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NHS Crawley CCG

NHS Horsham and Mid Sussex CCG

LIST OF Clinical Policies

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EQUALITY Statement

As statutory bodies the CCGs are required to make clear and transparent decisions about the availability of medicines and treatments. The NHS Constitution makes clear that patients have '*the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.'*

The policies within this document have been formulated through a clear process and are based on evidence of clinical effectiveness and value for money. The intention is to have equitably applied clinically based policies which are transparent and are not influenced by the protected characteristics of the patient.

In addition the CCG Code of Conduct positively promotes standards of behaviour by stating that 'Individuals must not do anything, in carrying out their CCG activities, to breach their equality duties' and that CCG members behaviours should evidence 'Promoting equality and diversity in the treatment of staff, patients, their families and carers, and the community, and in the design and delivery of services for which they are responsible'.

If you have identified a potential discriminatory impact of this procedural document, please contact the Governance Office, NHS Crawley CCG or NHS Horsham and Mid Sussex CCG.

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
5	27-01-15	AH	Agreed	Updated from CPMAP
6	26-05-15	AH	Agreed	Updated from CPMAP
7	4/11/15	AH		Change to IFR contact details.
8	27-10-15	AH		Updated from CPMAP
9	24-11-15	AH		Updated from CPMAP meeting
10	27 1 16	AH		Updated from CPMAP and CSU review of Clinical Policies
11	27.4.16	AH	Agreed	Updated from CPMAP meeting
12	26.6.16	AH		Updated from CPMAP. Public version not updated as only dates of review have been changed which are excluded from the public version.
13	27.7.16	AH	agreed	Updated from CPMAP meeting
14	28.9.16	AH	Agreed	Updated from CPMAP meeting
15	29.11.16	AH	Agreed	Updated from CPMAP meeting. This version submitted for use in acute contract documentation.
16	3.2.17	AH	Agreed	Addition of laparoscopic cholecystectomy
17	10.3.17	AH	Agreed	Revision to tonsillectomy and addition of bariatric surgery (and revision).
18	29.3.17	AH	AGREED	Addition of back pain and sciatica guidance – amendment of acupuncture.
19	3.5.17	AH	Agreed	Revisions of Female genital prolapse policy
20	27.7.17	AH	Agreed	Addition of Haemorrhoid policy. Minor changes to FGP
21	29.8.17	AH	Agreed	Revision of female sterilisation, Breast reduction, revision augmentation, trigger finger. Change to IFR contacts.
22	26.9.17	AH	Agreed	Updated policies in line with clinically effective commissioning for: Blepharoplasty, Chalazion, dilatation and curettage, circumcision, hallux valgus, Rhinoplasty/septoplasty, tonsillectomy.

CONTENTS

Treatments not routinely funded and Treatments with restrictions or thresholds

Trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria.

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

The rationale for tightening restrictions on procedures is as follows:

- To allow funding to be concentrated on treatments which result in the most health gain and hence make the best use of limited resources for our population
- To offer better treatment access to patients with a high clinical priority by reducing referrals/admissions to the waiting lists.

In seeking to make appropriate use of limited resources the CCG has taken into account the following factors:-
a) The extent to which the problem in question is an illness, disease, injury or impairment.
b) Whether the proposed treatment represents the appropriate clinical strategy to address the problem.
c) Whether the service to address the problem can and should be subject to NHS funding.
d) The evidence of clinical and cost effectiveness of the treatments.
e) To ensure as far as possible that policies are in keeping with other government guidelines e.g DVLA
f) Considering policies made locally, regionally and nationally to reduce differences between commissioners where possible

NHS Crawley CCG and NHS Horsham and Mid Sussex CCG have considered evidence of clinical effectiveness and experience, information on current activity, resources, costs and provision across the South East Coast in order to formulate the following policies.

There is no blanket ban on these procedures. There is an established mechanism for dealing with individual funding requests (IFR)/exceptions where it is felt that a possible exception to the policy criteria may exist so as to require a panel assessment of the individual case brought forward as an exception . The application form for clinicians wishing to request funding for individuals that are eligible against the definitions of **a "rarity request"** or an **"exceptionality request"** as set out in the NHS Crawley CCG/NHS Horsham and Mid Sussex CCG Policy and Operating Procedures for dealing with Individual Funding Requests (IFRs). The IFR application can be found on the CCG's website.

Shared Decision Making
In line with the standard 2017/18 acute NHS contract the CCG's Clinical Policies confirm the expectation that all patients considering clinical procedures should have Shared Decision Making conversations to discuss their individual chance of benefit or harm and to identify their personal preference.

A**ll clinicians** recommending treatment to patients are expected to follow the recommendations from 'Choosing Wisely' that are applicable to their Royal College/representative body[1].

All Choosing Wisely recommendations are designed to support a conversation between patients and their doctor or nurse. Every patient is unique and so a tailored conversation about what is right for that patient must take place.

Background:
During October 2016 The Academy of Medical Royal Colleges, which represents all medical royal colleges in the UK, launched a 'Choosing Wisely' programme and published a list of procedures with little evidence for clinical effectiveness[2].

'Choosing Wisely 'supports the evidence for Shared Decision Making in the form of 'Choosing Wisely' conversations between clinicians and patients[3]. These conversations will cover risks and benefits of procedures, supporting doctors and patients to make a decision that a minor potential benefit may not outweigh potential harm and that doing nothing might be the favourable option. The five questions are:

1. Do I really need this test, treatment or procedure?
2. What are the risks or downsides?
3. What are the possible side effects?
4. Are there simpler, safer options?
5. What will happen if I do nothing?

[1] Royal College of Anaesthetists, Royal College of General Practitioners, Royal College of Obstetricians & Gynaecologists, Royal College of Ophthalmologists, Royal College of Paediatrics & Child Health, Royal College of Pathologists, Royal College of Psychiatrists, Royal College of Radiologists, Faculty of Intensive care Medicine, Faculty of Sexual & Reproductive Health
[2] **http://www.choosingwisely.co.uk/i-am-a-clinician/recommendations/**
[3] **http://www.choosingwisely.co.uk/i-am-a-clinician/shared-decision-making/**

NOTES On the Tables

OPCS codes - Please note that the OPCS codes are included for CCG's use only. They are included so they can be used as part of a series of data challenges and the inclusion or exclusion of specific codes does not directly relate to whether that particular procedure is excluded or not.

Advice / Prior Approvals
If patients do not meet the criteria to have the procedure or they want to undergo a procedure/treatment which is not normally commissioned their clinicians can apply for an Individual Funding Request if they consider their case exceptional or rare

Where it is indicated that prior approval is required, subject to the patient meeting the indicated criteria, application will be by consultant letter to the clinical triage panel. This should be sent to the usual IFR email address Email: **ifr.southeast@nhs.net**Where GPs are unsure whether patients meet the criteria, prior to referral, they can seek advice from the clinical triage panel, which can be contacted by the same address as IFR as above.

IFR
Where patients are outside the thresholds and it is not a prior approval request, an IFR request should be submitted by the relevant clinician.
Contacts details and detailed processes can be found on the CCGs' Website.

Brief details are
Email: ifr.southeast@nhs.net Tel: 01732 375256

Online Funding Application Site: **https://www.blueteq-secure.co.uk/trust**
For clinicians registering to make an application or seeking technical help from Blueteq there is a dedicated email address: **trust@blueteq.co.uk**

The NPC Handbook makes clear, commissioners and Provider Trusts will need to work with clinicians to ensure that only IFRs which can meet the criteria of 'exceptionality' or 'rarity' are submitted to the IFR process. Submissions to the IFR process by NHS Trusts should have been screened by the Provider Trust's own systems before being passed to SECSU.

SECSU IFR service is likely to receive a number of submissions that are not appropriate for consideration by IFR Panels in accordance with national guidance. SECSU IFR services will ensure that inappropriate requests are signposted to the most appropriate route and advise the CCGs accordingly.

Timely and efficient processing of submissions by the IFR Team will play an essential role in helping clinicians locate the appropriate route for requests for individual level funding.

This document contains some medical and technical terms which patients may wish to discuss with their doctor to understand how policies may apply in their individual circumstances.

TRIAGE
Funding requests are assessed against criteria/pathways by the Triage Group to consider appropriateness for IFR Panel consideration.
Triage outcomes have no right of appeal, but new information will be re-triaged.

Review of Policies
Clinical policies should be reviewed at least every three years or earlier if new guidance or clinical evidence justifies an earlier review.

Notes on these tables. A ‘Y’ in the prior approvals column indicates that clinicians should always submit a request for clinical triage.

Procedure/Treatment	TNRF Guidance Notes	OPCS Code(s)	Prior approval	Status
1. Alternative Therapies				
Acupuncture	**This procedure is not routinely funded by the CCG but may be available in some cases as part of a defined package of care.** See also back pain and sciatica in MSK section.	A705, A706, Y331		
Aromatherapy	**This procedure not routinely funded by the CCG. It is only available occasionally in hospices and hospitals as part of palliative care packages.**	No code		
Chinese medicines	**This treatment is not routinely funded.**	No code		
Chiropractic therapy	**This treatment is not routinely funded but may be available in some cases as part of a defined package of care**	No code		
Clinical ecology	**These procedures are not routinely funded.**	No code		
Herbal remedies	**This treatment is not routinely funded. There is little evidence that herbal remedies are effective.**	No code		
Homoeopathy	**This treatment is not routinely funded. There is no strong evidence that homeopathy is clinically effective.**	No code		
Hydrotherapy, unless part of an established care package	**This treatment is not routinely funded.**	No code		
Hypnotherapy	**This procedure is not routinely funded.**	No code		
Massage	**This treatment is not routinely funded. (It is only available as part of commissioned palliative care packages)**	X613		
Osteopathy	**This treatment is not routinely funded but may be available in some cases as part of a defined package of care.**	No code		
Reflexology	**This procedure is not routinely funded.**	No code		

2. Cosmetic/plastic surgery				
Body contouring procedures				
Apronectomy/Abdominoplasty	**This procedure is not routinely funded.**			
Removal of excess skin following weight loss *See also Excision of redundant skin below*	**This procedure is not routinely funded,** in line with CPMAP PR2016-07 Bariatric Surgeons, GPs and other clinicians supporting patients in losing weight should document discussions with patients regarding the possibility of being left with excess skin after profound weight loss, and inform patients that surgery to remove excess skin is not routinely available on the NHS. Where appropriate, this should be part of the consent process.	S021, S022		
Body contouring	**This procedure is not routinely funded.**	S038, S039		
Brachioplasty / Upper arm lift	**This procedure is not routinely funded.**	S033		
Buttock lift	**This procedure is not routinely funded.**	S031		
Calf implants	**This procedure is not routinely funded.**	No code		
Excision of redundant skin or fat	**This procedure is not routinely funded.**	No code		
Liposuction	The CCG will **not routinely fund cosmetic liposuction.**	S61, S622		
Neck lift	**This procedure is not routinely funded.**	S011		
Plastic operations on umbilicus	**This procedure is not routinely funded.**	T296		
Refashioning of scar	**This procedure is not routinely funded.**	S604		
Submental lipectomy	**This procedure is not routinely funded**	S013		
Thigh lift	**This procedure is not routinely funded.**	S032		
Upper arm reduction	**This procedure is not routinely funded.**	Same code as Brachioplasty/ upper arm lift		

Breast Surgery for				
Breast augmentation	**Breast augmentation is not routinely funded for any patient group.** This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer.	B312, B314, B301, B302, B303, B304, B308, B309, B291, B292, B293, B294, B295		
Revision of Breast augmentation (see also breast implant removal)	*Revision of breast augmentation is not routinely funded for any patient group.* *Replacement of breast implants is not routinely funded within the local NHS for any patient group, this includes following removal of breast implants where it is considered clinically necessary and available on the local NHS.*		Y	
Breast Implant Removal (see also revision of breast augmentation)	*The CCG will consider a funding application for the removal of breast implant(s) where it is clinically indicated but will not routinely fund replacement implants.* *The above statement applies to both patients who underwent their original breast augmentation privately and those who received it on the NHS.* *These recommendations do not apply to the following:* *• Patients undergoing breast reconstruction as part of treatment for breast cancer.* *• Patients with PIP implants for whom national guidance applies* *This does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer or gender reassignment surgery. Sex reassignment surgery services commissioned by NHS England offer surgical procedures (which may include breast augmentation and/or breast removal) as part of the gender dysphoria treatment pathway.* *Where implants have been fitted in the private sector it is not an NHS responsibility and /or priority to remove and replace implants. The NHS is not responsible for follow up cosmetic breast surgery*		Y	

	following an earlier privately funded augmentation. *Patients are required to refer to their breast implant provider for removal*			
Reduction Mammoplasty Breast reduction	Funding for this procedure requires prior approval. A funding application for breast reduction will be considered an option for patients who fulfil all of the following criteria: • Documented on-going physical symptoms of back, neck and/or shoulder pain due to large breasts (plus documented evidence for treatment of pain). • Requires more than 500g tissue to be removed from each breast (to be assessed by the surgeon) • BMI<26kg/m2 • Non-smoker • Breast development is complete (documented for at least 18 months) This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer. Trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria.	B311, B318, B319,	Y	
Mastopexy	**Mastopexy is not routinely funded for any patient group.** This recommendation does not apply to patients undergoing breast reconstruction as part if treatment for breast cancer.	B313		
Correction of inverted nipple Nipple Eversion	**Nipple eversion is not routinely funded for any patient group.** This recommendation does not apply to patients undergoing breast reconstruction as part of treatment for breast cancer.	B356		
Correction of Gynaecomastia	**Correction of gynaecomastia is not routinely funded for any patient group.**	Same code as Breast Reduction		
Facial Procedures				
Blepharoplasty	The CCG will consider funding if there is evidence of impairment of visual fields in the relaxed, non-compensated state. All applications should be submitted with copies of both taped and non-taped in the form of either the 120 point Humphrey screening	C131,C132, C133, C134, C138, C139, C151, C152, C154, C155,	Y	

	test results or Superior 36 screening test. This procedure will not be funded for cosmetic reasons. Please note the CCG supports the correction of ectropion and entropion where clinically indicated. Facial Reconstruction and treatment of cancers is out of scope of this policy.	C181, C182, C183, C184, C185, C186, C188, C189		
Face lift	**This procedure is not routinely funded.**	S012,		
Brow lift	**This procedure is not routinely funded.**	S014, S015,S016		
Correction of brow ptosis	**This procedure will not be funded for cosmetic reasons**. Funding for this procedure requires prior approval. The CCG will fund if there is evidence of impairment of visual fields in the relaxed, non-compensated state due to brow ptosis. All applications should be submitted with a copy of the 120 point Humphrey screening test results. Applications should be made to clinical triage through the same process as IFR. **Trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria.**	As above	Y	
Skin and Subcutaneous Procedures				
Hair transplant / Hair graft/ Hair replacement/ Intralace hair system for abnormal hair loss	**Procedures for this are not routinely funded.** In certain circumstances, people may be eligible for free or reduced cost wigs on the NHS. More information on buying wigs and NHS policy is available **here**	S211, S212, S218, S219, S331, S332, S333, S338, S339		
Irregularities of aesthetic significance	**Procedures for this are not routinely funded.**	No code		
Repair of chronic tear of lobe of external ear	**This procedure is not routinely funded.**	D062		
Repair of chronic clefts due to avulsion of body piercing	**This procedure is not routinely funded.**	No code		
Skin grafts for scars	This procedure is not routinely funded except in the following circumstances: • For burns, or	No code		

	• As part of reconstruction following major trauma			
Tattoo removal (see dermatology)				

3. Dental

All dental referrals are triaged through the Dental Referral Management Service. Referrals which have not been through the Dental Referral Management Service will not be funded.

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

Dental Implants		This service is commissioned and applications are managed by NHS England Area Dental Team.
Orthodontics (Grade 3.5 and below on the Index of Orthodontic Treatment Need)		This service is commissioned and applications are managed by NHS England Area Dental Team.
Orthognathic surgery		This service is commissioned and applications are managed by NHS England Area Dental Team.
Impacted third molars		This service is commissioned and applications are managed by NHS England Area Dental Team.
Dental extraction of non-impacted teeth		This service is commissioned and applications are managed by NHS England Area Dental Team.

4. Dermatology

Removal of benign skin lesions See also: Chalazia – Ophthalmology Viral Warts Laser therapy xanthelasma	Curettage or Cryotherapy of lesion of skin is **not routinely funded** (unless undertaken in primary care as part of PMS/GMS contract). *Where malignancy is suspected, the patient should be referred to an appropriate service. Clinically benign lesions should not be removed for cosmetic reasons and such procedures will not be funded. Referral to secondary care should only be made where primary or community services are inappropriate or unavailable.* *1. Removal of benign skin lesions is available as a treatment option for patients where the lesion is associated with any one of the following:* *a. Recurrent infection, discharge or bleeding;* *b. Pain;* *c. Obstruction of an orifice to the extent that function is or is likely to become impaired;* *d. Pressure symptoms, e.g. on an organ, nerve or tissue.* ***Or** where the lesion if left untreated, would require a more invasive intervention for removal.* *All clinicians must be prepared to justify the criteria applicable for the treatment of any benign skin lesions. Any treatment of skin lesions outside of the criterion will not be funded by the CCG.* ***New HPSU/CPMAP Policy reference in due course***	S088,S089, S082, S111, S112 **E094, S051, S052, S053, S054, S055, S058, S059, S061, S062, S063, S064, S065, S068 S069, S081, S083, S091, S092, S093, S094, S095, S098, S099, S101, S102, S103, S104, S105, S108, S109, S111, S112, S113, S114, S115, S118, S119,Y088, H482, S028, S029, S031, S032, S033, S038, S039,**		
Chemical peels	**This procedure is not routinely funded.**	S103, S113		
Dermabrasion of skin	**This procedure is not routinely funded.**	S601, S602		
Electrolysis	**This procedure is not routinely funded** with the exception of	S104, S114, S606		

	the treatment of in-growing eyelashes which is routinely funded.			
Hirsutism procedures	Hair removal procedures for hirsutism are **not routinely funded**.	No code		
Hyperhidrosis Treatments	Procedures for hyperhidrosis are not routinely funded	S041, S042, S043,		
Laser therapy / Laser treatment/Tunable dye laser for aesthetic reasons	These procedures are not routinely funded. Commissioning responsibility for skin conditions requiring laser therapy is with NHS England under some circumstances (http://www.england.nhs.uk/wp-content/uploads/2013/06/a12-spec-dermatology.pdf). Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net	No code		
Tattooing of the skin	**This procedure is not routinely funded.**	S603		
Tattoo removal	**This procedure is not routinely funded.**			
Viral warts procedures and verrucae procedures	Viral warts are usually of aesthetic significance only and surgical removal and / or laser treatment is not routinely funded by the CCG. The CCG will fund removal of viral warts in patients who are immunocompromised. There are no restrictions on treatment of genital or anal warts.			

5. Ear Nose and Throat				
Adenoidectomy	(see section on grommets).	**E201, E208, E209**		
Bone anchored hearing aid - unilateral	This service is commissioned and applications are managed by NHS England Area Team.	**D131, D132, D133, D134, D135, D136, D138, D139,**		
Bone anchored hearing aids - bilateral	This service is commissioned and applications are managed by NHS England Area Team.	As above		
Cochlear implants	This service is commissioned and applications are managed by NHS England Area Team.			
Grommets and Adenoidectomy	*Grommets for Children* *Grommets will not be routinely funded except for children who will benefit from surgical intervention as outlined below. Children with another second disability eg: cleft palate or downs syndrome should be assessed by services with expertise in treating these children in accordance with NICE guidance.* ***Eligibility criteria*** *Children with persistent bilateral Otitis media with effusions (OME) documented over a period of 3 months with a hearing in the better ear of 25 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.* *Exceptionally, healthcare professionals should consider surgical intervention is children with persistent bilateral OME with a hearing loss of less than 25 dBHL where the impact of hearing loss on a child's development, social or educational status is judged to be significant.* *Grommets for adults* Funding for this procedure requires prior approval' *Grommets will be funded for adults who fulfil the criteria below. However an application for funding must be submitted to the CCG for approval to ensure the criteria are met* ***Eligibility criteria*** 1. *A middle ear effusion causing measured conductive hearing loss, persisting for at least 6 months and resistant to*	D151	Y	

	medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician; or *2. Persistent Eustachian tube dysfunction resulting in pain (eg: flying); or* *3. As one possible treatment for Meniere's disease or* *4. Severe retraction of the tympanic membrane if the clinician feels this may be reversible and reversing it may avoid erosion of the ossicular chain or the development of cholesteatoma.* 5.			

Pinnaplasty/Otoplasty	**This procedure is not routinely funded.**	D033		
Procedures to correct Rhinophyma	Surgical procedures / treatments for this condition are not routinely funded. However, some commissioning responsibility under some circumstances is with **NHS England**. Queries around treatment availability and eligibility, as well as referrals and applications for funding should be made centrally through the NHS England email: england.contactus@nhs.net	E094, E096		
Rhinoplasty for cosmetic reasons	**This procedure is not routinely funded.**	E026		
Rhinoplasty/Septo-Rhinoplasty	These procedures are not routinely funded. The CCG will only fund these procedures for the following conditions: a) Correction of nasal deformity causing nasal blockage. OR b) Correction of nasal deformity associated with recognised facial congenital disorders, unless this is the commissioning responsibility of NHS England*. These procedures should not be carried out for cosmetic reasons. **Policy Exclusions** Rhinoplasty / Septo-Rhinoplasty to address the effects of facial trauma as part of the initial care pathway for that trauma are excluded from this policy. Rhinoplasty / Septo-Rhinoplasty as part of the pathway of care for relevant cancers are excluded from this policy	**E023, E024, E025, E027, E031, E032, E034, E036, E037, E07**		
Tonsillectomy	Tonsillectomy with or without adenoidectomy will be routinely funded according to the following criteria: Malignancy: Suspicion or evidence of malignancy. Patients should be referred and treated as appropriate, OR Tonsillitis: ≥7 well documented and diagnosed, clinically significant, adequately treated episodes of acute tonsillitis in the preceding year	**F341, F342, F343, F344, F345, F346, F347, F348, F349, F361, F368, F369**		

	Or ≥5 such episodes in each of the preceding two years OR ≥3 such episodes in each of the preceding three years. Episodes must be disabling and prevent normal functioning. (two or more weeks absence from work/ school/ college/ duties as a carer.) OR Peritonsillar abscesses (PTA): ≥2 episodes resulting in hospital stay, OR Obstructive sleep disordered breathing in people aged under 16 demonstrated by accepted method of diagnosis including sleep study, which impacts on development, behaviour and quality of life, OR Other: People with specific clinical conditions that require tonsillectomy as part of their on-going management strategy (e.g. psoriasis, nephritis, periodic fever aphthous pharyngitis and cervical adenopathy [PFAPA] syndrome). Shared decision making tools should be used in discussions between patients and their healthcare professionals about management options before referral to surgery and in Acute care before deciding to have surgery			

6. Gynaecology				
Dilatation and curettage	The CCG will fund Dilatation and Curettage for HMB if the following criteria, in accordance with NICE criteria, are met: • As an investigation for structural and histological abnormalities where ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive. • Where dilatation is required for non-hysteroscopic ablative procedures, hysteroscopy should be used immediately prior to the procedure to ensure correct placement of the device. • The patient has had outpatient negative pressure endometrial sampling (e.g. Pipelle TM sampling) with an unsatisfactory result: or • The patient has had a hysteroscopy and endometrial biopsy with an unsatisfactory histological result • Transvaginal ultrasound has demonstrated focal pathology and facilities for a hysteroscopy with targeted biopsy are unavailable The Commissioning Organisation will not commission D&C for therapeutic intervention for HMB. The Commissioning Organisation will not commission D&C as a diagnostic tool for HMB in isolation.	**Q103, Q108, Q109**		
Female genital prolapse (surgical management of) (see also recurrence or failure below)	Asymptomatic patients should not be referred to secondary care. Surgery is not routinely funded for asymptomatic patients or those with mild symptoms. Referral for specialist assessment may only be considered for: • Prolapse combined with urethral sphincter incompetence or faecal incontinence (referral to a specialist urogynaecologist should be considered), OR • Failure of pessary* AND moderate to severe symptoms (women with symptoms that only relate to the prolapse can be referred to a general gynaecologist). Reassurance and self-help information such as weight loss, avoidance of constipation and managing persistent coughing (stopping smoking will help), which may help improve the prolapse or reduce the risk of it getting worse, should be provided**. Patients should be counselled on all the treatment options available (pelvic floor muscle training, pessary and surgery**), including the risks and benefits. ** Pessary has failed or is not clinically appropriate or has been declined after documented discussion with clinician. Pessaries may not always be available in primary care; in such*	**P221, P222, P223, P228, P229, P231, P232, P233, P234, P235, P236, P237, P238, P239**		

	cases patients can be referred for specialist assessment and pessaries reconsidered. ** A simple guide for patients to the pros and cons of different treatments for FGP is available on **NHS choices**.			

Recurrent Female genital prolapse	NHS England commissions the investigation and management of women whose primary surgery for pelvic organ prolapse has failed or who have recurrence of the condition			
Female sterilisation	*Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Long Acting Reversible Contraception (LARC) and found it unsuitable.* *The CCG will fund this procedure :* *- Where sterilisation is to take place at the time of another procedure such as caesarean section.* *OR* *- Where there is a clinical contraindication to the use of a LARC.* *OR* *- Where there are severe side effects with the use of LARC.* *OR* *- Where there is an absolute clinical contraindication to pregnancy. These include:-* *- young women (under 45 years of age) undergoing endometrial ablation for heavy periods.* *- women with severe diabetes.* *- women with severe heart disease.* *AND* *Women should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancies and that there is less risk related to the procedure.* *Prior to referral and performance of the surgery the required consenting and counselling process as per RCOG guidelines must be followed. (Faculty of Sexual & Reproductive Healthcare. Service Standards on Obtaining Valid Consent in Sexual Health Services. 2011.* ***http://www.fsrh.org/pdfs/ServiceStandardsObtainingValidConsent.pdf*** *[Accessed 8 September 2014].*	**Q271,Q272, Q278,Q279, Q351,Q352, Q353,Q358, Q359,Q361, Q368,Q369,**		
Fertility Treatment	See 'Other Surgery'			
Hysterectomy for heavy menstrual bleeding	Prior to referral to secondary care treatment with non-steroidal anti-inflammatory agents and/or tranexamic acid should have been tried unless contraindicated. The CCG will not routinely fund hysterectomy for dysfunctional uterine bleeding except where: • There has been a prior trial with a levonorgestrel intrauterine system (Mirena®) (unless contraindicated) and/or endometrial resection/ablation which has not successfully relieved	**Q072, Q074, Q075, Q082,**		

	symptoms. Contraindications to the levonorgestrel intrauterine system are: ・ Severe anaemia, unresponsive to transfusion or other treatment, whilst a levonorgestrel intrauterine system trial is in progress. • Distorted or small uterine cavity (with proven ultrasound measurements). • Genital malignancy • Active trophoblastic disease • Pelvic inflammatory disease • Established or marked immunosuppression • Submucous fibroid			
Reversal of female sterilisation	The CCG **will not routinely fund** female sterilisation reversals. Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.	Q371, Q378, Q379, Q291, Q292, Q298, Q299		
Labial reduction/ Labiaplasty	This procedure is not routinely funded.	No code		

7. Musculoskeletal				
Arthroscopy of the knee	**Knee Arthroscopy** is not routinely funded. Arthroscopy of the knee can be undertaken where there is reasonable evidence as shown by MRI or other procedures/examination that treatment is needed for one or more of the following: **1.** Removal of loose body; **2.** Meniscal surgery (report or resection); **3.** Ligament reconstruction / repair (including lateral relapse); **4.** Synovectomy; **5.** Treatment of articular defects eg: micro-fracture Funding will NOT be approved for: 1. Arthroscopic lavage and debridement as part of treatment for osteoarthritis (as per NICE interventional procedure guidance 230) 2. Use as a primary diagnostic tool	**W871, W878, W879**		
Arthroscopy of the Hand/Wrist	It is anticipated that approximately 25% of hand/wrist arthroscopies will be necessarily diagnostic. Surgeons are asked to ensure that coding of the arthroscopy is undertaken after the procedure has taken place.	**W888 +Z735, W888 +Z739, W888 +Z828, W888 +Z829, W888 +Z894, W889 +Z735, W889 +Z739, W889 +Z828, W889 +Z829, W889 +Z894,**		
Arthroscopy of the Elbow	It is anticipated that approximately 5% of elbow arthroscopies will be necessarily diagnostic. Surgeons are asked to ensure that coding of the arthroscopy is undertaken after the procedure has taken place.	**W888 +Z815 W889 +Z815**		
Back Pain and Sciatica	Following the publication of NICE guidelines NG59 the following procedures will NOT be considered for funding (except through clinical exceptionality): 1. Spinal fusion for people with low back pain unless as part of a randomised controlled trial; 2. Disc replacement in people with low back pain; 3. Epidural injections for neurogenic claudication in people who have central spinal canal stenosis 4. Acupuncture for managing low back pain with or without sciatica.			

Carpal tunnel syndrome (Surgical techniques for the treatment of)	Carpal Tunnel surgery will be funded if:- 1. Acute, severe symptoms persist after conservative therapy having tried local corticosteroid injection by a trained, competent practitioner, and nocturnal splinting. 2. Mild to moderate symptoms persist for at least 4 months after conservative therapy having tried local corticosteroid injection (if appropriate) and nocturnal splinting (used for at least 8 weeks). 3. Intrusive symptoms continue after ALL conservative management options have been tried or 4. Sensory loss defined as objective evidence of reduced sensation or 5. Muscle wasting 6. **AND** for all of the above shared decision making is adopted and the patient wants surgery. The patient may be referred for surgery by the referring clinician if all the criteria have been met.	**W021, W022, W023, W024, W028, W029, A 651, A658**		
Disc Replacement for low back pain	See back pain and sciatica			
Dupuytren's contracture - Surgical Treatment/Interventional Procedures including Needle Fasciotomy	Surgical correction or Xiapex Injection for Dupuytrens Contracture will be funded if:- 1. There is a fixed flexion in one or more joints exceeding 30 degrees♦ or 2. A contracture affecting fixed flexion/ loss of extension exceeding 10 degrees at the interphalangeal joint♦. 3. And Patients are aware of the implications of the surgical procedure such as 50% recurrence rate within 3-5 years or that the longer term recurrence rate with Xiapex▪ has not been determined.	**T521, T522, T525, T526**		

	4. AND for all of the above that the patient wants surgery or Xiapex and that shared decision making aids will be used once available ♦ If an exact measurement is not possible then clinical assessment should evaluate the extent of the disease and severity/ deformity. The patient may be referred for surgery or Xiapex by the referring clinician if the criteria are met			

EXOGEN ultrasound bone healing system	The CCG supports funding the EXOGEN ultrasound bone healing system to treat long bone fractures with **non-union** (failure to heal after 9 months). The CCG does not fund EXOGEN for delayed healing long bone fractures.			
Ganglia: techniques for the treatment of	Surgery for ganglion will be funded if:- 1. The ganglion is very painful and/ or restricts activities of daily living or 2. The ganglion is of a significant size or 3. There is evidence of neurological loss or weakness and 4. Patient is aware of complications following excision (recurrence and scarring). 5. AND for all of the above that the patient wants surgery and that shared decision making aids will be used once available The patient may be referred for surgery by the referring clinician if the criteria have been met.	**T591, T592, T593, T594, T598, T599, T601, T602, T603, T604, T608, T609**		
Hallux valgus: Surgical treatment of	The CCG will fund surgery for Hallux Valgus when: The patient experiences persistent significant pain and functional impairment that is interfering with the activities of daily living. AND all appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: up to 6 months of evidence based non-surgical treatments. Conservative management techniques include: • Avoiding high heel shoes and wearing wide fitting leather shoes which stretch; • Exercises specifically designed to alleviate the effects of a Hallux Valgus and keep it flexible; • Applying ice and elevating painful and swollen Hallux	**W791, W151 W152, W153 W154, W155 W156, W158 W159, W161 W591, W592, W593, W594, W595, W596, W598, W599**		

	Valgus; • Use of Hallux Valgus pads, splints, insoles or shields AND the patient understands that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks, (2 weeks if left side and driving automatic car). In addition to the above criteria, smoking cessation and weight management should be considered as an integral part of appropriate clinical management prior to consideration of any elective surgery (with referral to appropriate services if indicated). Current evidence on safety and efficacy in relation to the correction of hallux valgus using minimal access techniques is inadequate NICE (IPG 332) OR there is a higher risk of ulceration or other complications, for example, neuropathy, for patients with diabetes. Such patients should be referred for an early assessment. OR There is evidence of severe deformity (overriding toes) OR Physical examination and X-ray show degenerative changes in the 1st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees. A patient should not be referred for surgery for prophylactic or cosmetic reasons for asymptomatic Hallux Valgus.			

Spinal Fusion	See Back pain and sciatica			
Trigger finger: surgical techniques for the treatment of	Conservative methods of treatment should always be pursued in the first instance either by the patient's GP or, where appropriate, the MSK service before referring into secondary care. The CCG will agree to fund surgical intervention for trigger finger where the following criteria have been met: The patient has failed to respond to conservative management over a period of 6 months including at least two corticosteroid injections except where the corticosteroid injection is contraindicated AND The patient has a fixed flexion deformity that cannot be corrected by conservative measures. OR The patient is suffering from significant functional impairment. Significant functional impairment is defined by the CCG as: Symptoms that prevent the patient fulfilling routine work or educational responsibilities, or symptoms prevent the patient carrying out routine domestic or carer activities Patients with Trigger Finger and Inflammatory Arthritis The CCG will agree to fund surgical intervention for trigger finger where the: 1. Patient has been diagnosed with inflammatory arthritis. AND 2. There is a joint agreement by the patient's Rheumatoid Arthritis Consultant and Hand Surgeon that their trigger finger is unlikely to be corrected by conservative treatment. This needs to be documented in the patient's medical record through relevant clinic letters.	**T711,T723, T744**		
Vertebroplasty Percutaneous vertebroplasty and percutaneous balloon kyphoplasty for treating osteoporotic vertebral compression fractures	This procedure will only be funded in line with NICE TA279.	V444		

8. Neurology/neurosurgery	
Cerebellar stimulator implants	This service is commissioned and applications are managed by NHS England Area Team.
Spinal cord stimulation (SCS) for ischaemic pain	This service is commissioned and applications are managed by NHS England Area Team.
Neurosurgery for cerebral metastases	This service is commissioned and applications are managed by NHS England Area Team.

9. Oncology	
Indwelling pleural catheter for the treatment of malignant pleural effusions in a community setting	This service is commissioned and applications are managed by NHS England Area Team.
Stereotactic Radiation Therapy	This service is commissioned and applications are managed by NHS England Area Team.

10. Ophthalmology				
Excimer laser surgery for short sight/long sight or Astigmatism	**This procedure is not routinely funded.**	C442		
Cataract	Any suspicion of cataracts in children should be referred urgently**.** Adults with a visual acuity of 6/12 or better (with the aid of glasses or contact lenses if worn) in the cataract affected eye are considered a low priority for cataract surgery. Referrals from GP/ community services should only be made after an assessment of the patient's visual acuity and consideration of the patients reported effect of glare on their ability to manage activities of daily living. Referral of patients to ophthalmologists should be based on the following indications: 1. Best corrected visual acuity must be worse than 6/12 in the cataract affected eye OR 2. Where glare affects the patient's ability to manage their activities of daily living 3. AND willingness to have cataract surgery; • The referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral. Patients should only undergo surgery of the second eye when that cataract affected eye meets the thresholds of worse than 6/12 visual acuity or glare affects their ability to manage their activities of daily living. Exceptions Cataract surgery can continue to be performed for medical reasons such as glaucoma and diabetes and on patients with severe anisometropia who wear glasses. The clinical reason for the surgery should be clearly documented. **Trusts will not be paid for undertaking treatments that fall outside of the eligibility criteria.**	**C751, C711, C712, C713, C718, C719, C721, C722, C723, C728, C729, C731, C732, C733, C734, C738, C739, C741, C742, C743, C748, C749, C751, C752, C753, C754, C758, C759**		

Chalazion	This procedure is not routinely funded. The CCG will fund excision of chalazia when all of the following criteria are met: • The chalazia has been present for more than 6 months • And it is situated on the upper eyelid • And it is causing blurring of vision In common with all types of lesions, the CCG will fund removal where malignancy is suspected.	C121		
Xanthelasma	**Surgical treatment of xanthelasma is not routinely funded.**	C121		

11. Other surgery				
Double Balloon Enteroscopy	The CCG has adopted a policy with respect to double balloon enteroscopy. This can be found in a separate policy document on our website.			
Endoscopic thoracic sympathectomy for facial blushing. Endoscopic thoracic sympathectomy for sweating.	**These procedures are not routinely funded**	No code		
Fertility Treatment	The CCG has adopted a number of recommendations with respect to fertility treatment. From March 2016, these have been consolidated into a single document **'Crawley CCG and Horsham and Mid Sussex CCG Schedule of policy statements for assisted reproductive technologies (ART)**' which can be found on our website, along with a summary of our eligibility criteria. This incorporates the following policy recommendations, which are available on request. 1. SE CSU Health Policy Support Unit (2016) *Template Criteria for NHS Funded Assisted Reproductive Technologies* 2. SE CSU Health Policy Support Unit (2016) *CPMAP PR 2016-01: In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)* 3. KMCS Health Policy Support Unit (2013) *TP2013-02: Surgical sperm retrieval* 4. KMCS Health Policy Support Unit (2013) *TP2013-03: Assisted conception treatments (ACTs) using donated genetic materials* 5. KMCS Health Policy Support Unit (2013) *TP2013-04: Assisted conception treatments (ACTs) involving surrogates* 6. SE CSU Health Policy Support Unit (2015) *CPMAP PR 2015-03: Assisted reproductive technologies (ART) for*			

	fertility preservation for patients receiving gonadotoxic treatments 7. KMCS Health Policy Support Unit (2013) *TP 2013-06: Intra-uterine insemination (IUI) using partners sperm* 8. KMCS Health Policy Support Unit (2013) *TP 2013-07: Sperm washing* 9. SE CSU Health Policy Support Unit (2016) *CPMAP PR 2016-02: Time lapse systems for embryo incubation and assessment* 10. SE CSU Health Policy Support Unit (2016) *CPMAP PR 2016-03: Adherence compounds in embryo transfer media for assisted reproductive technologies*			

Fertility Preservation	From December 2015 the CCG has adopted Policy Recommendation (PR)2015-03: Assisted reproductive technologies (ART) for fertility preservation for patients receiving gonadotoxic treatments This can be found in a separate policy document on our website'			
Laparoscopic cholecystectomy	Gallbladder Stones Patients with an incidental finding of stones in an otherwise normal gallbladder and biliary tree require no further investigation or referral; asymptomatic patients should not be referred to secondary care. Surgery for asymptomatic gallstones is not routinely funded Laparoscopic cholecystectomy will be funded for people diagnosed with symptomatic gallbladder stones. The decision to operate should be made by the patient with guidance from the surgeon. This will include assessment of the risk of recurrent symptoms and complications of the gallstones and the risks and complication rates of surgery in relation to the individual patient's co-morbidities and preference. Common bile duct stones Bile duct clearance and laparoscopic cholecystectomy will be funded for people with symptomatic or asymptomatic common bile duct stones (see Policy recommendation CPMAP PR 2017-01)	J18.1 to J18.9 With Y75.2		
Gender reassignment	The gender reassignment service is commissioned, and applications are managed by, NHS England. Non-Core procedures which are not included within the national service specification are the responsibility of the CCG.	X15		

	Examples of Non-core procedures include: • Breast augmentation (where no response to hormone treatment) • Facial feminisation surgery (e.g. thyroid chondroplasty / tracheal shave, rhinoplasty, facial bone reduction, blepharoplasty / facelift) • Lipoplasty / contouring • Gamete storage Requests for non-core procedures will be considered against the CCG's policy for the treatment being requested. Where patients fulfil the criteria, funding should be made available; appropriate IFRs can be considered through the CCGs' IFR process When developing or reviewing clinical policies which may be considered 'non-core', the CCG will give due regard to the specific needs of this population to ensure they are adhering to the Equality Act 2010.			

Haemorrhoids	This policy does not apply to referrals for suspected cancer or other serious pathologies, or where urgent admissions are required. Initial management • Minimally symptomatic haemorrhoids may be safely observed in primary care (see Table 1). • Routine referral for assessment and treatment in secondary care may only be considered for patients with persistent or highly symptomatic haemorrhoids for which conservative measures (e.g. lifestyle changes and pharmacological treatment) have been tried and failed or are not suitable. Information on self-care, lifestyle changes and treatments, including a simple guide for patients on the pros and cons of different treatment options for haemorrhoids is available on **NHS Choices** Criteria for surgery[1] Surgery for haemorrhoids may only be considered where the following criteria are met: • Conservative measures (e.g. lifestyle changes and pharmacological treatment) and non-surgical treatment (e.g. rubber band ligation, injection sclerotherapy or infrared photocoagulation) have been tried and failed OR are not suitable AND • Haemorrhoids are associated with frequently re-occurring persistent pain significantly affecting quality of life OR with frequently re-occurring persistent bleeding			
Hernia Treatments	Inguinal hernia repair Inguinal hernia repair will only be funded for patients with one or more of the following: • History of incarceration or real difficulty reducing hernia • Pain/ symptoms interfering with activities of daily living Threatened strangulation	T191, T192, T193, T198, T199, T201, T202, T203, T204, T208, T209, T211, T212, T213, T214, T218, T219		

	• Pain during strenuous activity • Inguino-scrotal hernia • Significantly increasing in size (assessed by GP follow up or reported history) <u>Umbilical hernia repair</u> Umbilical hernia repair will only be funded for patients with one or more of the following: • Pain/ symptoms interfering with activities of daily living • Threatened strangulation • Significantly increasing in size (assessed by GP follow up or reported history) <u>Incisional hernia repair</u> Incisional hernia repair will only be funded for patients with one or more of the following: • Pain/ symptoms interfering with activities of daily living AND conservative management e.g. weight loss, has been tried first where appropriate Hernia repair using Strattice Mesh • Strattice Mesh will not be funded for hernia repair surgery See Policy recommendation document **CPMAP PR 2015-02: Hernia repair in adults** for full details.			
Surgical Repair of divarication of rectus abdominus muscles in adults	Surgical repair of divarication of the rectus muscles is not routinely funded in the local NHS for any patient group See policy recommendation document CPMAP PR 2015-02			

12. Other Procedures/Equipment				
Epidural injections for neurological claudication in people who have central spinal canal stenosis	**See back pain and sciatica.**			
Prostheses for body parts (Prosthetic components not covered by the NHS contract will not be funded)	A range of prosthetics are available on the NHS. Prosthetic components not routinely provided by the NHS will not be funded. Prostheses service is commissioned and applications are managed by NHS England Area Team.			
Hyperbaric oxygen	This service is commissioned and applications are managed by NHS England Area Team	X521, X528, X529		
NHS patient transfers to private treatment providers.	When clinicians retire from the NHS they may continue to practice privately. There are often patients who wish to continue seeing them, rather than see a new NHS clinician. The CCG will not routinely fund private consultations/treatment in these circumstances where previously provided in an NHS funded service.	No code		
Functional electrical stimulation (FES) in dropped foot	This procedure is not routinely funded			
Foetal Alcohol Spectrum Disorder	Assessment for and diagnosis of FASD should be undertaken by local specialists; referral to the National FASD Clinic for specialist assessment will not be routinely funded. Ref Policy recommendation CPMAP PR2016-04			
Residential pain management programmes	This service is commissioned and applications are managed by NHS England Area Team.			

13. Urology				
Circumcision	CCG will fund circumcision surgery for following indications: • Suspected cancer or balanitis xerotica obliterans (lichen sclerosus) • Congenital urological abnormalities when skin is required for grafting. • Symptomatic cases of paraphimosis. • Symptomatic cases of minor hypospadias. • Recurrent balanoposthitis resistant to antibiotic treatment • The nature of the phimosis severely interferes with sexual function. • Traumatic (e.g. zipper injury)			
Penile Implants	**This procedure is not routinely funded.**	N291, N292, N298, N299		
Reversal of vasectomy	**This procedure is not routinely funded.** Patients who have a sterilisation procedure should be made aware that subsequent reversal of sterilisation will not normally be available on the NHS.	N181		
Retractile penile surgery	**This procedure is not routinely funded.**	N348, N349		

14. Vascular Surgery				
Varicose vein surgery (Classes 1 and 2)	**This procedure is not routinely funded.**			
Varicose veins	Interventional treatments for varicose veins will only be funded for patients who have any one of the following: • Bleeding varicose veins • Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency • Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence • A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks) • A healed venous leg ulcer See policy recommendation document **CPMAP PR 2015-01: Management of varicose veins** for full details	L841, L842, L843, L844, L845, L846, L848, L849, L851, L852, L853, L858, L859, L861, L862, L868, L869, L871, L872, L873, L874, L875, L876, L877, L878, L879, L881, L882, L883, L888,		

15. Weight management				
Bariatric surgery	Bariatric surgery will be funded where all of the following criteria are fulfilled: • The patient has a BMI of 40 kg/m^2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (e.g. type 2 diabetes or high blood pressure) that could be improved if they lost weight. For people of Asian family origin who have recent-onset[4] type 2 diabetes, the BMI threshold will be reduced by 2.5 points. • All appropriate non-surgical measures have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss. • The individual has recently received and complied with a local specialist weight management programme (tier 3) for a duration considered appropriate by the multi-disciplinary team (MDT) • The person is generally fit for anaesthesia and surgery. • The person commits to the need for long-term follow-up. • A formalised MDT led process for the screening of co-morbidities and the detection of other significant diseases has been completed. These should include identification, diagnosis, severity/complexity assessment, risk stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway. • The specialist hospital bariatric MDT agrees surgery is indicated; for each patient a risk:benefit evaluation should favour bariatric surgery. In addition the bariatric surgery			

4 Diagnosis has been made within the previous 10 years.

	team must satisfy themselves that there are no contraindications for surgery, risks have been minimised and the patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure.			
Revision of Bariatric surgery	*Revision of bariatric surgery*[5] *will be funded as per NHS England Clinical Guidance on revision surgery for complex obesity (2016):* a. *Revision surgery will be routinely funded for patients presenting with a clinical history, symptoms and/or signs that suggest acute / acute on chronic / worsening medical and/or surgical complications - related to their primary obesity operation. This will include patients with adverse anatomical complications of the primary surgery but exclude loss of restriction due to dilatations of the gastric pouch and/ or the gastro-jejunal junction.* b. *Revision surgery will not be routinely funded for patients who have failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight (unless criterion a is met).* c. *Revision surgery will not be routinely funded for patients who have comorbitidies which have persisted or re-emerged following primary obesity surgery (unless criterion a is met).* ***d.*** *Where patients have had their primary obesity surgery outside of NHS contracts but subsequently present at NHS facilities as clinical emergencies, the NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment.*			

5 Revision surgery is defined by NHS England as surgery clinically indicated to treat complications arising >90 days after the index surgical procedure. Early re-operation (i.e. surgery < 90 days of the index surgical procedure) should be regarded as a complication of the primary surgical procedure and will be the responsibility of the provider undertaking the primary bariatric operation

6. Interventional Procedure Guidance

NICE issues Interventional Procedure Guidance (IPGs) with the aim of protecting the safety of patients and supporting the NHS in the process of introducing new procedures. The IPGs are not covered by the Secretary of State's directions to NHS organisations to fund the implementation of NICE recommendations within a given timescale because this direction relates only to NICE Technology Appraisal Guidance (TAGs).

The CCGs expect its providers to be aware of and act in accordance with IPG guidance.

The CCG will not routinely fund health care interventions that are subject to a NICE IPG where the IPG states:

- Current evidence on safety is inadequate.
- Current evidence on efficacy is inadequate.
- Evidence of safety and efficacy is on small numbers of patients and of limited quality.
- No major safety concerns, but efficacy has not been shown.
- Evidence is limited to a small number of patients. Good short term efficacy but little evidence of long term efficacy.
- There is adequate evidence of safety and efficacy but the technical demands are such that is should not be used without special arrangements.
- Evidence for short term efficacy is limited and long term outcomes are uncertain.

Research Only

The CCG will not routinely fund health care interventions that the NICE IPG programme has recommended should only be undertaken in the context of research. Clinicians wishing to undertake such procedures should ensure they fulfil the normal requirements for undertaking research.

Where there is a possibility that there may be impacts on NHS funded care following the cessation of the trial, or a patient's completion of a trial, clinicians are strongly encouraged to discuss this with the CCG at the earliest opportunity.

Do not use

The CCG will not fund health care interventions where a NICE IPG recommends that the intervention should not be used in the NHS.