NHS REVIEW WORKING PAPER (3)

PRACTICE BUDGETS FOR GENERAL MEDICAL PRACTITIONERS

Foreword

This paper is number 3 in a series of eight working papers following the Review of the NHS. Other papers are:

1. Self-governing Hospitals
2. Funding and Contracts for Hospital Services
4. Indicative Prescribing Budgets for General Medical Practitioners
5. Capital Charges
6. Medical Audit
7. NHS Consultants: Appointments, Contracts and Distinction Awards
8. Implications for Family Practitioner Committees

These papers describe in greater detail how particular proposals in the White Paper "Working for Patients" (Cm 555) will be implemented, and will form the basis of further discussion with interested parties. Many of the White Paper proposals will depend on primary legislation. The Government intends to complete discussions on any such matters by May 1989 to enable preparation of the necessary legislation.

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Summary

This paper deals with the following aspects:

SECTION 1 (paragraphs 1.1-1.2)	Introduction
SECTION 2 (paragraphs 2.1-2.2)	Eligibility for participation
SECTION 3 (paragraphs 3.1-3.11)	Scope of budgets
SECTION 4 (paragraphs 4.1-4.16)	Setting of budgets
SECTION 5 (paragraphs 5.1-5.4)	Income, Expenditure and Audit Arrangements
SECTION 6 (paragraphs 6.1-6.3)	Quality of Care and the Purchase of Services
SECTION 7 (paragraphs 7.1-7.5)	Information requirements
SECTION 8 (paragraphs 8.1)	Implementation

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PRACTICE BUDGETS FOR GENERAL MEDICAL PRACTITIONERS

SECTION 1: INTRODUCTION

1.1 "Working For Patients" announced the Government's proposal to offer larger GP practices the opportunity to manage a budget out of which they will be responsible for securing a defined range of hospital and primary care services on behalf of their patients. This paper sets out the Government's proposals for establishing and operating the GP practice budget scheme.

1.2 The Government believes that practice budgets offer GPs an opportunity to improve the quality of services on offer to patients, to stimulate hospitals to be more responsive to the needs of GPs and their patients and to develop their own practices for the benefit of their patients. It will also enable the practices which take part to play a more important role in the way in which NHS money is used to provide services for their patients. The scheme will be structured to ensure that GPs have no financial incentives to refuse to treat any categories of patients or accept them onto their lists. Budgets will be set at a level which will reflect the relative need for services by patients registered with the practice. The elderly will attract a higher contribution to the practice's budget than younger age groups. In exceptional cases, adjustments will be made in respect of individual patients who require more costly treatment. There will be an upper limit on the cost to the budget of hospital treatment for a particular patient in any one year.

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SECTION 2: ELIGIBILITY

2.1 It will be up to practices themselves to consider whether to propose themselves as potential candidates. Practices which have joined the scheme will be free to leave it again if they wish, subject to giving the RHA sufficient notice to allow health authorities to make suitable arrangements for the continuing funding and provision of hospital services to, patients registered with the practice. There will be no question of cessation of, or disruption to, patient services from practices when joining or leaving the scheme. No financial penalties will fall on GPs or practices which leave the scheme. Application to participate in the Practice Budget scheme will be made to, and approved by, the RHA. Where RHAs do not agree any application, practices will be able to appeal to the Secretary of State for Health.

2.2 The first participating practices will be able to satisfy the following criteria:

(i) Their registered list will be at least 11,000 patients (approximately twice the average practice list size). Smaller practices will be able to group together if they wish to do so in order to opt for GP practice budgets.

This will ensure that practice budgets are large enough to provide the flexibility GPs need to meet the needs of their patients. The Government will consider relaxing the 11,000 patient minimum if experience shows that budgets for practices of this size are more than large enough to allow the necessary flexibility.

(ii) The ability to manage budgets; for example, adequate administrative support and IT and information systems.

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SECTION 3: SCOPE OF BUDGET

3.1 Only a proportion of the services currently used by GP practices will fall within the scope of the scheme. The White Paper proposes that budgets will meet the cost of the following services:

(a) Hospital services

(i) A defined group of surgical in-patient and day case treatment covering most elective procedures. Emergency admissions and medical admissions are excluded;

(ii) Out-patient services;

(iii) Diagnostic investigation of patients and specimens;

(b) Practice Services and prescribing

(i) The proportion of approved practice team staff costs which at the outset are currently directly reimbursed, together with a pro-rata proportion of the additional cash allocated to the FPC in future for these purposes.

(ii) Certain directly reimbursed practice accommodation costs; together with a pro-rata proportion of the additional cash allocated to the FPC in future for these purposes.

(iii) Drugs prescribed and dispensed.

The following paragraphs set out in more detail the Government's proposals. The Government will discuss further with the medical profession and managers the range of hospital services and treatments falling within the scope of budgets.

Hospital services

In-patient and Day Case Procedures

3.2 Budgets will cover the costs of the more common in-patient/day case procedures for which there is often a choice over time and place of treatment. The Annex to this paper lists the more common waiting list operations and surgical diagnostic procedures. The Department will discuss further with interested parties the composition of the list of treatments. The aim will be to agree a list which can be regarded as definitive and which will not give rise to misunderstandings and disputes. Should any such disputes nevertheless arise, Regions will be expected to adjudicate.

3.3 Once a patient is referred, decisions over the treatment of the patient are for the hospital consultant, who may take clinical responsibility for the patient. The GP will need to be aware in advance of the consequences for the budget of referral to hospital for diagnosis and treatment.

3.4 In many cases, when the GP refers a patient to hospital, he will be confident of diagnosis, the likely subsequent treatment, and whether this is likely to be a call upon his practice budget. Treatments which are a charge to the budget will generally be 'elective' and GPs will indicate to the hospital their requirement concerning the timing of treatment. The cost per patient will normally be fixed in advance and will reflect the hospital's assessment of the likelihood of

complications in some cases, and their cost, in relation to any particular treatment. The hospital bears the cost (or reaps the benefit) if the outcome differs from this assessment.

Out-patient Services

3.5 For out-patient services, budgets will cover the costs of:

- attendances for diagnosis; including
- diagnostic tests and investigations ordered by the hospital consultant (see paragraph 3.7);
- direct access to diagnostic investigations including standard pathological tests, radiology and electro-cardiography;
- attendances for treatment; including
- direct access to treatments such as physiotherapy;
- continuing out-patient treatment;
- out-patient attendances following in-patient and day case surgery within the scope of budgets.

3.6 The Department will discuss with the medical profession whether budgets should be set at a level which includes the costs of diagnostic investigations associated with health prevention and screening or whether they should be excluded from the scope of the scheme and charged to the patient's DHA. As new diagnostic procedures are introduced, the Government will consider on the basis of professional advice, whether the range of investigations covered by practice budgets should be widened.

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3.7 Where referrals are for initial diagnostic investigation the contracts negotiated between the practice and the hospital(s) might specify a fixed charge in advance. These could be on a cost per case or cost per attendance basis (differentiated by diagnostic group or category) or else fixed in terms of an annual fee irrespective of the number of referrals. The cost of diagnostic tests likely to be ordered by the consultant (or his deputy) will be reflected in the charges negotiated: should the consultant request more (or fewer) tests than is reflected in the charge, the cost (or benefit) will fall to the hospital, not the practice budget. Section 6 refers briefly to the arrangements for purchasing services.

3.8 It is proposed that the costs of treatment in an A and E Department will not fall as a charge against the budget but borne by the hospital and reflected in contracts with the hospital's "parent" DHA. Authorities will be expected to monitor attendances to ensure that A and E referral is not used as a substitute for out-patient referral. (Working Paper 2 on Funding and Contracts for Hospital Services describes the Government's proposals for the funding of A and E.)

3.9 There will be rare cases in which the cost of necessary hospital treatment falling within the scope of the scheme would be exceptionally high or represent an unpredictable call on the GP's budget either due to a succession of one-off treatments or continuing care. Such cases should not be allowed to distort hospital referral practices and budgetary concerns cannot be allowed to affect good patient care. The Government therefore proposes that costs for any individual within a year in excess of, say, £5000 will be charged to the patient's DHA's budget. The practice would be responsible for initiating this process once the limit is reached.

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Practice services and prescribing

3.10 GPs are currently directly reimbursed in respect of the following expenses: 70 per cent of approved staff costs; and payments under the "Cost Rent Scheme" and improvement grants. Under powers in the Health and Medicines Act 1988, these expenditures will be cash limited from April 1990 and the Government is currently discussing with the profession how the new cash limiting arrangements will operate. This expenditure will come within the scope of GP practice budgets. GPs in participating practices will continue to receive a contribution towards staff costs and other expenses indirectly via fees and allowances. This avoids introducing separate remuneration systems for participating practices, and the generality of practices outside the scheme.

3.11 The White Paper (Chapter 7) sets out the Government's proposals to allocate budgets to FPCs in respect of drugs prescribed by GPs and dispensed. FPCs will then set indicative budgets for each practice in discussion with the GPs themselves. Where a practice participates in the Practice Budget Scheme, the element within it for drugs will be an actual allocation rather than an indicative one. Where a practice dispenses drugs to patients, the budget will exclude remuneration in respect of dispensing activity which will continue to be paid separately along with other fees and allowances.

SECTION 4: SETTING OF BUDGETS

4.1 Regions will have responsibility for allocations: to DHAs in respect of hospital and community services, to FPCs for expenditure on drugs and other primary care services; and to GP practice budgets. This will ensure that the allocation of funds to DHAs, FPCs and GPs are based on consistent principles and that no problem arises when patients registered with a practice are drawn from more than one District.

4.2 GP practices within the scheme will receive their budgets direct from the relevant RHA. Where patients are drawn from more than one Region, the Region within which the practice is located will take lead responsibility, negotiating an appropriate financial contribution from the other(s). The FPC will continue to hold the GPs' contracts and be responsible for monitoring expenditure against the budget. The Government expects FPCs to work closely with RHAs in agreeing budgets with participating practices. The Government recognises that GPs may need to look to other disciplines for skills associated with managing and controlling budgets. Accordingly, each practice's budget would include a fee set at a level which recognises the management and other costs associated with participation. The Government will discuss with the profession the size of the fee.

4.3 It is the Government's intention to move towards a weighted capitation approach to setting budgets in line with that proposed for RHAs and DHAs. Initially, however, budget setting will need to have regard to the different expenditure components contributing to the total budget. In addition, the overriding principle that budgets must sensitively reflect at the practice level the requirements of patients, for hospital and primary care services, of necessity points towards more

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detailed assessments than might be justified at DHA or RHA level. Once the practice budget scheme is bedded down, however, a simpler approach is anticipated.

Hospital services

4.4 Budgets must reflect the relative needs of patients for specific hospital services. The NHS Management Executive will discuss with the profession the factors, other than size of list, that need to be taken into account when agreeing the budget component in respect of hospital and community health services and the relative weights to be attached to them.

4.5 The hospital services component of the practice budget will be determined by comparison of the costs of the relevant services provided as a result of the practice's referral pattern in the previous year with the average for the District(s) taking account of the number, age, sex and health of the practice's patients. The actual budget will be set at a point between the two taking account of local and social factors. Budgets will not, however, underwrite high referral rates for which there is no demonstrable cause. Both Regions and GP practices will have access to the available information on the costs and use of services by practices.

Directly reimbursed expenses

4.6 Budgets will be based initially on the existing amounts the practice receives as directly reimbursed expenses in respect of practice staff and premises (cost-rent and improvement grants - paragraph 3.9), together with a pro-rata addition out of the additional cash allocated to the FPC in future for these purposes.

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4.7 GPs currently receive direct payments for the cost of rent and rates. Where the GP is an owner occupier he would receive 'notional' rent based on the District Valuers' assessment of current market rents. GPs may also receive payments under the cost-rent scheme and improvement grants where they improve premises, including building new ones. These payments would be in place of notional rents. Over time, payments under the cost-rent scheme decline in real terms and become lower than notional rent. At this point, GPs may opt to receive notional rent instead of cost-rent. When a participating practice whose budget was initially based on cost-rent payment opts for notional rent, budgets will be reduced to reflect the cessation of cost-rent payments. Notional rent will become payable separately by the FPC, as now.

Drugs

4.8 Working Paper 4 outlines the Government's proposals on indicative prescribing drug budgets for the generality of practices. It is proposed that indicative budgets be based on the Net Ingredient Cost (NIC) of prescriptions (basic list price). For GPs participating in the Practice Budget Scheme, the prescribing costs element of their global budgets will be found from within the overall drug budgets for RHAs. The drug component of practice budgets allocated by Regions will be in accordance with the principles outlined for indicative budgets.

4.9 FPCs will continue to be responsible for reimbursing pharmacists in respect of drugs dispensed. FPCs will need to invoice participating practices in respect of drugs prescribed by the practice and dispensed by retail pharmacists. Where the practice dispenses drugs for some patients, the costs of drugs will fall as a direct charge against the practice budget. When agreeing budgets, RHAs will need to take account of the average

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discounts received by dispensing doctors on the price of drugs purchased. Dispensing practice also incur VAT in respect of the cost of drugs dispensed and which is included in the costs currently reimbursed by FPCs to dispensing doctors. The drug component of practice budgets will need, therefore, also to include an allowance for VAT where appropriate.

Budgetary flexibility

4.10 Within the total budget agreed, participating practices will be completely free to shift expenditure within the year between the individual components. Practices participating in the scheme will be well placed to generate savings within their budgets. The Government intends that they should be able to spend any such savings on improving their practices as they judge best and offering more and better services to their patients.

Control of expenditure

4.11 Practices will be expected to stay within the agreed budget. Practices will be permitted to overspend in any one year by up to 5 per cent of budget, but on the basis that a corresponding reduction is made in the budget for the following year. Where overspend is due to the changed circumstances of the practice, the practice may ask for a budgetary review (see paragraph 4.13). Regions will need to hold a contingency reserve to meet any overspends. Regions, or Districts will be required to keep reserves to cover the costs of an individual's hospital treatment in excess of, say, £5000 (see paragraph 3.11).

4.12 If a practice overspends in excess of 5 per cent, or persistently overspends at a lower level, the FPC will initiate a thorough audit, including a review by other doctors of any

medical judgements which seem to be causing budgetary problems. An overspend in excess of 5 per cent for two years in succession may result in a practice losing the right to hold its own budget. Withdrawal would be subject to the right of appeal to the Secretary of State for Health.

Budgetary review

4.13 Practice requirements are not static. Budgets will therefore be reviewed periodically. This is an important safeguard particularly during the early stages of the scheme whilst Regions gain experience of setting budgets and the quality of information, upon which budgets are based, improves. Regions and practices will each be able to ask for a review. It is the intention that all budgets should be reviewed at least once every three years. When reviewing the budgets, Regions will continue to have regard to the principles outlined in paragraphs 4.4-4.9 above. Reviews will need to take into account the extent to which expenditure on one component has declined in order to support increased expenditure on another. Such virement within the budget will result from practice decisions over the most effective mix of services to meet patient needs and must be reflected in any revised assessment. Between reviews, annual budgets will be uprated in line with relevant DHA and FPC allocations. Within year, budgets would be varied pro-rata to reflect significant changes in list size.

Emergency treatment/Temporary residents

4.14 As now, there will be occasions when GPs will need to provide treatment to patients who are not registered with them. Such treatment often leads to drugs being prescribed and dispensed. Under the prescribing budgets proposals, Regional FPC and indicative budgets will take into account prescribing

for temporary residents and emergency treatment (Working Paper 4). The drugs element of total budgets under the GP practice budget scheme will reflect the same principles (paragraph 4.9). Participating practices will be required, therefore, to meet the prescribing costs of temporary residents from within their budget.

4.15 If the patient has to be referred to hospital for further treatment, the costs associated with the referral will not fall as a charge upon the practice's budget. The 'temporary' GP will need to make this clear to the hospital who will recover the cost of providing hospital treatment to temporary residents from the patient's DHA as described in Working Paper 2.

Topping-up

4.16 The existing distinction between NHS and private patients will be maintained under the practice budget scheme. Where GPs refer patients for non-NHS treatment, no payments will fall to the practice budget. While GP practice budget holders will be able to refer NHS patients to private hospitals for NHS treatment, patients seeking NHS treatment will not be permitted to top-up the practice budget in order to secure treatment. The full cost of relevant NHS treatments must be met out of the GP practice budget. Under the current terms and conditions of service, GPs are not permitted to receive payment from NHS patients in respect of NHS treatment provided. The Government will discuss with the profession and FPCs the necessary amendments to existing terms of service to make topping-up a breach of their terms of service.

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SECTION 5: INCOME, EXPENDITURE AND AUDIT ARRANGEMENTS

Income and expenditure

5.1 GPs currently receive quarterly cash payments from FPCs. Generally speaking GPs receive advance payment in respect of allowances and payment in arrears of fees and directly reimbursed expenses. Under the Practice Budget Scheme, participating practices will incur expenditure, some of which is currently incurred by health authorities. Practices will be required to pay hospitals in respect of services purchased on behalf of their patients. Participating practices will in addition incur expenditure in relation to drugs prescribed and dispensed and, as now, practice team staff and accommodation cost:.

5.2 In line with their responsibility for setting budgets, Regions will allocate cash to practices in respect of such expenditures. In allocating cash to practices the Region has to balance the requirement not to allocate cash in advance of need with the desire to provide practices with the necessary flexibility within budgets to meet expenditures as they fall due; and to permit ease of virement between the different components of the budget. All participating practices will be required to operate separate bank accounts in respect of income and expenditure associated with the operation of practice budgets. Where commercial bank accounts are used, the Region will make monthly payments in advance into the account. Where additional sums are required the practice will be permitted to draw additional funds from its budget facility, in line with practice for health authorities. Similar arrangements to those operating for health authorities, whereby authorities are

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penalised for holding excessive cash balances, will need to operate. Such arrangements are necessary in order to ensure that money does not flow from the Exchequer too far in advance of requirements.

Audit arrangements

5.3 The practice budget scheme will be subject to statutory audit by the Audit Commission, who will in future be responsible for the statutory external audit of health authorities and other NHS bodies. Participating practices will need to prepare accounts in a form to be prescribed by the Government. The scheme may also be the subject of value for money studies by the Audit Commission and the National Audit Office. The Government and the Audit Commission will be considering the detailed arrangements required and the Government will take the necessary legal powers.

Practice budgets and indirectly reimbursed expenses

5.4 GPs in participating practices will continue to receive, as now, an indirect contribution to their other practice expenses, mainly via the payment of fees and allowances (see paragraph 3.10). The level of expenses is based on a sample of practice accounts submitted for tax purposes to the Inland Revenue. Where participating practices vire money within the budget to improve practice facilities (including practice teams, premises and equipment), the cost of such improvements should not be included in the practice accounts as a business expense. Accounts for participating practices will need to be certified accordingly by the practice's accountants.

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SECTION 6: QUALITY OF CARE AND THE PURCHASE OF SERVICES

6.1 The Government believes that practice budgets offer GPs an opportunity to improve quality and standards of care provided to individual patients. Participating practices will be able to decide for themselves how to make the most effective use of their funds to enhance the services for patients. In 'Promoting Better Health', the Government outlined its proposals for improving the flow of practice information to patients, making it easier to change doctors and increasing the proportion of remuneration delivered via capitation payments. The Government believes that these changes will give patients more choice and that GPs will have a stronger incentive to improve services to their patients. The proposals to develop medical audit in general practice should provide an assurance that standards are being maintained, both generally and in participating practices. Further details are provided in Working Paper 6 on Medical Audit.

6.2 Practices participating in the scheme will not be expected to be selective over who may be registered with them. As outlined in section 4, budgets will be set rationally and fairly to ensure that doctors have no reason to refuse patients for financial reasons. As the practice list increases so, pro rata, will the budget (paragraph 4.13). The Government does not believe that doctors will seek to remove patients from their lists on budgetary grounds nor be slow to accept patients.

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6.3 GPs with their own budgets will purchase services from hospitals under contract in a similar way to health authorities. GPs will be free to purchase services from DHA managed hospitals, self-governing hospitals or the private sector. Working Paper 2 describes how these arrangements will work. The range of hospital services purchased by GPs will be narrower than for health authorities, but the basic forms of contractual arrangement will be similar; for example, the use of block contracts for securing access to services. Under a block contract the practice pays the hospital(s) an annual fee, in instalments, in return for access to a defined range of services rather than pay for each referral. It will be necessary for practices participating in the scheme to have contractual arrangements in place prior to becoming budget holders to ensure continuity of care.

SECTION 7: INFORMATION REQUIREMENTS

Hospital services

7.1 Before the level of budget can be agreed both the practice and the RHA will need information on current rates of usage of hospital facilities (laboratory and X-ray usage, attendances at out-patient clinics and in-patient admissions by condition and treatment). Similar information will be required during the year for monitoring of expenditure against budget. The progressive implementation of the Korner information systems will provide a sound basis on which to move forward. Some health authorities are already supplying GPs with some information of this type. Other systems are under development, for example on referral rates in East Anglia.

7.2 Hospitals will need to be able to attach costs to individual treatments and procedures so as to build up profiles of patient costs to inform decisions on the pricing of

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services. This information is required more generally to permit contract funding of services. The Resource Management Initiative has allowed some hospitals to develop data systems of this sort and the lessons learned will be more generally applied.

7.3 The increasingly rapid introduction of high quality micro-computers into general practice is being accompanied by the development of national "core specifications" of data requirements. To these will be added financial systems to enable budget holders to monitor expenditure against budget.

7.4 The Government will discuss with interested parties the information systems and data capture required to facilitate the introduction of GP budgets and will consider the need for additional developmental support. The Government envisages developments on information systems for budget holders to be consistent with, and run in tandem with, developments on introducing indicative prescribing budgets and the provision by hospitals of a wider range of information for GPs - for instance on waiting lists and times.

Prescribing costs

7.5 The FPC will need to invoice practices in respect of the cost of drugs dispensed (paragraph 4.9). The Government will discuss further with FPCs and the PPA the changes required to the present notifications to enable them to be used as a basis for invoicing participating practices.

SECTION 8: IMPLEMENTATION

8.1 The NHS Management Executive will arrange discussion with those most closely involved in the implementation of these proposals, in particular:

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- list of treatments falling within the scope of budgets (paragraph 3.2-3.6);

- size of the management fee included within budgets (paragraph 4.2);

- factors and their relative weight to be taken into account in estimating the hospital services component of practice budgets (paragraphs 4.4 and 4.5);

- development of information systems to support budget setting and monitoring and audit of expenditure (paragraphs 4.20, 5.3, 7.4 and 7.5).

In addition, discussions will be held on other working papers which will impact on the implementation of these proposals; for example, on the funding and contracting of services (paragraph 6.3) and indicative prescribing budgets (paragraph 4.8).

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ANNEX

COMMON DIAGNOSTIC AND TREATMENT PROCEDURES

OPHTHALMOLOGY

Operations on muscles of the eyeball for strabismus (squint)

eg tenotomy or myotomy of oblique muscle
tenotomy or myotomy of superior or inferior recti

Operations on eye lens

eg discission of cataract and capsulotomy
extra capsular extraction of cataract and insertion of intra-ocular aphakia implant

EAR NOSE AND THROAT

Myringotomy and tympanostomy

Operations on nasal septum

eg electrocautery of nasal septum
submucous resection of septum
closure of perforation
implant prosthetic material

Other operations on nose

eg turbinectomy
polypectomy

Operations on accessory air sinuses

eg puncture of maxillary antrum
operative drainage of maxillary antrum

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Operations on tonsils and adenoids

eg tonsillectomy
adenoidectomy
tonsillectomy with adenoidectomy

ORAL SURGERY

Operations on teeth, gums, jaws, palate and salivary glands

eg drainage of abscess
resection of salivary gland
removal of salivary calculus

ABDOMEN/GASTROINTESTINAL

Endoscopy (oesophagoscopy, gastroscopy and Sigmoidoscopy)

Herniorraphy (simple inguinal or femoral or epigastric hernia)

Operations on haemorrhoids

eg ligature of haemorrhoids
haemorrhoidectomy

Operations on the gall bladder

eg cholecystectomy

GENITO URINARY

Procedures on the urinary bladder

eg cystoscopy and biopsy of bladder
cystoscopy with destruction of lesion of bladder

Orchidopexy

Operations on prostate

eg supra-pubic prostatectomy
transurethral prostatectomy

Operations on penis

eg circumcision
preputiotomy

GYNAECOLOGY

Operations on uterus

eg vaginal hysterectomy
total abdominal hysterectomy
dilatation of cervix and curettage of uterus

Colporrhaphy with repair of pelvic floor

ORTHOPAEDIC

Investigations and operations on joints and related structures

eg total hip replacement
meniscectomy
arthroscopy
ostectomy for hallux valgus
ganglionectomy
bursectomy
excision palmar fascia in Dupuytrens contracture
decompression of carpal tunnel

VASCULAR/CARDIOTHORACIC

Bronchoscopy

Operations on heart and intra-thoracic vessels
eg insertion of pacemaker
heart valve replacement
coronary artery bypass graft

Operations on veins
eg operation on varicose veins

DERMATOLOGY/PLASTIC SURGERY

Operations on skin and subcutaneous tissue
eg excision of skin growth