HYWEL DDA UNIVERSITY HEALTH BOARD

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda
Hywel Dda University Health Board

Interventions Not Normally Undertaken (INNU) Policy

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1.0	2014	Dr M Thomas	Amendments	Chair: CPRG	25.7.14	
				Chair: CPRG		31/03/2016

Brief Summary of Document:	This Policy sets out a list of interventions considered to be low priority and not normally undertaken by Hywel Dda University Health Board

To be read in conjunction with:	Not applicable

Classification:	Clinical	Category:	Policy	Freedom Of Information Status	Open

Authorised by:	Teresa Owen	Job Title	Director of Public Health	Signature:	A SIGNED COPY OF THIS DOCUMENT IS STORED WITH CORPORATE GOVERNANCE

HYWEL DDA UNIVERSITY HEALTH BOARD

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Scope	ORGANISATION WIDE	✓	DIRECTORATE		DEPARTMENT ONLY		COUNTY ONLY	

Staff Group	Administrative/ Estates		Allied Health Professionals		Ancillary		Maintenance	
	Medical & Dental	✓	Nursing		Scientific & Professional		Other	

CONSULTATION	Please indicate the name of the individual(s)/group(s) or committee(s) involved in the consultation process and state date agreement obtained.			
	Individual(s)	Director of Public Health Medical Director	Date(s)	March 2014
	Group(s)	Executive Team, Primary and Secondary Care Medical Staff MDAB	Date(s)	September/October 2013 9.1.14
	Committee(s)		Date(s)	

RATIFYING AUTHORITY (in accordance with the Schedule of Delegation)	KEY		COMMENTS/ POINTS TO NOTE
NAME OF COMMITTEE	A = Approval Required FR = Final Ratification	Date Approval Obtained	
CPRG	A	25.7.14	

Date Equality Impact Assessment Undertaken	20.11.13	Group completing Equality impact assessment	Dr Michael Thomas

Please enter any keywords to be used in the policy search system to enable staff to locate this policy	Interventions Not Normally Undertaken

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1. INTRODUCTION

1.1 The NHS has historically identified either marginally effective or ineffective treatments/procedures that are currently deemed to have limited clinical value. These are routinely considered to be low priority and will not normally be provided by the NHS. It is acknowledged that the evidence-base for some clinical practice is lacking and frequently has not been subject to review by the National Institute for Health and Care Excellence (NICE), or guidance in the form of a National Service Framework or the subject of peer-reviewed journals of high scientific quality. In these circumstances, the evidence-base available, including an assessment of potential health gain against potential harm, is considered along with an economic assessment of impact on a resource limited NHS.

1.2 This Policy sets out a list of interventions in Appendix 1 considered to be low priority and not normally undertaken by Hywel Dda University Health Board ('HDHB'), alongside links to the available evidence. Where applicable, the specific circumstances in which they will be undertaken by HDHB are set out. It is important to note that blanket bans for these interventions do not exist.

1.3 The process for assessing individual requests for these interventions can be found in the Policy for Individual Patient Funding Requests for Treatment (IPFR).

1.4 HDHB Clinical Effectiveness Group considers the following sources of advice when assessing whether individual treatments and procedures should be undertaken:
(a) Evidence published by NICE and the All Wales Medicine Strategy Group
(b) Evidence from peer reviewed clinical journals
(c) Evidence from clinical practice and local clinical consensus
(d) Public Health Wales (PHW) reviews of evidence of a,b,c above.
Following detailed clinical discussion and consideration by the Group, a policy statement is drafted and presented as a recommendation to the HDHB Quality and Safety Committee for approval.

1.5 In some cases, it is important to note that policy statements may also be based on value judgements – these judgements will be based on the same principles for decision making as set out in the Policy for Individual Patient Funding Requests for Treatment. They are openness and transparency; inclusiveness; accountability; reasonableness; effectiveness and efficiency; exercising duty of care; lawful decision making; right to appeal.

1.6 This Policy is a live document and will be routinely updated as new/updated evidence becomes available. Each change to the Policy will be ratified by the Quality and Safety Committee and the document will also be considered by the full HDHB Board twice a year

2. POLICY STATEMENT

Hywel Dda University Health Board has developed a Policy on Interventions Not Normally Undertaken which identifies those interventions which are considered to be low priority and not normally undertaken by the Health Board, alongside links to the available evidence. It is important that NHS resources are used to best effect and historically the NHS has identified either marginally effective or ineffective treatments or procedures that are currently deemed to have little clinical value. For these procedures, the evidence base available, including an assessment of potential health gain against potential harm, is considered along with an economic impact assessment on a

resource limited NHS. Through the full implementation of the Policy on Interventions Not Normally Undertaken this should ensure that procedures of marginally effective or ineffective treatments are not performed. This should free a resource for those treatments which have a well recognised clinical benefit for patients.

3. SCOPE

The Hywel Dda University Health Board Policy on Interventions Not Normally Undertaken considers all areas of practice within all specialties when the procedure, based on the currently available evidence, is identified as being either marginally effective or ineffective and currently deemed to have limited clinical value. The Policy on Interventions Not Normally Undertaken has therefore been circulated to all practicing clinicians in primary and secondary care to ensure that referrals are managed appropriately.

4. AIMS

The Policy on Interventions Not Normally Undertaken identifies interventions which are considered to be low priority and not normally performed within Hywel Dda University Health Board, alongside links to the available evidence of best practice.

5. OBJECTIVES

The Hywel Dda University Health Board Policy on Interventions Not Normally Undertaken will ensure that marginally effective or ineffective treatments or procedures that are currently deemed to have limited clinical value are not performed in Hywel Dda University Health Board.

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1. ABRASION ARTHROPLASTY FOR KNEES

Background:	Abrasion is to grind down and arthroplasty is reshaping of the joint. An abrasion arthroplasty is a surgical procedure to reshape the joint by grinding down the damaged surface to bleeding bone with a rotating bur.
Guidance:	There is a lack of published research on abrasion arthroplasty for knees. Those that comment, are of the opinion that the treatments are not always effective and may be transitory, resulting in the need for a total knee replacement.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Abrasion arthroplasty for knees.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/Main%20Frameset?OpenFrameSet&Frame=Right&Src=%2Fhealthserviceqdtdocs.nsf%2FPublicPage%3FOpenPage%26AutoFramed [Accessed 26/10/2012].
OPCS Code:	No code
Review:	Review date: Planned next review date:

2. APICECTOMY

Background:	Apicectomy is a surgical procedure involving the removal of the infected tip of the root of a tooth and a small amount of surrounding bone and tissue. Apicectomy is carried out under local anaesthetic, often in hospital though it can be done in general dental practice depending on the clinician and their experience. Repeat procedures can be carried out on the same patient, but only on different teeth.
Guidance:	Should NOT be used except in the following circumstances: • presence of peri-radicular 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 • presence of peri-radicular disease in a tooth where iatrogenic or developmental anomalies prevent non surgical root canal treatment being undertaken • where a biopsy of peri-radicular tissue is needed • where visualisation of the peri-radicular tissue and tooth root is required when perforation, root crack or fracture is suspected • where procedures are required that need either tooth sectioning or root amputation • where it may not be expedient to undertake prolonged non-surgical root canal re-treatment because of patient considerations
Referral:	Health Board
Links to information sources:	Evans, GE; Bishop, K; Renton, T. Guidelines for Surgical Endodontics. London: Royal College of Surgeons; 2012. Available at: http://www.rcseng.ac.uk/fds [Accessed 26/10/2012] Public Health Wales Variation in Elective Surgical Procedures across Wales (page 35) [Word, 1.6Mb] - Public Health Wales Observatory 2010. [Accessed 26/10/2012] Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012] Data for this procedure http://howis.wales.nhs.uk/sitesplus/888/page/49043 [links to separate webpage]
OPCS Code:	F12 Surgery on apex of tooth F12.1 Apicectomy of tooth
Review:	Review date: Planned next review date:

3. ASSISTED CONCEPTION TECHNIQUES

Background:	Assisted conception techniques include – IVF, ICSI, Donor Insemination, MESA, TESE, PESA. Egg sperm & gonadal tissue cryostorage, Other micro-manipulation techniques, Egg donation where no other treatment is available, IVF surrogacy.
Guidance:	See WHSSC for criteria
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy http://www.wales.nhs.uk/sites3/page.cfm?orgid=898&pid=46592 [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	N34.2 N34.4>6 Q131>9 Q383 Y96
Review:	Review date: Planned next review date:

4. AUTOLOGOUS CHONDROCYTE IMPLANTATION FOR KNEE/ANKLE PROBLEMS CAUSED BY DAMAGED ARTICULAR CARTILAGE

Background:	Autologous chondrocyte implantation *(*ACI) is also referred to as Autologous Chondrocyte Transplantation (ACT).
Guidance:	Can be used in research studies that are designed to produce good quality information about the results of this procedure.
Referral:	Health Board
Links to information sources:	National Institute for Health and clinical Excellence. *Cartilage injury - autologous chondrocyte implantation (ACI) (review)*. TA89. London: NICE; 2010. Available at: http://www.nice.org.uk/page.aspx?o=TA089 [Accessed 26/10/2012] Public Health Wales Evidence-Based Information. Autologous Chondrocyte implantation for the ankle. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9 1 21fd080256f2a004937ed/af2a5cd5f229ac02802570f3003bede1/$FILE/Autologous%20Chondrocyte%20implantation.doc [Accessed 26/10/2012].
OPCS Code:	Y71.4
Review:	Review date: Planned next review date:

5. BACK PAIN LOWER

Background:	The lower back is commonly defined as the area between the bottom of the rib cage and the buttock creases. Some people with non-specific low back pain may also feel pain in their upper legs, but the low back pain usually predominates [1]. Non-specific low back pain is tension, soreness and/or stiffness in the lower back region for which it is not possible to identify a specific cause of the pain. Several structures in the back, including the joints, discs and connective tissues, may contribute to symptoms [1].

Guidance:	Plain x-rays of lumbar spine & MRI scans Should NOT be used EXCEPT in the context of a referral for an opinion on spinal fusion or if a diagnosis other than non-specific back pain is suspected. For example:
	• Age <20 years or new back pain in >55 years
	• Symptoms of immediate serious risks or 'Red Flags' indicating conditions such as:
	    • Malignancy
	    • Infection
	    • Fracture
	    • Cauda Equina Syndrome
	    • Adjacent pathology (for example aortic aneurysm)
	    • Ankylosing Spondylitis or another Inflammatory Disorder
	
	The following treatments should not be used for the early management of persistent non-specific low back pain [1]:
	• Serotonin reuptake inhibitors - SSRIs
	• Injections of therapeutic substances into the back
	• Laser therapy
	• Interferential therapy
	• Therapeutic ultrasound
	• Transcutaneous nerve stimulation - TENS
	• Lumbar supports
	• Traction
	
	The following referrals should not offered for the early management of persistent non-specific low back pain [1]:
	• Radiofrequency facet joint denervation
	• Intradiscal electothermal therapy - IDET
	• Percutaneous intradiscal radiofrequency thermocoagulation - PIRFT

Referral:	Health Board
Links to information sources:	[1]: National Institute for Health and Clinical Excellence. *Low back pain Early management of persistent non-specific low back pain*. CG88. London: NICE; 2009. Available at: http://www.nice.org.uk/nicemedia/pdf/CG88NICEGuideline.pdf [Accessed 26/10/2012] The Welsh Medicines Resource Centre. *Management of acute low back pain.* WeMeReC Bulletin. 2008. Available at: http://www.wemerec.org/Documents/Bulletins/BacksBulletinOnlineOPT.pdf [Accessed 26/10/2012]

OPCS Code:	U05.4 or U05.5 + Y98.2 + Z66.3>5 Z66.8 Z67.- M45.59
Review:	Review date: Planned next review date:

6. BARIATRIC SURGERY

Background:	Weight loss surgery, also called bariatric surgery, is used as a last resort to treat people who are dangerously obese (carrying an abnormally excessive amount of body fat). This type of surgery is only available on the NHS to treat people with potentially life-threatening obesity that will not respond to non-surgical treatments, such as lifestyle changes.
Guidance:	Please check the WHSSC criteria (very detailed)
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012]. See: http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf *Commissioning Policy for Bariatric Surgery, CP29*, Wales: WHSCC; 2009: http://www.wales.nhs.uk/sites3/Documents/898/CP29%20Bariatric%20Surgery.pdf
OPCS Code:	G28.4 G30.1>2 G30.4 G30.8>9 G71.6
Review:	Review date: Planned next review date:

7. BODY CONTOURING: ABDOMINOPLASTY AND APRONECTOMY (TUMMY TUCK)

<table>
<tr><td>Background:</td><td>Abdominoplasty or tummy tuck is the removal of excess skin and fatty tissue from the anterior abdominal walls.

An Apronectomy or mini tummy tuck is less radical than abdominoplasty.</td></tr>
<tr><td>Guidance:</td><td>Should NOT be used EXCEPT for the following groups of patients who should have achieved a stable BMI between 18 and 25Kg/m2 and suffer from severe functional problems:

• those with scarring following trauma or previous abdominal surgery
• those who are undergoing treatment for morbid obesity and have excessive abdominal skin folds
• previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years
• when required as part of abdominal hernia correction or other abdominal wall surgery

Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced.

If there is severe and disabling psychological distress as a result of abdominal wall scarring, psychological therapy should be the initial treatment. Severe functional problems include:

• recurrent intertrigo beneath the skin fold
• experiencing severe difficulties with daily living i.e. ambulatory restrictions
• where previous trauma or surgical scarring (usually midline vertical, or multiple) leads to very poor appearance and results in disabling psychological distress or risk of infection

Problems associated with poorly fitting stoma bags.</td></tr>
<tr><td>Referral:</td><td>WHSSC</td></tr>
<tr><td>Links to information sources:</td><td>Welsh Health Specialised Services Committee. Specialised Services Policy: Commissioning Criteria Plastic Surgery, CP39. Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf</td></tr>
<tr><td>OPCS Code:</td><td>S02.1>2
S02.8>9</td></tr>
<tr><td>Review:</td><td>Review date:
Planned next review date:</td></tr>
</table>

8. BODY CONTOURING: OTHER

Background:	Other body contouring examples include Buttock lift; Thigh lift; Arm lift (brachioplasty).
Guidance:	Should NOT be USED except in exceptional circumstances. The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is less likely to be indicated except for appearance.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S03.1>3 S03.8>9
Review:	Review date: Planned next review date:

9. **BOTULINUM TOXIN**

Background:	Botulinum toxin (abbreviated either as BTX or BoNT) is produced by *Clostridium botulinum,* a gram-positive anaerobic bacterium. BoNT is broken into 7 neurotoxins (labeled as types A, B, C [C1, C2], D, E, F, and G), which are antigenically and serologically distinct but structurally similar. The various botulinum toxins possess individual potencies.
Guidance:	Botulinum toxin should Not be used EXCEPT for the treatment of pathological conditions by appropriate specialists in cases of: • Frey's syndrome • Blepharospasm • Cerebral Palsy • Spasticity in adults following neurological illness or injury • Hyperhidrosis • Treatment of overactive bladder in women Botulinum toxin is not available for the treatment of facial ageing or excessive wrinkles For treatment of overactive bladder in women, bladder wall injection should only be used in the treatment of idiopathic detrusor over activity only in women who have not responded to conservative treatments (including antimuscarinic drugs e.g. oxybutynin) and who are willing and able to self catheterize. NICE notes that there is a gap in treatment between conservative treatment and surgery and botulinum toxin has been adopted to fill this position, however, this is in advance of high quality data on efficacy, safety and long term outcomes [1].
Referral:	Health Board
Links to information sources:	[1] National Institute for Health and Clinical Excellence. Urinary Incontinence: the management of urinary incontinence in women. CG40. London: NICE; 2006. Available at: http://publications.nice.org.uk/urinary-incontinence-cg40 [Accessed 26/10/2012] Welsh Health Specialised Services Committee. Specialised Services Policy: Commissioning Criteria Plastic Surgery, CP39. Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf Royal College of Physicians. Spasticity in adults: management using botulinum toxin National guidelines. London; 2009. Available at: http://bookshop.rcplondon.ac.uk/contents/6988a14a-1179-4071-8f56-dc2a865f0a43.pdf [Accessed 26/10/2012]
OPCS Code:	X85.1
Review:	Review date: Planned next review date:

10. BREAST PROSTHESIS REMOVAL OR REPLACEMENT

Background:	Female breast reduction, also known as reduction mammoplasty, is an operation to reduce the weight and volume of the breasts.
Guidance:	Should NOT be used EXCEPT if the NHS performed the original surgery and complications arise Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. If revision surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision There is separate guidance for PIP breast implants (2012)
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B30.-
Review:	Review date: Planned next review date:

11. CAPSULE ENDOSCOPY

Background:	A small capsule consisting of a camera, a light source and a wireless circuit is swallowed, as the capsule moves through the gastrointestinal tract, images are transmitted to a data recorder worn on a belt outside the body, the data is transferred to a computer for interpretation.
Guidance:	The main indication for capsule endoscopy is obscure gastrointestinal bleeding, which is defined as bleeding of unknown origin that persists or recurs after a negative initial endoscopy i.e. colonoscopy and/or upper gastrointestinal endoscopy. Other investigations should be considered prior to wireless capsule endoscopy particularly in patients with Crohn's disease in whom strictures are suspected [1]. Capsule endoscopy should NOT be used EXCEPT for disease of the small bowel for: • Overt or transfusion dependant bleeding from the gastrointestinal (GI) tract, when source not identified on OGD (Oesophago-gastro-duodenoscopy)/Colonoscopy • Crohns Disease in whom strictures are not suspected • Hereditary GI polyposis syndromes
Referral:	Health Board
Links to information sources:	[1] National Institute for Health and Clinical Excellence. *Wireless capsule endoscopy for investigation of the small bowel. IPG 101*. London: NICE; 2011. Available at: http://guidance.nice.org.uk/IPG101 [Accessed 26/10/2012]
OPCS Code:	G80.2
Review:	Review date: Planned next review date:

12. **CHOLECYSTECTOMY FOR ASYMPTOMATIC GALLSTONES**

Background:	Cholecystectomy is the surgical removal of the gall bladder
Guidance:	Can be used in patients who are at increased risk of developing gallbladder carcinoma or gallstone complications. An IPFR is required for all other circumstances
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Cholecystectomy for Asymptomatic Gallstones.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/6957010eaade44138025763f002d4976/$FILE/Cholecystectomy%20for%20asymptomatic%20gall%20stones%20(1)%2004092009.doc [Accessed 26/10/2012]
OPCS Code:	J18.1 J18.2 J18.3 J18.4 J18.5 J18.8 J18.9
Review:	Review date: Planned next review date:

13. CHRONIC FATIGUE SYNDROME

Background:	Chronic fatigue syndrome (CFS) is a debilitating condition characterised by unexplained fatigue that lasts for at least 6 months, accompanied by symptoms including headaches, muscle pain and cognitive difficulties such as poor memory and concentration. The terms CFS and myalgic encephalomyelitis/encephalopathy (ME) are very often used interchangeably, although there is dispute about whether the two conditions are identical entities.
Guidance:	There is no agreed criteria for treatment.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Guidelines and care pathways for chronic fatigue syndrome: a rapid review of the evidence.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/1f40b342fecb1f0880257641004 93e6a/$FILE/CHRONIC%20FATIGUE%20SYNDROME%20Approved%20version%201.doc [Accessed 26/10/2012]. National Institute for Health and Clinical Excellence. *Chronic Fatigue Syndrome/ Myalgic encephalomyelitis. Diagnosis and management of CFS/ME in adults and children.* CG53. London: NICE; 2007. Available at: http://www.nice.org.uk/Search.do?searchText=chronic+fatigue+syndrome&newsearch=true&x=16&y=15#/search/?reload [Accessed 26/10/2012].
OPCS Code:	D93.3
Review:	Review date: Planned next review date:

14. CIRCUMCISION

Background:	Circumcision is a surgical procedure to remove the foreskin of the penis
Guidance:	Should NOT be used EXCEPT in the following cases: • Phimosis • Paraphimosis • Balanitis and Balanoposthitis • Penile Cancer affecting the foreskin Circumcision carried out for medical reasons should be rare and should only be carried out for urgent medical conditions. Circumcision for religious or cultural reasons should only be carried out and paid for on a private basis.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. Specialised Services Policy: *Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	N30.3
Review:	Review date: Planned next review date:

15. COCHLEAR IMPLANTS

Background:	WHSSC is responsible for the commissioning of Cochlear Implants services including assessment, surgical implantation, rehabilitation and maintenance of implants for both paediatric and adult patients in Wales. A cochlear implant is an implanted electronic hearing device designed to produce useful hearing sensations to a person with a severe to profound nerve deafness by bypassing the damaged hair cells in the inner ear and stimulating the hearing nerve directly.
Guidance:	Should NOT be used EXCEPT in the following: *Paediatric* cases that meet agreed audiological, physical and emotional criteria: • Bilateral sensorineural hearing loss of > 90 dBhl at 2 KHz and 4 KHz • Primary form of communication is spoken • Radiological examination has excluded retro-cochlear pathologies /cerebral defects • Patient should be fit for general anaesthesia • Referrals accepted for both acquired and congenital hearing loss • Parental understanding and agreement to the long-term commitment of a cochlear implant • *Adult* cases that meet agreed audiological, physical and emotional criteria: • Have severe - profound hearing loss bilaterally with an average hearing loss > 90 dBhl at 2 KHz and 4 KHz • Radiological examination has excluded retro-cochlear pathologies / cerebral defects • Patient should be fit for general anaesthesia and surgery • Have understanding and agreement to the long-term commitment of a cochlear implant
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	D24.-
Review:	Review date: Planned next review date:

16. COMPLEMENTARY THERAPIES AND ALTERNATIVE MEDICINES

Background:	Complementary therapies and alternative medicine include various healing approaches that originate from around the world that are not based on conventional clinical medicine.
Guidance:	Complementary medicine/ alternative therapies are generally NOT used by the NHS. They are occasionally used as a treatment as part of a mainstream service care plan (e.g. as part of an integrated multidisciplinary approach to symptom control by a hospital based pain management team) and as such will be used as part of an existing contract. On existing available evidence the LHB will not support referral outside of the NHS for these services. Prior approval is required on a case by case basis for any requests outside the above criteria. The request for referral would need to be supported by evidence of the clinical effectiveness of the treatment and be to appropriately trained and qualified practitioners with recognised qualifications The evidence suggests that there are large numbers of complementary and alternative therapies that have not been subject to the trials used to establish the effectiveness of conventional clinical treatments. The evidence base is developing and up to date evidence on complementary therapies and alternative treatments can be obtained from the Cochrane library and specialist evidence of NHS Library
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Complementary therapies and alternative medicine.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/5152d0678687f2da8025763f002f0a7f/$FILE/Complementary%20therapies%20and%20alternative%20medicine%20-%20STATIC%2021092009%20(1).doc [Accessed 26/10/2012]
OPCS Code:	A70.6 X61.1>4 X61.8>9
Review:	Review date: Planned next review date:

17. COMPUTER BASED COGNITIVE BEHAVIOUR THERAPY

Background:	Cognitive behavioural therapy (CBT) is a talking therapy to help manage your problems by changing the way you manage your thoughts and behaviour.
Guidance:	NICE recommends Beating the Blues for the management of mild and moderate depression and FearFighter for the management of panic and phobia, computerised cognitive behaviour therapy (CCBT).
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Computerised cognitive behaviour therapy for depression and anxiety*. TA51. London: NICE; 2006. Available at: http://www.nice.org.uk/Search.do?searchText=TA+97&newsearch=true#/search/?reload [Accessed 26/10/2012]
OPCS Code:	X66
Review:	Review date: Planned next review date:

18. CORNEAL IMPLANTS FOR THE CORRECTION OF REFRACTIVE ERROR IN THE ABSENCE OF OTHER OCCULAR PATHOLOGY SUCH AS KERATOCONUS

Background:	Corneal implants are flexible, crescent-shaped rings of polymethyl methacrylate that are inserted in the periphery of the cornea. They affect refraction in the eye by physically changing the shape of the cornea, flattening the front of the eye.
Guidance:	Current evidence on the efficacy of corneal implants for the correction of refractive error shows limited and unpredictable benefit. In addition, there are concerns about the safety of the procedure for patients with refractive error which can be corrected by other means, such as spectacles, contact lenses, or laser refractive surgery.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Corneal implants for the correction of refractive error. IPG 225*. London: NICE; 2007. Available at: http://guidance.nice.org.uk/IPG225/guidance/pdf/English [Accessed 26/10/2012]
OPCS Code:	C40.4 C44.1>2 C46.1 C46.7 C47.6
Review:	Review date: Planned next review date:

19. **DENTAL IMPLANTS**

Background:	An endosseous dental implant is a surgically implanted device which replaces the lost root of a tooth. An artificial tooth, partial denture, or denture can be attached to the implant.
Guidance:	Should NOT be used EXCEPT for patients who need post cancer reconstruction, major trauma with bone loss, anodontia, or on the advice of NHS specialists The Faculty of Dental Surgery has produced guidance [1] on the selection of patients for dental implant treatment within the NHS, these include three groups of patients for consideration: 1. Endentulous in one or both jaws: • Severe denture intolerance (e.g. gagging, pain); • Prevention of severe alveolar bone loss 2. Partially dentate: • Preservation of remaining health teeth; • Complete unilateral loss of teeth in one jaw 3. Maxillofacial and cranial defects: • Intraoral protheses e.g. considerable amounts of missing hard and soft tissue; • Extraoral/cranial prostheses e.g. partial or total loss of ears, eyes or nose. The evidence suggests that dental implants have been shown to be a successful treatment [2]. However, dental implant treatment should only be provided by appropriately trained dentists in accordance with General Dental Council guidance [3].
Referral:	Health Board
Links to information sources:	[1] The Royal College of Surgeons of England. Faculty of Dental Surgery. *National Clinical Guidelines 1997*. London: RCSENG; 1997. Available at: http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/ncg97.pdf [Accessed 26/10/2012] [2] National Public Health Service. Public health evidence-based summary, Dental Implants. Public Health Wales NHS Trust: Wales; 2009. Available at: PHW Evidence-Based Information http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/Main%20Frameset?OpenFrameSet&Frame=Right&Src=%2Fhealthserviceqdtdocs.nsf%2FPublicPage%3FOpenPage%26AutoFramed [Accessed 26/10/2012] [3] General Dental Council. Implantology. [website] Available at: http://www.gdcuk.org/dentalprofessionals/standards/pages/implantology.aspx [Accessed 26/10/2012]
OPCS Code:	F11.5>6

Review:	Review date: Planned next review date:

20. EAR: CORRECTION OF PROMINENT EARS (PINNAPLASTY/OTOPLASTY)

Background:	Pinnaplasty also called an otoplasty – is an operation to reshape the cartilage of the ear to hold the ears back.
Guidance:	Should NOT be used EXCEPT in the following criteria: • The patient must be under the age of 19 at the time of the referral. • Patients seeking pinnaplasty should be seen by a surgeon with accredited skills and following assessment, if there is any concern, assessed by a psychologist. Children under the age of five are usually oblivious and referrals may reflect concerns expressed by the parents rather than the child. Prominent ears 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. The National Service Framework for Children defines childhood as ending at 19 years. Some patients are only able to seek correction once they are in control of their own healthcare decisions.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery, CP39*. Wales: WHSSC: 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	D03.3
Review:	Review date: Planned next review date:

21. EAR: REMODELLING OF LOBE OF EXTERNAL EAR

Background:	Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
Guidance:	Should NOT be used EXCEPT for the repair of totally split ear lobes as a result of direct trauma. Prior to surgical correction, patients should receive pre-operative advice to inform them of: • Likely success rates • The risk of keloid and hypertrophic scarring in this site • The risk of further trauma with re-piercing of the ear lobule
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	D03.1>2
Review:	Review date: Planned next review date:

22. ELECTIVE CAESAREAN SECTION

Background:	Caesarean sections are carried out in hospital. The length of stay varies, though women usually stay for 3-4 days after the procedure. Once a woman has had one caesarean section it is more likely that she will have one for subsequent pregnancies. Caesarean section rates are progressively rising in many parts of the world. One suggested reason is increasing requests by women for caesarean section in the absence of clear medical indications, such as placenta praevia, HIV infection or pelvic organ abnormalities. There is a common perception that increasing requests relate to women from higher socio-economic backgrounds.
Guidance:	Can be undertaken when patients meet one or more of the following: • HIV (only if recommended by a HIV consultant) • Both HIV and Hepatitis C (as above, there is no evidence that CS should be performed for Hepatitis C alone) • Primary genital herpes in the third trimester (active genital herpes at the onset of labour) • Grade 3 and 4 placenta previa • Previous upper segment caesarean section / type unknown • Previous significant uterine perforation / surgery breaching the cavity • A term singleton breech (if external cephalic version is contraindicated, failed or declined) • A twin pregnancy regardless of chorionicity with breech or smaller first twin • A monochorionic twin pregnancy after appropriate discussion about the risks of acute TTTS • A previous caesarean section if VBAC (Vaginal Birth after Caesarean) has been declined or is felt to be inappropriate • A previous traumatic vaginal delivery if VBAC has been fully explored but declined • A foetus at high risk of fetal distress in labour e.g. known severe placental insufficiency • A woman with tocophobia who has requested caesarean section, providing that her concerns have been fully explored and documented AND support and counselling has been made available AND the patient has attended the Birth Choices Clinic (she should have been offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her fears in a supportive manner. If, after providing such support, a vaginal birth is still not an acceptable option, an elective c-section can be supported).
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. Caesarean section. CG132. London: NICE; 2011. Available at: http://www.nice.org.uk/Guidance/cg132 [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales.*

	Public Health Wales Observatory – page 56; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	R17 Elective caesarean delivery R17.1 Elective upper uterine segment caesarean delivery R17.2 Elective lower uterine segment caesarean delivery R17.8 Other specified R17.9 Unspecified R18.1 R18.2 R18.9 The codes used all refer specifically to elective procedures, as used in the original demand and variation report and work in England. There is a separate code (R18) that refers to emergency caesarean deliveries. The difficulty with caesarean sections arises when mothers for whom an elective caesarean section is planned are admitted as emergencies and have an emergency section performed. As it was already decided that the birth would be via caesarean section then the procedure is classified as an elective caesarean delivery
Review:	Review date: Planned next review date:

23. ELECTRICAL AND ELECTROMAGNETIC FIELD TREATMENTS IN NON-UNION OF BONES

Background:	Most broken bones heal without problems; non-union is the failure of a broken bone to heal.
Guidance:	Electrical and electromagnetic treatment for the non-union of bones has been used for a number of years, its efficacy is uncertain.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary.* Electrical and electromagnetic field treatment for non-union of bones. 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/3b4a088cd3368f028025763f0032baf7/$FILE/Electrical%20and%20Electromagnetic%20Field%20Treatment%20(1)2004092009.doc [Accessed 26/10/2012].
OPCS Code:	No code
Review:	Review date: Planned next review date:

24. ELECTRO-CONVULSIVE THERAPY

Background:	Electro convulsive therapy (ECT) involves sending an electric current through the brain to trigger a seizure, or fit.
Guidance:	It is recommended that electroconvulsive therapy (ECT) is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with: • severe depressive illness • catatonia • a prolonged or severe manic episode
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Guidance on the use of electroconvulsive therapy.* TA59. London: NICE; 2010. Available at: http://guidance.nice.org.uk/TA59/Guidance/pdf/English [Accessed 26/10/2012].
OPCS Code:	A83.8 A83.9
Review:	Review date: Planned next review date:

25. ENDOSCOPIC LUMBAR DECOMPRESSION AND LASER DISC DECOMPRESSION

Background:	Endoscopic lumbar decompression procedures serve to remove pressure that is placed on the spinal cord and/or nerve roots in the spinal column. Laser disc decompression is a treatment for chronic back or lower extremity pain resulting from herniated 'bulging' discs that compress the spinal nerve.
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Endoscopic laser foraminoplasty*. IPG31. London: NICE; 2003. Available at: http://publications.nice.org.uk/endoscopic-laser-foraminoplasty-ipg31 [Accessed 26/10/2012]. National Institute for Health and Clinical Excellence. *Automated percutaneous mechanical lumbar discectomy*. IPG141. London: NICE; 2005. Available at: http://publications.nice.org.uk/automated-percutaneous-mechanical-lumbar-discectomy-ipg141 [Accessed 26/10/2012]. National Institute for Health and Clinical Excellence. *Percutaneous endoscopic laser lumbar discectomy. IPG300*. London: NICE; 2010. Available at: http://guidance.nice.org.uk/IPG300/Guidance/pdf/English [Accessed 26/10/2012].
OPCS Code:	V25 Y08 Y76.3
Review:	Review date: Planned next review date:

26. EYELID: BLEPHAROPLASTY

Background:	Blepharoplasty is surgical modification of the eyelid.
Guidance:	Surgery on the *upper eyelid* should NOT be used EXCEPT to correct functional impairment (not purely for cosmetic reasons), as demonstrated by: • Impairment of visual fields in the relaxed, non-compensated state. • Clinical observation of poor eyelid function, discomfort e.g. headache worsening towards the end of the day and / or evidence of chronic compensation through elevation of the brow. Surgery on the *lower eyelid* should NOT be used EXCEPT for: • correction of ectropion or entropion • for the removal of lesions of the eyelid skin or lid margin. Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented. Excessive skin in the lower lid may cause “eye bags” but does not affect function of the eyelid or vision and therefore does not need correction.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. Specialised Services Policy: *Commissioning Criteria Plastic Surgery, CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	C12.1>6 C12.8>9 C13.1>4 C13.8>9 C15.1>5 C15.8>9
Review:	Review date: Planned next review date:

27. FACE: FACE OR BROW LIFT (RHYTIDECTOMY)

Background:	These procedures will not be used for purely cosmetic reasons nor to treat the natural processes of ageing.
Guidance:	However, there are a number of specific conditions for which these procedures may form part of the treatment to restore appearance and function. Should NOT be used EXCEPT for treatment of: • Congenital facial abnormalities • Facial palsy (congenital or acquired paralysis) • As part of the treatment of specific conditions affecting the facial skin e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis • The correction of the consequences of trauma • To correct deformity following surgery
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S01.-
Review:	Review date: Planned next review date:

28. FACE: XANTHELASMA PALPEBRUM

Background:	Xanthelasma palpebrum is a sharply demarcated yellowish deposit of cholesterol underneath the skin, usually on or around the eyelids.
Guidance:	Please see WHSSC criteria for referral.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	C.13
Review:	Review date: Planned next review date:

29. FACIAL ATROPHY: NEW FILL PROCEDURES

Background:	Facial atrophy is a loss of fat from the skin. Gel polymers such as New-Fill can be injected under the skin to re-contour the depleted areas.
Guidance:	Please see WHSSC criteria for referral These are not routinely commissioned, but a case for exceptionality may be made to WHSSC.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	No code
Review:	Review date: Planned next review date:

30. FEMALE BREAST: CORRECTION OF NIPPLE INVERSION

Background:	This is surgical correction of an inverted nipple. Surgery is not normally used to improve appearance alone in nipple inversion
Guidance:	Should NOT be used EXCEPT for functional reasons in a post-pubertal woman and if the inversion has not been corrected by correct use of a non-invasive suction device. Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B35.6
Review:	Review date: Planned next review date:

31. FEMALE BREAST ENLARGEMENT

Background:	Breast implant surgery is the most common cosmetic procedure to be carried out on women in the UK.
Guidance:	Should NOT be used EXCEPT for women with an absence of breast tissue unilaterally or bilaterally, or in women with a significant degree of asymmetry of breast shape and / or volume (one cup size difference). Such situations may arise as a result of: • Previous mastectomy or excisional breast surgery • Trauma to the breast during or after development • Congenital amastia (total failure of breast development) • Endocrine abnormalities • Developmental asymmetry • Patients must have a BMI within the range of 18Kg/m^2 to 25Kg/m^2 Patients who are offered breast augmentation in the NHS should be encouraged to participate in the UK national breast implant registration system and be fully counselled regarding the risks & natural history of breast implants. Patients should be provided with a copy of the DoH guidance booklet 'Breast implants information for women considering breast implants' (See website: http://www.dh.gov.uk/en/Publicationsandstatistics/ Publications/PublicationsPolicyAndGuidance/DH_4010394) It is important that patients understand that they may not automatically be entitled to replacement of the implants in the future if they do not meet the criteria for augmentation at that time.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B30.1 B31.2
Review:	Review date: Planned next review date:

32. **FEMALE BREAST LIFT (MASTOPEXY)**

Background:	Breast ptosis is inevitable in most women due to a combination of maturity, gravity and pregnancy/lactation. Mastopexy, or a breast lift, involves the relocation of the nipple and shaping the breast. Breast uplift surgery involves removing skin from underneath the breast or from around the areola (the area of dark tissue surrounding the nipple). The skin and tissue of the breast is tightened and the nipple is moved to a higher position to give a more youthful and firm appearance. A breast enlargement or reduction procedure may be done at the same time.
Guidance:	Should NOT be used EXCEPT in severe cases (Regnault Grade III) where the nipple lies below the infra-mammary fold and below the most projecting portion of the breast in the erect position. This is included as part of the treatment of breast asymmetry and reduction (see previous) but not for purely cosmetic/aesthetic purposes such as post-lactation ptosis.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B31.3
Review:	Review date: Planned next review date:

33. FEMALE BREAST REDUCTION

Background:	Female breast reduction, also known as reduction mammoplasty, is an operation to reduce the weight and volume of the breasts.
Guidance:	Should NOT be used EXCEPT if ALL the following circumstances are met: • The patient is suffering from neck ache, backache and/or severe intertrigo • The wearing of a professionally fitted brassiere has not relieved the symptoms • The patient has a body mass index (BMI) of 25Kg/m^2 or less Only in very exceptional circumstances will girls under the age of 16 be considered for this procedure Following initial consideration of the referral by the Case Officer or equivalent, appropriate patients should ideally have an initial assessment prior to an appointment with a Consultant Plastic Surgeon to ensure that these criteria are met. (In the future consideration may be given to evaluating the benefits of having access to a trained bra fitter and introducing laser scanning of the thorax).
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B31.1 B31.4
Review:	Review date: Planned next review date:

34. **FIBROMYALGIA IN ADULTS**

Background:	Fibromyalgia syndrome (FMS) is one of a group of soft tissue pain disorders that affects muscles and soft tissues such as tendons and ligaments and is a common cause of chronic musculoskeletal pain.
Guidance:	There is no cure for FMS and treatment is aimed at alleviation of symptoms.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public Health Advice–17 Fibromyalgia in Adults*. 2006. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/a5dafac0a1e009748025763f0033accc/$FILE/Fibromyalgia%20in%20Adults(2)%2017092009.doc [Accessed 26/10/2012]
OPCS Code:	No code
Review:	Review date: Planned next review date:

35. **GANGLIA SURGICAL REMOVAL**

Background:	Ganglia are benign fluid filled, firm lumps that are rubbery in texture. 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%).
Guidance:	The evidence suggests that there is a high rate of spontaneous resolution for ganglia and that reassurance should be the first therapeutic intervention for most patients and all children.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Ganglia.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/e5592429d06b85858025763f0035e7f1/$FILE/Ganglia%20-%20STATIC%20(1)%2004092009%20(2).doc [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 38; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	T59 Excision of ganglion T59.1 Excision of ganglion of wrist T59.2 Excision of ganglion of hand NEC T59.3 Excision of ganglion of knee T59.4 Excision of ganglion of foot T59.8 Other specified T59.9 Unspecified T60 Re-excision of ganglion T60.1 Re-excision of ganglion of wrist T60.2 Re-excision of ganglion of hand NEC T60.3 Re-excision of ganglion of knee T60.4 Re-excision of ganglion of foot T60.8 Other specified T60.9 Unspecified
Review:	Review date: Planned next review date:

36. GENDER REASSIGNMENT

Background:	WHSSC is responsible for the commissioning of Gender Reassignment.
Guidance:	See WHSCC policy.
Referral:	WHSCC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: CP21. Specialised Adult Gender Identity Services.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012]. See: http://www.wales.nhs.uk/sites3/Documents/898/Specialies%20Services%20Policy%20Gender%20Services%20CP21%20Approved%20120925.pdf
OPCS Code:	X15
Review:	Review date: Planned next review date:

37. **HAEMORRHOIDECTOMY**

<table>
<tr><td>Background:</td><td>Haemorrhoids, also known as piles, are enlarged and swollen blood vessels in or around the lower rectum and anus.

They can occur at any age and affect both sexes

Some of the procedures described above may be carried out in the operating theatre with general, regional or local anaesthetic, whilst others, such as rubber band ligation may be carried out in a clinic setting. This might result in procedures being coded as outpatient rather than day case or inpatient procedures so they would not be included in this analysis.

Haemorrhoids may recur so there is the possibility of repeat procedures being carried out.</td></tr>
<tr><td>Guidance:</td><td>Haemorrhoidectomy should NOT be used EXCEPT in cases of:

• recurrent haemorrhoids
• persistent bleeding
• failed conservative treatment

First and second degree haemorrhoids are classically treated with some form of non-surgical ablative/fixative intervention, third degree are treated with rubber band ligation or haemorrhoidectomy and fourth degree with haemorrhoidectomy [1,2,3].</td></tr>
<tr><td>Referral:</td><td>Health Board</td></tr>
<tr><td>Links to information sources:</td><td>[1] Davies RJ. Haemorrhoids. BMJ Clinical Evidence 2006

[2] National Institute for Health and Clinical Excellence. Stapled haemorrhoidopexy for the treatment of haemorrhoids. TA128. London: NICE; 2007. Available at: http://www.nice.org.uk/nicemedia/pdf/TA128guidance.pdf. [Accessed 26/10/2012]

[3] Burch J et al. Stapled haemorrhoidectomy (haemorrhoidopexy) for the treatment of haemorrhoids: a systematic review and economic evaluation. Health Technol Assess 2008; 12(8)

[4] Malhotra N, Jackson B. Save to invest. Developing criteria-based commissioning for planned health care in London. Methods and assumptions. London: London Health Observatory; 2007. Available at: http://www.lho.org.uk/Download/Public/11591/1/Save%20To%20Invest%20-%20Methods%20and%20Assumptions.pdf

Public Health Wales. Variation in Elective Surgery Procedures across Wales. Public Health Wales Observatory – page 38; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1</td></tr>
</table>

	%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	**H51 Excision of haemorrhoid** H51.1 Haemorrhoidectomy H51.2 Partial internal sphincterotomy for haemorrhoid H51.3 Stapled haemorrhoidectomy H51.8 Other specified H51.9 Unspecified **H52 Destruction of haemorrhoid** H52.1 Cryotherapy to haemorrhoid H52.2 Infrared photocoagulation of haemorrhoid H52.3 Injection of sclerosing substance into haemorrhoid H52.4 Rubber band ligation of haemorrhoid H52.8 Other specified H52.9 Unspecified The above codes include all excisional and destructive procedures on haemorrhoids, as were included in previous iterations of this work in Wales. The title of this section has been changed from haemorrhoidectomy, as this is a specific surgical operation and the codes used here are wider than this. The work carried out by the London Health Observatory [4] widens this even further and looks at anal procedures, including other procedures on the anus and perianal region.
Review:	Review date: Planned next review date:

38. HAIR DEPILATION (HIRSUTISM)

Background:	Hirsutism is excessive hair growth in women in areas of the body where only men tend to develop coarse hair, primarily on the face and neck [1]. Unwanted and excessive hair growth is a common problem and considerable amounts of time and money are spent on hair removal. It affects about 5-10% of women, and is often quoted as a cause of emotional distress. Possible underlying causes include Polycystic Ovarian Syndrome (PCOS), (a condition of unknown cause characterised by reduced fertility, ovarian cysts and increased androgen production), other rare hormone disorders and some forms of medication. Traditional treatments include shaving, waxing and plucking. Most endocrine causes of hirsutism respond to hormone suppression therapy with a contraceptive pill containing an anti-androgen or an anti-androgen alone [2]. Hirsutism also improves with weight loss [3].
Guidance:	Should NOT be used EXCEPT for patients who [4]: • Have undergone reconstructive surgery leading to abnormally located hair-bearing skin. • Have a proven underlying endocrine disturbance resulting in Hirsutism (e.g. polycystic ovarian syndrome). • Are undergoing treatment for pilonidal sinuses to reduce recurrence. • Hirsutism leading to significant psychological impairment The method of depilation (hair removal) used should be diathermy, electrolysis performed by a registered electrologist, or laser centre. Where laser services are being developed reference to the available evidence base should be made.
Referral:	Health Board
Links to information sources:	[1] Azziz R, Carmina E and Sawaya M. (2000): Idiopathic Hirsutism. The Endocrine Society, Endocrine Reviews 21 (4): 347-362 [2] Carmina, E, Anti-androgens for the treatment of hirsutism, Expert Opin Investig Drugs, 2002, 11(3):357-63 [3] Bernasconi D et al, The impact of obesity on hormonal parameters in hirsute and nonhirsute women, Metabolism, 1996, 45(1):72-5 [4] Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S60.6>7
Review:	Review date: Planned next review date:

39. HAIR TRANSPLANTATION/CORRECTION OF HAIR LOSS (ALOPECIA)/CORRECTION OF MALE PATTERN BALDNESS

Background:	Most men and women considering hair loss surgery have male-pattern or female-pattern baldness. However, surgery is sometimes suitable for a range of alopecia conditions. Surgery for hair loss should only be considered after trying less invasive treatments, such as medical treatment. These can often halt the hair loss process and sometimes help regrowth. But if that is not enough, then surgery is an option. However, surgery is not usually available on the NHS.
Guidance:	Hair transplantation should NOT be used EXCEPT in exceptional cases, such as reconstruction of the eyebrow following cancer or trauma. It should not be used, regardless of gender, for cosmetic reasons. Correction of alopecia should NOT be used EXCEPT when alopecia is a result of previous surgery or trauma, including burns. 'Male pattern' baldness is a normal process for many men at whatever age it occurs.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S33.1>3 S33.8>9 Z41.0 (ICD-10)
Review:	Review date: Planned next review date:

40. HALLUX VALGUS (BUNION) SURGERY

Background:	A bunion – hallux valgus, is a bony deformity of the joint at the base of the big toe at the metatarsophalangeal (MTP) joint.
Guidance:	Should NOT be used EXCEPT for patients who have: • Significant osteoarthritis and/ or pain, which is impairing mobility, affecting the first metatarsal phalangeal joint • Impending or actual skin compromise • Evidence of transfer metatarsalgia with mechanical changes requiring intervention e.g. claw toe Any other referral should explicitly state reasons (e.g. hallux rigidis, or specialised shoes).
Referral:	Health Board
Links to information sources:	Criteria agreed on All Wales basis – REFERENCE REQUIRED
OPCS Code:	W15* with M201. Diagnosis code W79.1 W79.2
Review:	Review date: Planned next review date:

41. HEAVY MENSTRUAL BLEEDING: DILATION AND CURETTAGE/HYSTEROSCOPY

Background:	Dilatation and curettage (D&C) is a common gynaecological operation performed for both diagnostic and therapeutic purposes that involves scraping of the inner lining (endometrium) of the uterus. Dilatation and curettage is carried out in an operating theatre in a hospital by a gynaecologist. It is usually carried out under general anaesthetic, but may be done under local anaesthesia. It does not usually require an overnight stay in hospital.
Guidance:	D&C should NOT be used as a therapeutic treatment or as a diagnostic tool for heavy menstrual bleeding so will not receive prior approval for these conditions. The risk of anesthesia, uterine perforation and cervical laceration outweighs the minimum potential benefit. Hysteroscopy should NOT be used EXCEPT when it is carried out: • As an investigation for structural and histological abnormalities where ultrasound has been used as the first line diagnostic tool and where the outcomes are inconclusive when undertaking endometrial ablation.
Referral:	Health Board
Links to information sources:	National Collaborating Centre for Women's and Children's Health. *Heavy menstrual bleeding.* London: RCOG; 2007. Available at: http://www.nice.org.uk/nicemedia/live/11002/30401/30401.pdf [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 38; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	Q10 Curettage of uterus Q10.3 Dilation of cervix uteri and curettage of uterus NEC Q10.8 Other specified Q10.9 Unspecified These codes do not include codes covering removal of products of conception from the uterus, either following miscarriage or for termination of pregnancy.
Review:	Review date: Planned next review date:

42. HEAVY MENSTRUAL BLEEDING: HYSTERECTOMY

Background:	Hysterectomy is removal of the uterus and is one of the most frequently performed female surgical procedures. Common indications include fibroids, endometriosis, uterine prolapse and cancer of uterus and cervix. Hysterectomies are major operations performed in an operating theatre in a hospital. Some common indications for elective hysterectomy are listed above, but the operation can also be carried out as an emergency procedure for obstetric haemorrhage. Hysterectomy is one of the five surgical procedures that the Department of Health monitors as indicators of excess surgical activity.
Guidance:	There is evidence that the woman fits the clinical criteria of heavy menstrual bleeding (HMB). This is defined as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms. Women offered a hysterectomy should have a full discussion of the implications of surgery and the increased risk of serious complications. Any interventions should aim to improve quality of life measures. For hysterectomy a patient must have documented evidence of heavy bleeding due to fibroids greater than 3cm and the following must apply: • Other symptoms (e.g. pressure) are present • There is evidence of severe impact on quality of life • Other pharmaceutical options have failed • Patient has been offered myomectomy and/or uterine ablation (unless medically contra-indicated) For HMB alone hysterectomy should not be the first line of treatment. In line with NICE hysterectomy for HMB should only be undertaken when there is documented evidence that there has been an unsuccessful use of a levonorgestrel intrauterine system (e.g. Mirena) unless medically contraindicated. And at least two of the following treatments have failed, are not appropriate or are contra-indicated: • Non –steroidal anti-inflammatory agents • Tranexamic acid • Injected progesterone's • Combined oral contraceptives A hysterectomy patient with HMB should meet **all** of the following criteria: • There is evidence that all other treatment options have failed, are contraindicated or have been offered and declined by the woman • There is a wish for amenorrhoea • The woman has been fully informed of all options and requests it • The woman no longer wishes to retain her uterus and fertility

	In women with HMB alone, with uterus no bigger than a 10-week pregnancy, endometrial ablation should be considered preferable to hysterectomy.
Referral:	Health Board
Links to information sources:	National Collaborating Centre for Women's and Children's Health. *Heavy menstrual bleeding.* London: RCOG; 2007. Available at: http://www.nice.org.uk/nicemedia/live/11002/30401/30401.pdf [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 43; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	Q07 Abdominal excision of uterus Q07.1 Abdominal hysterocolpectomy and excision of periuterine tissue Q07.2 Abdominal hysterectomy and excision of periuterine tissue NEC Q07.3 Abdominal hysterocolpectomy nec Q07.4 Total abdominal hysterectomy nec Q07.5 Subtotal abdominal hysterectomy Q07.6 Excision of accessory uterus Q07.8 Other specified Q07.9 Unspecified Q08 Vaginal excision of uterus Q08.1 Vaginal hysterocolpectomy and excision of periuterine tissue Q08.2 Vaginal hysterectomy and excision of periuterine tissue NEC Q08.3 Vaginal hysterocolpectomy NEC Q08.8 Other specified Q08.9 Unspecified
Review:	Review date: Planned next review date:

43. **HIP ARTHROSCOPY DEBRIDEMENT**

Background:	Hip arthroscopy is a minimally invasive technique that uses arthroscopic instruments to treat various disorders of the hip such as: removal of loose bodies (usually cartilage); debridement/repair of labral tears (the labrum is an O-ring of cartilage around the hip socket) and removal of pathologic synovium (joint lining).
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Arthroscopic femoro-acetabular surgery for hip impingement syndrome.* IPG408. London: NICE; 2011. Available at: http://www.nice.org.uk/guidance/ip/365 [Accessed 26/10/2012]
OPCS Code:	OPCS 4.6 Code(s) This procedure cannot be expressed in the OPCS-4 classification by a single code. Procedures could vary for each patient depending on the nature of the condition, and these would be coded on a case by case basis based on the specific procedures carried out.
Review:	Review date: Planned next review date:

44. HIP PROTHESIS

Background:	The replacement of a damaged hip joint with an artificial one is referred to as a prosthesis.
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	*National Institute for Health and Clinical Excellence. *Guidance on the use of metal on metal hip resurfacing arthroplasty* TA44. London: NICE; 2002. Available at: http://publications.nice.org.uk/guidance-on-the-use-of-metal-on-metal-hip-resurfacing-arthroplasty-ta44 [Accessed 26/10/2012] *National Institute for Health and Clinical Excellence. *Guidance on the Selection of Prosthesis for Primary Total Hip Replacement* TA2. London: NICE; 2003. Available at: http://publications.nice.org.uk/guidance-on-the-selection-of-prostheses-for-primary-total-hip-replacement-ta2 [Accessed 26/10/2012] Note: *Being reviewed – expected date of issue December 2013 National Institute for Health and Clinical Excellence. *Hip fracture: The Management of hip fracture in adults* CG124. London: NICE; 2011. Available at: http://publications.nice.org.uk/hip-fracture-cg124 [Accessed 26/10/2012] National Institute for Health and Clinical Excellence. *Osteoarthritis: The care and management of osteoarthritis in adults* CG59. London: NICE; 2008. Available at: http://publications.nice.org.uk/osteoarthritis-cg59 [Accessed 26/10/2012] National Institute for Health and Clinical Excellence. *Minimally invasive total hip replacement* IPG363. London: NICE; 2010. Available at: http://publications.nice.org.uk/minimally-invasive-total-hip-replacement-ipg363 [Accessed 26/10/2012]
OPCS Code:	W37 W38 W39 W93 W94 W95
Review:	Review date: Planned next review date:

45. HIP RESURFACING TECHNIQUE

Background:	Metal on metal (often referred to as MoM) hip resurfacing involves replacing the diseased or damaged surfaces in the hip joint (that is at the top of the thigh bone and inside the socket of the hip bone) with metal surfaces.
Guidance:	Can be undertaken in line with NICE guidance.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Hip disease – metal on metal hip resurfacing arthroplasty.* TA44. London: Nice; 2002. Available at: http://www.nice.org.uk/Search.do?searchText=+ta44&newsearch=true&x=15&y=12#/search/?reload [Accessed 26/10/2012].
OPCS Code:	W581
Review:	Review date: Planned next review date:

46. HYPERBARIC OXYGEN THERAPY

Background:	Hyperbaric oxygen therapy is a form of treatment which involves providing the body with extra oxygen delivered under pressure.
Guidance:	Please see WHSSC criteria for referral. WHSSC will only commission emergency HBOT. WHSSC will be notified by the hyperbaric chamber of emergency admission retrospectively and will not require prior approval. HBOT should not be used for: • Mild / Moderate Carbon Monoxide Poisoning responding to Normobaric Oxygen treatment • Osteoradionecrosis • Non-healing diabetic wounds/ulcers
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	X52.1
Review:	Review date: Planned next review date:

47. INTRATHECAL BACLOFEN THERAPY

Background:	Intrathecal baclofen therapy (IBT) is variously referred to as continuous intrathecal baclofen infusion (CIBI), intrathecal baclofen, intrathecally-administered baclofen, and intrathecal baclofen infusion and has been used as a treatment for severe spasticity since the mid 1980s.
Guidance:	In carefully selected patients with severe spasticity and disability IBT may improve patient quality of life.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Intrathecal baclofen therapy*. 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/c929dbc51b67df048025763f003a32df/$FILE/Intrathecal%20baclofen%20therapy%20(1)%2004092009.doc [Accessed 26/10/2012].
OPCS Code:	No code
Review:	Review date: Planned next review date:

48. **LABIAPLASTY**

Background:	Labiaplasty is generally a cosmetic procedure to improve appearance alone and is not routinely used. The procedure is not without risk as surgery might damage the nerve supply to the area, impairing sexual sensitivity and satisfaction.
Guidance:	Should NOT be used EXCEPT for the following conditions: • Post-trauma, • Part of reconstruction following surgery • Part of the management of congenital abnormality • An iatrogenic condition • As part of agreed surgery for gender dysphoria
Referral:	Health Board
Links to information sources:	
OPCS Code:	No code
Review:	Review date: Planned next review date:

49. **LAPAROSCOPIC UTERINE NERVE ABLATION FOR CHRONIC PELVIC PAIN**

Background:	Chronic pelvic pain is commonly described as pain felt below the umbilicus which lasts for at least 6 months.
Guidance:	The evidence on laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain suggests that is not efficacious.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain IPG234.* London: NICE; 2009. Available at: http://publications.nice.org.uk/laparoscopic-uterine-nerve-ablation-luna-for-chronic-pelvic-pain-ipg234
OPCS Code:	A79.8 Y08
Review:	Review date: Planned next review date:

50. LUMBAR LASER MICRO DISCECTOMY

Background:	Also referred to as percutaneous laser disc decompression. Lumbar laser microdiscectomy involves the use of a laser to vaporise a herniated disc or tissue that is compressing a nerve
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. Percutaneous endoscopic laser lumbar discectomy. IPG300. London: NICE; 2009. Available at: http://guidance.nice.org.uk/IPG300/Guidance/pdf/English [Accessed 26/10/2012]
OPCS Code:	V33.7 Y08
Review:	Review date: Planned next review date:

51. LASER THERAPY FOR SHORT SIGHT

Background:	Photorefractive (laser) surgery is used to treat refractive errors such as myopia, astigmatism and hyperopia. Refractive errors are usually corrected by wearing spectacles or contact lenses. Surgical treatments have been developed to improve refraction by re-shaping the cornea.
Guidance:	Should NOT be used EXCEPT if the patient has a biometry error following cataract surgery. Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious for use in appropriately selected patients. However, the safety and effectiveness of this procedure should be considered against the alternative methods of correction: spectacles and contact lenses.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Photorefractive (laser) surgery for the correction of refractive errors*. IPG 164. London: NICE; 2006. http://publications.nice.org.uk/photorefractive-laser-surgery-for-the-correction-of-refractive-errors-ipg164 [Accessed 26/10/2012]
OPCS Code:	C44 C45 C46.1
Review:	Review date: Planned next review date:

52. LIPOSUCTION

Background:	Liposuction, also known as lipoplasty ("fat modelling"), liposculpture suction lipectomy ("suction-assisted fat removal") or simply lipo is a cosmetic surgery that removes fat from many different sites on the human body. Areas affected can range from the abdomen, thighs, buttocks, neck, backs of the arms and elsewhere.
Guidance:	Please see WHSSC criteria for referral. Should NOT be used EXCEPT it is sometimes an adjunct to other surgical procedures. It should not be used simply to correct the distribution of fat. Liposuction for chronic lymphoedema should NOT be used EXCEPT with special arrangements for clinical governance, consent and audit or research. Liposuction may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies).
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf National Institute for Clinical Excellence. *Liposuction for chronic lymphoedema. IPG 251*. London: NICE; 2001. Available at: http://www.nice.org.uk/nicemedia/pdf/IPG251Guidance.pdf [Accessed 26/10/2012]
OPCS Code:	S62.1 S62.2
Review:	Review date: Planned next review date:

53. **MALE BREAST REDUCTION FOR GYNAECOMASTIA**

Background:	For men who feel self-conscious about their appearance, breast reduction surgery may be considered to flatten the breast area.
Guidance:	Should NOT be used EXCEPT if the patient is post pubertal and of normal BMI i.e. 18 - 25Kg/m^2 There should be a pathway established to ensure appropriate screening for drug related and endocrinological causes and to exclude testicular cancer through examination in Primary Care prior to consultation with a Plastic Surgeon. Liposuction may form part of the treatment plan for this condition.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	B27.5 B31.1
Review:	Review date: Planned next review date:

54. MANOMETRY IMPEDENCE STUDIES

Background:	High-resolution manometry (HRM) and impedance-pH/manometry monitoring are research tools in clinical and investigation of the oesophagus. Oesophageal manometry is a test that measures the pressure in the stomach and gullet.
Guidance:	There is no agreed criteria.
Referral:	Health Board
Links to information sources:	British Society of Gastroenterology. Guidelines for oesophageal manometry and pH monitoring. 2006. London; Available at: http://www.bsg.org.uk/clinical/general/guidelines.html [Accessed 26/10/2012].
OPCS Code:	No code
Review:	Review date: Planned next review date:

55. **MELATONIN FOR DELAYED SLEEP PHASE DISORDER**

Background:	Delayed sleep phase disorder (DSP) or syndrome (DSPS), also called phase lag syndrome, is a circadian rhythm disorder. DSP consists of a typical sleep pattern that is "delayed" by two or more hours.
Guidance:	Is not effective in treating most primary sleep disorders with short-term use.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public Health Advice–Melatonin for Delayed Sleep Phase Disorder*. 2006. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/8665a7dfb648b0e980257640004dac63/$FILE/Melatonin%20for%20Delayed%20Sleep%20Phase%20Disorder%2010092009%20(1).doc [Accessed 26/10/2012].
OPCS Code:	No code
Review:	Review date: Planned next review date:

56. MIRROR THERAPY

Background:	Mirror therapy, mirror box therapy or mirror visual therapy uses an optical illusion for the relief of phantom limb pain A mirror box uses the principle of visual feedback to alleviate limb pain. The typical approach involves placing the good limb in front of the mirror and the ineffective limb behind the mirror Looking into the mirror with the reflection is of good limb and movement of the limb appears as if the phantom limb is also moving.
Guidance:	TBA
Referral:	Health Board
Links to information sources:	TBA
OPCS Code:	No code
Review:	Review date: Planned next review date:

57. **NOSE: RHINOPLASTY**

Background:	Rhinoplasty is re-shaping of the nose.
Guidance:	Should NOT be used EXCEPT for: • Problems caused by obstruction of the nasal airway. • Objective nasal deformity due to trauma • Correction of complex congenital conditions e.g. cleft lip and palate Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	E02* E073
Review:	Review date: Planned next review date:

58. OPEN MAGNETIC RESONANCE IMAGING (MRI) SCANS

Background:	Magnetic resonance imaging is a relatively safe, non-invasive diagnostic imaging procedure. MRI scans use radio waves, a magnet, and computer software to obtain two and three-dimensional (3D) images of the inside of the body.
Guidance:	Can be undertaken when patients meet one or both of the following criteria: **Criteria 1: Claustrophobia** Patients should have discussed their concerns about claustrophobia and scanning with their General Practitioner in the first instance. The patient should then be referred to the UHB Radiology Department so that a member of staff can describe the process and show them the scanner. If their concerns cannot be alleviated by the Radiology Department and the scan cannot be undertaken at that appointment, there is an option for sedation. If clinically appropriate, the patient will be referred back to their General Practitioner for a prescription of a sedative which can be used during the scan. In most cases this is sufficient to enable a conventional MRI scan to be performed **Criteria 2: Patient Size** The size of a patient and the restriction of the conventional MRI scanner tunnel will vary depending on the patient and the circumstances. Some patients may be large but would still be suitable for a conventional closed MRI. In the first instance, the patient should be referred to the Radiology Department, talked through the procedure, shown the scanner and be formally assessed by MRI Radiographer for suitability. The Radiographer will then make a judgement on whether to proceed with the conventional MRI scan.
Referral:	Health Board
Links to information sources:	TBA
OPCS Code:	No code
Review:	Review date: Planned next review date:

59. ORTHODONTIC TREATMENT OF ESSENTIALLY COSMETIC NATURE

Background:	Orthodontics comes from the Greek words “orthos”, meaning correct or straight and “odontes”, meaning teeth. It is a specialised branch of dentistry concerned with the development and management of deviations from the normal position of the teeth, jaws and face (malocclusions). A malocclusion is not a disease but simply a marked variation from what is considered to be the normal position of teeth. Orthodontic treatment can improve both the function and appearance of the mouth and face. Appliances (braces) can be fixed or removable and are used to straighten the teeth and encourage growth and development. The main aims of orthodontic care are to produce a healthy, functional bite, creating greater resistance to disease and improving personal appearance.
Guidance:	Should NOT be used for cases categorised as 1, 2 or 3 using the Index of Orthodontic Treatment Need (IOTN) EXCEPT for those cases in group 3 where the aesthetic component (AC) has been classified as 6 or higher.
Referral:	Health Board.
Links to information sources:	British Orthodontic Society. *The Justification for Orthodontic Treatment*. London: BOS; 2008. Available at: http://www.bos.org.uk/Resources/British%20Orthodontic%20Society/Author%20Content/Justification%20for%20orthodontic%20treatment.pdf [Accessed 26/10/2012] Brook, PH and Shaw, WC (1989) *The development of an index of orthodontic treatment priority.* European Journal of Orthodontics, 1989 Aug; 11(3):3069-320
OPCS Code:	F14.1>3 F14.8 >9 F15.1>4 F15.9
Review:	Review date: Planned next review date:

60. **OTITIS MEDIA WITH EFFUSION GROMMETS**

Background:	Otitis media with effusion (OME) is a common condition of early childhood in which an accumulation of fluid within the middle ear space causes hearing impairment. The hearing loss is usually transient and self-limiting over several weeks, but may be more persistent. Grommets are small tubes that are put inside children's ears to help drain away sticky fluid that is trapped there (glue ear) to improve their hearing. Grommets are often inserted as day case procedures, although sometimes an overnight stay is needed. Grommets fall out themselves, usually after 4-12 months, and the problem usually resolves. However, sometimes a repeat procedure is required and some children need a grommet inserted several times until the glue ear heals properly. It is possible to carry out a myringotomy, incision of the tympanic membrane, without insertion of a grommet, but these are coded separately and have been excluded here.
Guidance:	NICE guidelines on the surgical management of otitis media with effusion in children [1] makes recommendations specifically on the surgical management of OME in children under the age of 12. The guidelines state that a period of observation of the hearing loss over 3 months (with accurate audiometry), and its impact on the child's development, is recommended in order to determine whether resolution occurs or if further treatment is needed Persistence of hearing loss with adverse effects on the child will require further action, which may include surgery. Children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and 4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention. In children with Down's syndrome, hearing aids should normally be offered and OME with hearing loss. In children with cleft palate: • insertion of ventilation tubes at primary closure of the cleft palate should be performed only after careful otological and audiological assessment; • insertion of ventilation tubes should be offered as an alternative to hearing aids in children with cleft palate who have OME and persistent hearing loss.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Surgical management of otitis media with effusion in children*. CG60. London: NICE; 2008. Available at: http://www.nice.org.uk/nicemedia/pdf/CG60fullguideline.pdf [Accessed

	26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 20; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	D15.1 Myringotomy with insertion of ventilation tube through tympanic membrane.
Review:	Review date: Planned next review date:

61. PERCUTANEOUS LASER REVASCULARISATION FOR REFRACTORY ANGINA

Background:	Angina pectoris is chest discomfort, often described as pressure or pain, typically occurring on exertion. It is caused by inadequate delivery of oxygen to the heart muscle, usually because of coronary artery disease. Refractory angina is a severe angina form that cannot be controlled by normal medical or surgical treatment. Angina treatment depends on symptoms, medical history and angiography findings. Treatments include anti-anginal medication and revascularisation interventions (percutaneous coronary intervention or coronary artery bypass surgery). For patients with refractory angina, these treatments have either failed or are not clinically suitable. Percutaneous laser revascularisation for refractory angina pectoris is carried out with the patient under local anaesthesia. A catheter is inserted through the femoral artery, and advanced to the heart under fluoroscopic guidance. Ischaemic areas are selected for treatment using echocardiography or myocardial perfusion scan and coronary angiography. A laser device is then used to create a number of channels in the myocardium. A number of different types of laser can be used for this procedure.
Guidance:	Current evidence on percutaneous laser revascularisation (PLR) for refractory angina pectoris shows no efficacy and suggests that the procedure may pose unacceptable safety risks. There are no agreed criteria for use without an IPFR
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Percutaneous laser revascularisation for refractory angina pectoris*. IPG302. London: NICE; 2009. Available at: http://www.nice.org.uk/nicemedia/pdf/IPG302Guidance.pdf [Accessed 26/10/2012]
OPCS Code:	K23.4 Y53.- Y08.-
Review:	Review date: Planned next review date:

62. **PHOTODYNAMIC THERAPY FOR WET AGE RELATED MACULAR DEGENERATION**

Background:	The aim of photodynamic therapy (PDT) is to destroy CNV lesions without damaging the overlying retina, thereby slowing or halting the progression of vision loss. The treatment involves the infusion of a light-sensitive agent, followed by light activation of the drug.
Guidance:	Should NOT be used EXCEPT for individuals who have a confirmed diagnosis of classic with no occult subfoveal choroidal neovascularisation (CNV) (that is, whose lesions are composed of classic CNV with no evidence of an occult component) and best-corrected visual acuity 6/60 or better. PDT is NOT recommended for the treatment of people with predominantly classic subfoveal CNV (that is, 50% or more of the entire area of the lesion is classic CNV but some occult CNV is present) associated with wet age related macular degeneration, except as part of research.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Macular degeneration (age related) photodynamic therapy*. TA68. London: NICE; 2012. Available at: http://guidance.nice.org.uk/TA68 [Accessed 26/10/2012]
OPCS Code:	C88.2
Review:	Review date: Planned next review date:

63. **REVERSAL OF STERILISATION (MALE AND FEMALE)**

Background:	The evidence suggests that reversal of sterilisation for both females and males appear to be effective methods of restoring fertility. Those seeking sterilisation should be fully advised and counselled in accordance with Royal College of Obstetricians and Gynaecologists guidelines that the procedure is intended to be permanent. However, this procedure is not generally supported. Any provider carrying out sterilisation procedures should make it clear it will not be reversed on the NHS.
Guidance:	Should NOT be used EXCEPT in the following circumstances: • If death of an existing child has occurred • Remarriage following death of spouse • Loss of unborn child when vasectomy has taken place during the pregnancy
Referral:	Health Board
Links to information sources:	Royal College of Obstetricians & Gynaecologists. *Male and female sterilisation.* Guideline. London: RCOG; 2004. Available at: http://www.rcog.org.uk/womens-health/clinical-guidance/male-and-female-sterilisation [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales.* Public Health Wales Observatory – page 35; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	N18.1 Q29.1>2 Q29.8>9 Q37 Q37.1 Q37.8>9
Review:	Review date: Planned next review date:

64. RHINOPHYMA SURGERY OR LASER TREATMENT

Background:	Thickened skin (rhinophyma) is a symptom of rosacea that often affects the nose.
Guidance:	Please see WHSSC criteria for referral. Should not be used except for severe cases or those that do not respond to medical treatment. The first line treatment of this disfiguring condition of the nasal skin is medical.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	E02 S10.3 S11.3 S60.1>4 Y06.4
Review:	Review date: Planned next review date:

65. SCLERAL EXPANSION SURGERY FOR PRESBYOPIA

Background:	Presbyopia results from age-related deterioration of the lens in the eye. This leads to difficulty with accommodation (focusing on close objects). Sclera expansion surgery involves making small incisions in the eye and inserting bands to stretch the part of the sclera (the tough fibrous layer of the eyeball) that lies beneath the muscles controlling accommodation (ciliary muscles). This is claimed to improve accommodation.
Guidance:	There are no agreed criteria for use.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Scleral expansion surgery for presbyopia*. IPG 70. London: NICE; 2011. Available at: http://guidance.nice.org.uk/IPG70 [Accessed 26/10/2012]
OPCS Code:	C55.4
Review:	Review date: Planned next review date:

66. SKIN CONDITIONS (BENIGN): OTHER

Background:	Skin conditions (benign) other refers to removal of: e.g. benign pigmented moles, milia, skin tags, molluscum contagiosum, keratoses (basal cell papillomata), sebaceous cysts, corns/callous, dermatofibromas, comedones.
Guidance:	Should NOT be removed EXCEPT one or more of the following criteria are met: • benign lesions becomes infected • interferes with physical functioning of the body • if large or located on the face or on a site where they are subjected to trauma Clinically benign skin lesions should not be removed on purely cosmetic grounds. This will include, amongst other conditions, skin tags and seborrhoeic keratoses (warts) 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. Epidermoid or pillar cysts (commonly known as “Sebaceous cysts”) are always benign but some may become infected or be symptomatic. Some may require surgical excision particularly if large, located on the face or on a site where they are subject to trauma.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S04.1>3 S04.8 S05.1>5 S05.8>9 S06.1>5 S06.8>9 S09.1>5 S09.8>9 S10.1>5 S10.8>9 S11.1>5 S11.9>9
Review:	Review date: Planned next review date:

67. **SKIN CONDITIONS (BENIGN): REMOVAL OF LIPOMATA**

Background:	A lipomata is a benign tumour composed primarily of fat cells.
Guidance:	Should NOT be used EXCEPT in the following circumstances: • The lipoma (-ta) is / are symptomatic • There is functional impairment • The lump is rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular)
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S04.1>3 S04.8 S05.1>5 S05.8>9 S06.1>5 S06.8>9 S09.1>5 S09.8>9 S10.1>5 S10.8>9 S11.1>5 S11.9>9
Review:	Review date: Planned next review date:

68. SKIN CONDITIONS (BENIGN): REMOVAL OF VIRAL WARTS (NON-GENITAL)

Background:	Warts are tumours or growths of the skin caused by infection with Human Papillomavirus (HPV). Warts are particularly common in childhood and are spread by direct contact or autoinoculation. This means if a wart is scratched, the viral particles may be spread to another area of skin. It may take as long as twelve months for the wart to first appear.
Guidance:	Painful, persistent or extensive warts (particularly in the immunosuppressed patient) may need specialist assessment, by a dermatologist. For a small proportion surgical removal (cryotherapy, cautery, laser or excision) may be appropriate. Most viral warts will clear spontaneously or following application of topical treatments.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S04.1>3 S04.8 S05.1>5 S05.8>9 S06.1>5 S06.8>9 S09.1>5 S09.8>9 S10.1>5 S10.8>9 S11.1>5 S11.9>9
Review:	Review date: Planned next review date:

69. SKIN CONDITIONS: SCAR REVISION

Background:	Scar revision is surgery to improve or reduce the appearance of scars. It also restores function, and corrects skin changes (disfigurement) caused by an injury, wound, or previous surgery.
Guidance:	Please see WHSSC criteria for referral. Should NOT be used EXCEPT for treatment of scars which interfere with function following burns or treatments for keloid or post surgical scarring.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39.* Wales: WHSCC; 2006. Available at: WHSSC Joint Committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S06.5 or S06.9 + Y06.4 S23.1>4
Review:	Review date: Planned next review date:

70. SKIN HYPO PIGMENTATION

Background:	Hypo pigmentation is the loss of skin colour. It is caused by melanocyte or melanin depletion, or a decrease in the amino acid tyrosine which is used by melanocytes to make melanin.
Guidance:	The recommended NHS suitable treatment for hypo-pigmentation is cosmetic camouflage. Access to a qualified camouflage beautician should be available on the NHS for this and other skin conditions requiring camouflage.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	L81.9 (ICD 10)
Review:	Review date: Planned next review date:

71. SKIN RESURFACING TECHNIQUES

Background:	Skin resurfacing includes a variety of techniques to change the surface texture and appearance of the skin. Common skin resurfacing techniques include chemical peels, dermabrasion, and laser resurfacing.
Guidance:	Should NOT be used EXCEPT for post-traumatic scarring (including post-surgical) OR severe acne scarring once the active disease is controlled.
Referral:	Health Board
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S60.1>2
Review:	Review date: Planned next review date:

72. SOFT PALATE IMPLANTS FOR OBSTRUCTIVE SLEEP APNOEA

Background:	Obstructive sleep apnoea (OSA) is characterised by repeated, reversible episodes of apnoea (temporary suspension of breathing) and hypopnoea (abnormally slow or shallow respiration) during sleep, loud snoring and excessive daytime sleepiness. The soft pharyngeal structures of patients with OSA collapse when the patient is asleep, causing apnoea or hypopnoea (reduction of airflow by at least 50% over 10 seconds or more). In response to an episode of apnoea or hypopnoea the patient will spontaneously move or waken, often subconsciously, to reopen the airway. The episodes of apnoea or hypopnoea can recur throughout the night. Under local anaesthesia, a hollow introducer needle containing the implant is used to pierce the soft palate close to the junction with the hard palate, into its muscle layer. The needle is then withdrawn, leaving the implant in position. Typically, two or three implants are inserted in a single procedure, at the midline of the soft palate or parallel to it. The aim of the procedure is to stiffen the soft palate over subsequent weeks as a result of fibrosis.
Guidance:	Current NICE guidance on soft-palate implants for obstructive sleep apnoea (OSA) raises no major safety concerns, but there is inadequate evidence that the procedure is efficacious in the treatment of this potentially serious condition for which other treatments exist.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. Soft-palate implants for obstructive sleep apnoea. IPG241. London: NICE; 2007. Available at: http://www.nice.org.uk/nicemedia/pdf/IPG241Guidance.pdf [Accessed 26/10/2012]
OPCS Code:	F32.8
Review:	Review date: Planned next review date:

73. SUBTHALAMOTOMY FOR PARKINSON'S DISEASE

Background:	This procedure is used to treat Parkinson's Disease.
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. Subthalamotomy for Parkinson's Disease. IPG65. London: NICE; 2004. Available at: http://publications.nice.org.uk/subthalamotomy-for-parkinsons-disease-ipg65 [Accessed 26/10/2012].
OPCS Code:	A10.8 Other specified other operations on tissue of brain Y11.4 Radiofrequency controlled thermal destruction of organ NOC In addition the ICD-10 code G20.X Parkinson's disease would be recorded.
Review:	Review date: Planned next review date:

74. **TATTOO REMOVAL**

Background:	Tattoo removal has been performed with various tools during the history of tattooing. While tattoos were once considered permanent, it is now possible to remove them with treatments, fully or partially.
Guidance:	Please see WHSSC criteria for referral. Should NOT be used EXCEPT in the following circumstances: • The tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo") • The patient was not Gillick competent, and therefore did not have capacity for their actions at the time of the tattooing • Exceptions may be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided, given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial function).
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	S09.2
Review:	Review date: Planned next review date:

75. **THERAPEUTIC USE OF ULTRASOUND IN HIP AND KNEE OSTEOARTHRITIS**

Background:	Therapeutic ultrasound is commonly being used in the management of soft tissue lesions including rheumatic complaints
Guidance:	The evidence suggests that the therapeutic use of ultrasound in hip and knee osteoarthritis provides no benefits beyond placebo, ultrasound or other electrotherapy agents in the treatment of hip and knee osteoarthritis.
Referral:	Health Board
Links to information sources:	National Public Health Service for Wales. *Public health evidence-based summary. Therapeutic use of ultrasound in hip and knee osteoarthritis*. 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/5351baeeabd26cbe802576400054710f/$FILE/Therapeutic%20use%20of%20ultrasound%20in%20Hip%20and%20Knee%20osteoarthritis%2010092009%20(1).doc [Accessed 26/10/2012]
OPCS Code:	U13.2 Y53.2 Z84.3 Z84.6
Review:	Review date: Planned next review date:

76. **TONSILLECTOMY: ADULT AND CHILD**

Background:	Tonsillectomy is one of the most frequently performed surgical procedures in the UK. Tonsillectomies are only carried out in hospitals, usually as day surgery. Once tonsils have been removed they do not grow back, however if remnants of tonsillar tissue are left these may cause persistent problems and need to be removed as a further surgical procedure.
Guidance:	Should NOT be used in *children or adults* EXCEPT if they meet ALL of the following criteria prior to referral: • Sore throats are due to acute tonsillitis • Episodes of sore throat are disabling and prevent normal functioning • Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year OR • Five or more such episodes in each of the preceding two years OR • Three or more such episodes in each of the preceding three years When in doubt as to whether tonsillectomy would be beneficial, a six-month period of watchful waiting is recommended prior to tonsillectomy to establish firmly the patterns of symptoms and allow the patient to consider fully the implications of the operation.
Referral:	Health Board
Links to information sources:	Scottish Intercollegiate Guidelines Network. *Management of sore throat and indications for tonsillectomy: a national clinical guideline*. Scotland: SIGN; 2010. Available at: http://www.sign.ac.uk/guidelines/fulltext/117/index.html [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 15; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	F34.1>5 F34.7>9
Review:	Review date: Planned next review date:

77. TRANSMYOCARDIAL LASER REVASCULARISATION FOR REFRACTORY ANGINA PECTORIS

Background:	Angina pectoris is chest discomfort, often described as pressure or pain, typically occurring on exertion.
Guidance:	Current evidence on transmyocardial laser revascularisation (TMLR) for refractory angina pectoris shows no efficacy, based on objective measurements of myocardial function and survival. Current evidence on safety suggests that the procedure may pose unacceptable risks.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Transmyocardial laser revascularisation for refractory angina pectoris.* IPG 301. London: NICE; 2009. Available at: http://www.nice.org.uk/nicemedia/pdf/IPG301FullGuidance.pdf [Accessed 26/10/2012].
OPCS Code:	K23.4 Y08
Review:	Review date: Planned next review date:

78. **TREATMENT FOR ERECTILE DYSFUNCTION**

Background:	Erectile dysfunction may affect 30-50% of men aged 40-70 years, with age, smoking and obesity being the main risk factors, although 20% of cases have psychological causes [1].
Guidance:	Should NOT be used EXCEPT in the following circumstances: • assessment by specialist ED providers for men with ED referred by GPs • treatment (drug or mechanical device) for ED in line with WHC (1999) 06 i.e. for men suffering from ED who fall into the eligible groups for NHS prescriptions from GPs • treatment (drug or mechanical device) by specialist ED providers for men categorised as suffering with ED and severe distress who do not fall into 1(b). An IPFR is required for all other circumstances
Referral:	Health Board
Links to information sources:	[1] Tharyan P; Gopalkrishanan G. Erectile dysfunction. *BMJ Clinical Evidence.* 2006 National Public Health Service for Wales. *Public health evidence-based summary. Treatment for Erectile Dysfunction.* 2009. Available at: http://www2.nphs.wales.nhs.uk:8080/healthserviceqdtdocs.nsf/61c1e930f9121fd080256f2a004937ed/017d00d9af005a068025763f003e244e/$FILE/Treatment%20for20erectile%20dysfunction(2)%2018092009.doc [Accessed 26/10/2012]
OPCS Code:	N29.1
Review:	Review date: Planned next review date:

79. **TREATMENT FOR SLEEP APNOEA**

Background:	Sleep apnoea causes interrupted breathing during sleep it is often referred to as obstructive sleep apnoea (OSA). There are two types of breathing interruption characteristic of OSA: • apnoea - the muscles and soft tissues in the throat relax and collapse sufficiently to cause a total blockage of the airway; it is called an apnoea when the airflow is blocked for 10 seconds or more • hypopnoea - a partial blockage of the airway that results in an airflow reduction of greater than 50% for 10 seconds or more Continuous positive airway pressure (CPAP) may assist in moderate to severe cases of sleep apnoea, this involves using breathing apparatus to assist with breathing while sleeping.
Guidance:	Can be undertaken in line with NICE guidance. An IPFR is required for all other circumstances.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Continuous positive airway pressure for the treatment of obstructive sleep apnoea/hypopnoea syndrome* TA139. London: NICE; 2008. Available at: http://publications.nice.org.uk/continuous-positive-airway-pressure-for-the-treatment-of-obstructive-sleep-apnoeahypopnoea-ta139 [Accessed 26/10/2012]
OPCS Code:	
Review:	Review date: Planned next review date:

80. **VARICOSE VEINS**

Background:	Varicose veins are dilated superficial veins in the leg caused by incompetent venous valves. Evidence from recent population surveys indicates very little relationship between symptoms and varicose veins – substantial numbers of patients without varicose veins have similar symptoms. The most common complaint about varicose veins is their appearance. Most varicose veins require no treatment. When bleeding or ulceration occurs referral may be appropriate and of that number some may benefit from surgical intervention. Surgery or sclerotherapy can improve symptoms in the short term rather than long term. Sclerotherapy is less effective than surgery at improving symptoms and cosmetic appearance. After surgery 20-30% of patients develop recurrent varicose veins within 10 years. Varicose vein surgery is carried out in an operating theatre in a hospital. Repeat procedures may be indicated.
Guidance:	For asymptomatic and mild/moderate cases, specialist treatment should NOT be used EXCEPT in the following circumstances: • Ulcers/ history of ulcers secondary to superficial venous disease • liposclerosis • varicose eczema • history of phlebitis
Referral:	Health Board
Links to information sources:	National Institute for Clinical Excellence. *A guide to appropriate referral from general to specialist services.* London: NICE; 2001. Available at: http://www.nice.org.uk/media/94D/BE/Referraladvice.pdf [Accessed 26/10/2012] National Institute for Clinical Excellence. *Radiofrequency ablation of varicose veins (IPG8).* London: NICE; 2003. Available at: Available at: http://publications.nice.org.uk/radiofrequency-ablation-of-varicose-veins-ipg8 [Accessed 26/10/2012] National Institute for Clinical Excellence. *Transilluminated powered phlebotomy for varicose veins (IPG37).* London: NICE; 2004. Available at: http://publications.nice.org.uk/transilluminated-powered-phlebectomy-for-varicose-veins-ipg37 [Accessed 26/10/2012] National Institute for Clinical Excellence. *Ultrasound-guided foam sclerotherapy for varicose veins (IPG314).* London: NICE; 2009. Available at: http://publications.nice.org.uk/ultrasound-guided-foam-sclerotherapy-for-

<table>
<tr><td></td><td>varicose-veins-ipg314 [Accessed 26/10/2012]

National Institute for Clinical Excellence. Endovenous laser treatment for the long saphenous vein (IPG 52). London: NICE; 2004. Available at: http://publications.nice.org.uk/endovenous-laser-treatment-of-the-long-saphenous-vein-ipg52 [Accessed 26/10/2012]

Public Health Wales. Variation in Elective Surgery Procedures across Wales. Public Health Wales Observatory – page 25; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]</td></tr>
<tr><td>OPCS Code:</td><td>L84 Combined operations on varicose veins of leg
L84.1 Combined operations on primary long saphenous vein
L84.2 Combined operations on primary short saphenous vein
L84.3 Combined operations on primary long and short saphenous vein
L84.4 Combined operations on recurrent long saphenous vein
L84.5 Combined operations on recurrent short saphenous vein
L84.6 Combined operations on recurrent long and short saphenous vein
L84.8 Other specified
L84.9 Unspecified

L85 Ligation of varicose vein of leg
L85.1 Ligation of long saphenous vein
L85.2 Ligation of short saphenous vein
L85.3 Ligation of recurrent varicose vein of leg
L85.8 Other specified
L85.9 Unspecified

L86 Injection into varicose vein of leg
L86.1 Injection of sclerosing substance into varicose vein of leg NEC
L86.2 Ultrasound guided foam sclerotherapy for varicose vein of leg
L86.8 Other specified
L86.9 Unspecified

L87 Other operation of varicose vein of leg
L87.1 Stripping of long saphenous vein
L87.2 Stripping of short saphenous vein
L87.3 Stripping of varicose vein of leg NEC
L87.4 Avulsion of varicose vein of leg
L87.5 Local excision of varicose vein of leg
L87.6 Incision of varicose vein of leg
L87.7 Trans-illuminated powered phlebectomy of varicose vein of leg
L87.8 Other specified
L87.9 Unspecified

L88 Transluminal operations on varicose vein of leg
L88.1 Percutaneous transluminal laser ablation of long saphenous vein
L88.2 Radiofrequency ablation of varicose vein of leg
L88.3 Percutaneous transluminal laser ablation of varicose vein of leg NEC</td></tr>
</table>

	L88.8 Other specified L88.9 Unspecified
Review:	Review date: Planned next review date:

81. **VASCULAR SKIN LESIONS**

Background:	Vascular conditions affect the veins and arteries, which are blood vessels that carry blood to and away from the heart. When the small blood vessels underneath the skin are damaged or develop abnormally, they can cause lesions, bumps and discoloration of the skin. Vascular skin problems can develop any time from shortly after birth to late in life.
Guidance:	Please see WHSSC criteria for referral.
Referral:	WHSSC
Links to information sources:	Welsh Health Specialised Services Committee. *Specialised Services Policy: Commissioning Criteria Plastic Surgery. CP39*. Wales: WHSCC; 2006. Available at: WHSSC Joint committee Policy [Accessed 26/10/2012] http://www.wales.nhs.uk/sites3/Documents/898/CP39%20Plastics%20Policy.pdf
OPCS Code:	199 (ICD 10)
Review:	Review date: Planned next review date:

82. WISDOM TEETH

Background:	Removal of wisdom teeth is usually done as a day case under local anaesthesia, although general anaesthesia is also sometimes indicated and patients may have a short inpatient stay. There is no indication for repeat procedures on the same tooth as it is being removed. However it is possible for a patient to have the procedure on more than one of their wisdom teeth. Wisdom teeth are the third molars (upper and lower jaws) and erupt usually between the ages of eighteen and twenty four years. The four wisdom teeth may erupt normally into correct dental alignment and function, or conversely may develop in non or minimally functional positions. Impaction occurs when there is prevention of complete eruption due to lack of space, obstruction or development in an abnormal position. Impaction may be associated with pathological changes including pericoronitis, an increased risk of caries and periodontal disease in adjacent teeth, and orthodontic problems in later life.
Guidance:	Should not been done except where there is evidence of pathology. NICE guidance states that impacted wisdom teeth that are free from disease should not be operated on. The practice f prophylactic removal of pathology-free impacted third molars should be discontinued on the NHS.
Referral:	Health Board
Links to information sources:	National Institute for Health and Clinical Excellence. *Guidance on extraction of wisdom teeth*. TA1. London: NICE; 2000. Available at: http://publications.nice.org.uk/guidance-on-the-extraction-of-wisdom-teeth-ta1 [Accessed 26/10/2012] Public Health Wales. *Variation in Elective Surgery Procedures across Wales*. Public Health Wales Observatory – page 48; 2010. Available at: http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/2ece58ea6212e8d3802577ea003cf6fe/$FILE/Variation%20in%20elective%20procedures%20across%20Wales%20v1%2026112010.doc [Accessed 26/10/2012]
OPCS Code:	F09.1 Surgical removal of impacted wisdom tooth F09.3 Surgical removal of wisdom tooth NEC
Review:	Review date: Planned next review date:

7. RESPONSIBILITIES

The Hywel Dda University Health Board Policy on Interventions Not Normally Undertaken has already been circulated by the Medical Director to all Primary and Secondary Care Clinical Staff in a draft format. The Policy has also been shared with the Hywel Dda University Health Board CIP Sub-Committee and with the Hywel Dda University Health Board Commissioning Group. Presentations are currently progressing to each of the County Management Teams with meetings currently being arranged with clinical staff to ensure the appropriate implementation of the policy supported by a robust monitoring system within the information department.

8. TRAINING

The Policy on Interventions Not Normally Undertaken identifies interventions which are considered to be low priority and not normally undertaken by the Health Board. Many of these procedures are currently performed by clinical staff as in the last financial year over 3,500 procedures included in the policy were undertaken. It is a priority that the clinical staff are familiar with the current evidence of best practice to ensure that procedures that are currently deemed to have limited clinical value are not undertaken on a routine basis. It will however be important to note that blanket bans for the interventions do not exist and the process for assessing individual requests for the interventions can be found in the policy for Individual Patient Funding Request for Treatment.

9. IMPLEMENTATION

Action	By Whom	By When
Presentation of INNU Policy at CIP	Dr Michael Thomas	September 2013
Presentation of INNU Policy at Commissioning Group	Dr Sian Lewis	September 2013
Circulation of INNU Policy to Primary and Secondary Care Medical Staff	Dr Sue Fish	September/October 2013
INNU Policy to County Management Team	County Directors/ Consultants in Public Health	October/November 2013
INNU Policy to Clinical Policy Review Group	Dr Michael Thomas	November 2013
Meeting with Clinical Departments to Discuss INNU Policy and Monitoring	Dr Sian Lewis, Dr Michael Thomas and Teams	November/December 2013
Monitoring of INNU Policy	Mr Anthony Tracey, Dr Sian Lewis and Dr Michael Thomas	Quarterly

10. FURTHER INFORMATION

The Hywel Dda University Health Board Policy on Interventions Not Normally Undertaken considers the best available evidence and includes information published by the National Institute for Health and Care Excellence and also draws on guidance in the form of National Service Frameworks and information from peer reviewed journals of high scientific quality. The current best available evidence is also provided alongside information on the procedures.

11. CLINICAL POLICIES

All the current evidence of best practise is included within the Hywel Dda University Health Board Policy on Interventions Not Normally Undertaken.

12. REVIEW

This policy will be reviewed after one year, or sooner, as required.