
5. Orthodontics for Mild Malocclusions (ITON 1,2,3)
1. **Dental Extraction of Non-impacted Teeth**

Extraction of non-impacted teeth will not be routinely funded in secondary care. They will only be funded in secondary care for patients with the risk factors / conditions listed below. Where a patient has one of these conditions, the request does not need to be considered by the PIN Panel but will be processed through the newly integrated Dental Referral Management & PIN Service.

1.1 **Those at high risk of endocarditis**

Examples of these might include patients who have previously had bacterial endocarditis. Please refer to your current British National Formulary (BNF) for guidance. Such patients may need intravenous antibiotics, and/or anti-coagulant management.

1.2 **Bleeding or clotting disorders – such as:**

- Clotting factor deficiency states such as Haemophilia, Von Willebrands disease
- Bone marrow deficiency such as in myelodysplasia or leukaemia
- Platelet deficiency states, or platelet dysfunction disorders
- End stage liver or kidney disease

Such patients often need replacement blood products

1.3 **Anticoagulant medication**

Patients who take warfarin, Tinzaparin or similar medications, often will need tests such as an INR. If the INR is stable and <4 it is safe to treat in a primary care setting. However if the INR is unstable or >4 refer for secondary care treatment.

1.4 **Bone Marrow Necrosis States**

1.4.1 **IV Bisphosphonate Therapy**

Bisphosphonates are now commonly prescribed for conditions that cause bones to collapse, such as osteoporosis. These medications have a protracted half-life and work by inhibiting boney turnover. In some instances these drugs have been implicated in Osteochemonecrosis (OCN). This condition is similar to Osteoradionecrosis, and is seen after dental extractions. The risk with oral bisphosphonates is exceedingly low, but the risk with the IV forms, used in the treatment of bony malignancy is very high. The risk of OCN in this group is thought to persist many years after the original treatment.

1.4.2 **Osteoradionecrosis Risk**

Any patient who has had therapeutic radiotherapy (DXT) to the head and neck area is at risk of this complication, which chiefly effects molar extraction sites. Patients who have had radioactive iodine (and no other DXT) for thyroid malignancy are not at risk of this condition and should be managed as would normally be the case in the primary care setting.
1.5 Myocardial Infarct within 6 Months of Referral

Dental interventions within 6 months of an MI carry a high risk of adverse event. The chance of survival from a coronary event is greatly increased if this occurs in a setting where full resuscitation measures are immediately available.

1.6 Indications for a General Anaesthetic

- The need for multiple extractions (more than 10 teeth) in apprehensive patient.
- Lack of cooperation from patient due to psychiatric or medical factors.
- *Dental phobia,* [this may not always be clear cut]. Every effort must be made to offer LA or LA (sedation) as an option and all risks must be discussed and agreed.
- Procedure not tolerable e.g. Exposure and bracketing of buried canines
- Drainage of facial abscesses involving the head and neck & similar emergency treatment.

Those factors highlighted in italics may not always be clear cut. **The Dental Referral Management Service will seek to identify those practices where referral rates for GA are excessive, so that resources can be appropriately managed.**

If for any other reason options such as LA or LA (sedation) are deemed clinically inappropriate an application can be made to the PIN panel.

1.7 When Extraction(s) are an Essential Part of Other Treatment

Extractions may be indicated as part of a larger treatment plan. An example of this occurs when large jaw cysts have to be removed such as with Keratocysts, Dentigerous cysts, Odontogenic tumours, aneurysmal bone cysts etc.

Extraction(s) may be part of oral cancer staging, a process that is tightly constrained by target deadlines.

1.8 Brittle asthma

Patients with a history of admission to an intensive care unit (ICU) for management of their asthma represent a serious risk. In patients with such a history or where their condition has been demonstrated to be readily provoked in a dental setting, referral on is deemed appropriate. The minimum recommendations as set out by the Resuscitation Council 2005 in relation to dental practices are currently insufficient to allow the safe management of such patients in a community setting.

1.9 When there is a need to send tissue for histological analysis

It is sound clinical practice to submit excised pathological tissue for histological analysis. 1 in 4000 dental cysts, are odontogenic malignancies. There are certain radiological appearances that suggest a heightened risk of pathology such as ameloblastoma, odontogenic keratocyst or haemorrhagic bone cyst. It is therefore important if you suspect such pathology, or think there may be a need for histological analysis, that you state so in the referral letter. An accompanying contemporaneous radiograph (<3 months old) is desirable.
2. Apicectomy

The PCT will not routinely fund apicectomies in secondary care except in exceptional circumstances though the PCT prior approvals mechanism which is PIN. The indications for surgical apicectomy are well recognized. Many cases that are referred are inappropriate for such treatment, and are best managed by extraction in the primary care setting. Inappropriate referrals for apicectomies will be returned to the referring dentists for appropriate management in primary care.

2.1 Indications which will be considered by the PIN Review Panel

There are indications where if appropriate the Review Panel may consider approving funding for a clinical assessment to be undertaken if they deem it appropriate. These are:-

- Where the peri-radicular radiolucency is greater than 1cm and where a biopsy is indicated
- Where the post fits the root canal well, is longer than 11mm and there is no history of cementation failure and where the coronal seal is adequate but there is apical pathosis
- Where the root canal is not considered negotiable from the radiograph through its entire length and there is pathosis
- Where the tooth is a crucial abutment for a bridge and there is an adequate coronal seal
- Teeth with iatrogenic or traumatic damage, or resorption where surgery offers the opportunity to retain the tooth.

2.2 Inappropriate Referrals for Apicectomy

There are indications for apicectomy which would be considered as inappropriate referrals as these are best managed by extraction in the primary care setting. Such referrals if received by the Dental Referral Management Service will be returned to the referring dentist for appropriate management in primary care. Examples of such referrals are:-

- Repeat apicectomy
- Where the root canal therapy is inadequate obturated and there is access to the root canal system
- Apicectomy on molar teeth
- Where patients have poor oral hygiene, active periodontal disease or uncontrolled dental caries
- Where the tooth has inadequate coronal tooth tissue to support a conventional crown and the tooth has not previously been restored
- Teeth with a post crown where the post is less than 11mm
- Teeth which have post crowns where the post does not fit the canal, or the post has been re-cemented on more than 1 occasion
- Patient who require intravenous sedation or general anaesthesia
- Patients at risk from bacterial endocarditis or with haematological disorders.

Periapical cysts involving only a single root, without sinister radiological features and which are less than 1cm diameter are statistically unlikely to be anything other than benign periapical cysts. As such these are best managed in the primary sector as simple root treatment or extraction usually is curative.
3. Dental Implants

3.1 Indications which will be considered a priority

The PCT will not routinely fund dental implants except in exceptional circumstances. All requests for dental implants will be considered by the PIN Panel. Examples of patients who will be considered as a priority include:

- Patients who have received major head and neck reconstruction for oral cancer or major head and neck reconstruction following trauma where dental implants are indicated as a necessary part of the treatment package – at the time of the reconstruction.
- Patients suffering from congenital hypodontia
- When implants are needed for the retention of prosthetic ears/eyes/nose or other facial parts
- Obturation devices for jaw defects secondary to Cancer or Trauma

Clearly, the use of other simple restorative prostheses such as ordinary dentures or bridges may suffice for most.

3.2 Contraindications for dental implants

Listed below are some examples of contraindications for referrals for dental implant treatment:

- Patients who smoke
- Patients with active Periodontal Disease or uncontrolled dental disease
- Poorly controlled diabetic patients
- Patients who have not completed their physical growth
- Patients who are alcohol dependant or partake in substance abuse

There are indications where if appropriate the Review Panel may consider approving funding for a clinical assessment to be undertaken. Examples of such indications are:

- Rehabilitation following ablative surgery
- Patients with congenitally missing teeth including patients with Cleft Lip and Cleft Palates
- Patient with congenital defects of tooth tissue e.g. Amelogenesis or Dentinogenesis
- Patients with Cranio-facial defects

4. Asymptomatic Impacted Third Molars

Surgical extraction of asymptomatic impacted third molars is not routinely funded by the PCT save the circumstances recommended by NICE as set out below. In exceptional circumstances, funding may be approved on an individual basis, via the agreed PCT mechanism.

NICE have issued the following guidance:

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

5. Orthodontics for Mild Malocclusions (ITON 1,2,3)

Orthodontic treatment in secondary care will only be funded for patients who score 4 or 5 on the Index of Orthodontic Treatment Need (IOTN) and are under the age of 18.

Patients aged over 18 years at the time of the case assessment will be eligible for treatment in secondary care if they have complex occlusal and skeletal problems requiring multi-disciplinary treatment.

The PCT recognises there will be exceptional, individual or clinical circumstances when funding for treatments designated as low priority will be appropriate. In such cases, funding applications should be made to the NHS West Sussex IFR panel outlining the individual exceptional circumstances. NHS West Sussex will not pay for these procedures unless prior authorisation is obtained.

It is up to the requesting clinician to demonstrate why the patient should be considered as an exception. Orthodontic treatment is not available for aesthetic reasons alone.

Patients requesting treatment in primary care and assessed as below 3.6 IOTN and feel that they have exceptional circumstances can also appeal to the NHS West Sussex IFR panel.

The PCT will set up a mechanism in primary care to assess eligibility criteria for treatment in secondary care (IOTN 4 and 5).