Northern Ireland Evidence Based Commissioning Position: Effective Use of Resources

October 2022

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1.0 BACKGROUND

1.1 Introduction

This document updates the Department of Health (DoH) NI 2006 Effective Use of Resources (EUR) Commissioning Position. The commissioning position has been reviewed and updated to take account of emerging clinical evidence from the National Institute for Health and Care Excellence (NICE) and similar organisations, across a broad range of procedures/treatments. The commissioning position aims to ensure that interventions are provided with the greatest proven health gain within the context of the needs of the overall population.

The revised commissioning position expands the range of procedures/treatments which are commissioned within defined criteria or are not routinely commissioned. The commissioning position details the new procedures/treatments not previously included in the initial EUR policy and those procedures and treatments where the existing criteria have been updated.

The Strategic Planning and Performance Group (SPPG) will review the document on a biannual basis to ensure it reflects any new/emerging clinical evidence.

1.2 Overview

In 2006 the Department of Health, Social Services and Public Safety (DHSSPS) produced "a policy to make the best use of resources in plastic surgery and related specialties", known as the EUR Policy. This commissioning position set out the referral criterial for a small number of procedures, most of which related to the plastic surgery service.

In recent years Clinical Commissioning Groups in England and Wales have identified increased lists of procedures which are considered to be of low clinical value and have developed policies for commissioning these procedures. There are two key drivers for this:

- To ensure services provide the greatest clinical benefit and health gain for patients;
- To maximise the effectiveness of public resources, including clinical staff and health service infrastructure.

The SPPG has now expanded the range of procedures/treatments which we are proposing will be commissioned within defined criteria or are not routinely commissioned. Once implemented this updated commissioning position will guide the allocation of limited resources to those areas of greatest clinical benefit and support clinical staff to better manage patient expectations.

Where a patient has a disability that may prevent them from undergoing conservative treatment and will therefore not be able to meet some of the eligibility criteria, they should still be referred into the service normally.

1.3 Implementation

Commissioners, General Practitioners, and clinical staff in secondary care are expected to implement this commissioning position. When interventions are undertaken on the basis of meeting the criteria specified within the commissioning position, this should be clearly documented within patients' clinical notes.

Health and Social Care (HSC) Trusts will be responsible for ensuring compliance with the commissioning position in secondary care. Trusts will be accountable for any deviation from the commissioning position and will therefore need to ensure arrangements are in place to monitor referrals and activity pertaining to the procedures/treatments detailed in the commissioning position. This will include routinely collecting data on the number and type of procedure (by unit and surgeon) and the indication for the procedure.

1.4 Monitoring Arrangements

The SPPG will establish a monitoring framework to provide assurance that the commissioning position is being fully applied. The framework will monitor Trusts activity to ensure that procedures undertaken are consistent with the commissioning evidence from NICE.

The SPPG will work to ensure that the relevant referral criteria, once agreed, are populated into the Clinical Communications Gateway (CCG) referral template. The use of CCG will improve Primary Care access to referral guidance and will also facilitate the monitoring of demand.

1.5 Appeals Process

An appeals process will be developed whereby a consultant or GP can make an appeal on behalf of the patient. The panel will be led by the SPPG and will have clinical input from Trusts and the PHA.

An appeal can be made if the patient does not meet the criteria in this commissioning position but the consultant/GP believes that there are exceptional clinical circumstances that mean the patient should undergo the required procedure/intervention. The panel will consider the appeals and ensure that the decision making processes are fair, equitable and ethical.

The consultant/GP must:

- Provide details as to what extent, if at all, the patient meets the criteria;
- Describe why the consultant/GP considers the patient to be clinically exceptional.

The **definition of exceptionality** on which appeals will be considered is:

- The patient is significantly different to the general population of patients with the condition in question.

AND

- Is likely to gain significantly more benefit from the intervention than might normally be expected for patients with that condition.

A small panel will be convened, comprising SPPG, Public Health Agency (PHA) and HSC Trust representation (none of whom to have any previous involvement in the individual case) to assess the exceptional clinical circumstances. Every appeal shall be considered on its own merits, although particular care will be taken to identify and consider any exceptional circumstances that might demand or permit a departure from established policy and practice.

2.1 Body Contour

2.1.1 Abdominoplasty/Apronectomy (tummy tuck) – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Abdominoplasty/apronectomy (tummy tuck)
Policy and Minimum eligibility criteria	The SPPG will commission abdominoplasty/apronectomy (tummy tuck) providing all the following criteria are met: • The patient is suffering from severe functional problems directly related to the excess skin. Severe functional problems include: ▪ Difficulties with activities of daily living (e.g. walking and dressing) ▪ Recurrent skin infections in the skin fold ▪ Poorly fitting stoma bag **AND** • The patient has a body mass index (BMI) between 18 and 27 kg/m^2 for at least 2 years **OR** • Surgery is required as part of an abdominal hernia correction or other abdominal wall surgery ** Where a patient has a disability that may prevent them from meeting the above criteria i.e. having a disability which affects mobility and therefore the patient may not be able to maintain a BMI between 18 and 27 kg/m^2 they should still be referred into the service normally. An appeal will **NOT** be required.
Rationale	Excessive abdominal skin folds may occur following weight loss in obese patients. These skin folds can cause functional difficulties including difficulties walking or dressing and recurrent skin fold infections. If those difficulties are severe then abdominoplasty may be beneficial for these patients. It is important that prior to undergoing abdominoplasty, patients have demonstrated that they have achieved and maintained a stable normal BMI in order to reduce the risks of obesity recurring. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that the patient currently has and has had for a period of at least 2 years a BMI within the range 18 – 27 kg/m^2 • Assess the functional difficulties, confirm that they are severe and that they are directly related to the excessive abdominal skin folds • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.1.2 Liposuction – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Liposuction
Policy and Minimum eligibility criteria	The SPPG will commission liposuction providing all the following criteria are met: • The patient has pathological fat atrophy or hypertrophy that is the consequence of an underlying medical condition.
Rationale	Liposuction will not be commissioned for purely cosmetic reasons or to correct the distribution of fat. It may be useful for localised fat atrophy or pathological hypertrophy in conditions such as lipodystrophies. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	Referrals will only be accepted if the GP confirms that there is either fat atrophy or hypertrophy that is related to an underlying medical condition. The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that the patient has fat atrophy or hypertrophy and that that atrophy or hypertrophy is related to an underlying medical condition • Consider that atrophy or hypertrophy is severe enough to warrant the use of liposuction • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.2 Breast

2.2.1 Correction of Nipple Inversion – Updated Criteria

Procedure Not Commissioned	
Intervention	Correction of nipple inversion
Policy and Minimum eligibility criteria	The SPPG does not commission correction of nipple inversion where breast cancer has been excluded.
Rationale	Correct use of suction devices can often reverse nipple inversion. Three months sustained correct usage may be required. The devices are available commercially from chemists or online. *NB. Nipple inversion can be caused by underlying malignancy and it is essential that this is excluded.*
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must: • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

2.2.2 Breast Augmentation (Enlargement) – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Breast Enlargement (Augmentation)
Policy and Minimum eligibility criteria	The SPPG will commission breast enlargement (Augmentation) providing one or more of the following criteria are met: • Women with absence of breast tissue either unilaterally or bilaterally (e.g. due to congenital amastia (total failure of breast development)) **OR** • Women with a significant degree of developmental asymmetry of either breast shape or volume. This policy does not cover breast reconstruction /augmentation post-mastectomy. Breast reconstruction will be available to women post-mastectomy as part of the cancer treatment pathway for breast cancer and in consultation with the Multi-Disciplinary Team (MDT). Breast augmentation is **not commissioned** for: • enhancement of small, normal breasts • Breast tissue involution (including changes after pregnancy).
Rationale	Breast augmentation is a cosmetic procedure. Breast implants may be associated with significant side effects and the need for revisional, removal and replacement surgery is common, particularly in young people. Not all patients show improvement in psychosocial outcome measures following breast augmentation. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm which of the criteria the patient is being considered under • If the patient is requesting the procedure under criterion 1, confirm and record that breast tissue is totally absent at least unilaterally • If the patient is requesting the procedure under criterion 2, estimate and record the degree of the asymmetry and confirm that it is of a significant degree • Confirm that the request is not to treat normal small breasts or breast tissue involution • The information should be recorded appropriately for future audit purposes.

2.2.3 Breast Mastoplexy (Lift) – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Breast lift (Mastoplexy)
Policy and Minimum eligibility criteria	The SPPG will commission breast lift (mastoplexy) providing all of the following criteria are met. • When the breast lift is done as part of the treatment of breast asymmetry or breast reduction, including post-mastectomy and other reconstruction. The patient must meet the EUR criteria for the primary procedure. * Where a patient has a disability that may prevent them from meeting the above criteria i.e. having a disability which affects mobility and therefore may not be able to have a BMI of less than 25 kg/m2, they should still be referred into the service normally. An appeal will NOT be required.
Rationale	Breast ptosis (sagging breasts) develops as part of the ageing process. It may follow pregnancy. Correction is usually primarily a cosmetic procedure and therefore is not commissioned. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The need for a breast lift will usually be the decision of the operating surgeon and it is not anticipated that GPs will refer directly for breast lifts.
Responsibility of the consultant	The consultant must confirm that: • The patient meets the criteria for the primary procedure (see EUR policy No 2.2.2 on Breast augmentation for asymmetry and EUR policy No 2.2.4 on breast reduction) • Breast lift is indicated to ensure a satisfactory outcome for the patient • They have advised the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.2.4 Breast Reduction (Female) – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Breast Reduction (Female)
Policy and Minimum eligibility criteria	The SPPG will commission breast reduction (female) providing all the following criteria are met: • The patient has a body mass index (BMI) of less than 25kg/m2 **AND** • The patient is suffering from neckache, backache or intertrigo that is directly attributable to the size of the patient's breasts **AND** • The wearing of a professionally fitted bra has not relieved the symptoms. ** Where a patient has a disability that may prevent them from meeting the above criteria i.e. having a disability which affects mobility and therefore may not be able to have a BMI of less than 25 kg/m^2 they should still be referred into the service normally. An appeal will **NOT** be required.
Rationale	Breast reduction places considerable demand on services. Reduction has been shown to be an effective intervention. However, there is evidence that most women seeking breast reduction are not wearing a bra of the correct size and a well-fitted bra can alleviate symptoms. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP should ensure that the patient meets all of the criteria above, in particular the GP should ensure that: • The patient meets the BMI criteria above • The patient does not have another cause for the symptoms being attributed to the large breasts • The patient has had a reasonable trial of a professionally fitted bra The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that the patient meets the criteria and record an estimate of degree of impact on the patient • Confirm that the symptoms can reasonably be attributed to the size of the patient's breasts • Establish whether bra fitting was appropriate and the trial was sufficient to confirm that it did not work • Confirm that conservative treatments for at least 6 weeks have not resolved the intertrigo (treatments include appropriate hygiene, pharmacological and support bra interventions) • Confirm that conservative treatment for at least 6 weeks have not relieved the neck, back or shoulder pain

	• The information should be recorded appropriately for future audit purposes.

2.2.5 Removal of Breast Implants – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Removal of breast implants
Policy and Minimum eligibility criteria	The SPPG will commission removal of breast implants providing all the following criteria are met: • The original implants were part of surgery done within Health and Social Care (HSC) (or equivalent) or funded by the HSC (or equivalent) **AND** • The implants are a health risk to the women **OR** • The woman has symptoms confirmed as being directly attributable to the implants. Re-implantation will only be available for those women who meet the criteria in the EUR policy No 2.2.2: Breast enlargement. Women who had Poly Implant Prostheses (PIP) breast implants are subject to the arrangements detailed by the CMO in his letters HSS(MD) 2/2012 (13/01/12); HSS (MD) 8/2012(24/02/12); HSS (MD) 11/2012 (15/03/12).
Rationale	The SPPG does not normally commission augmentation of breasts. However, some women have conditions that require reconstruction (including implants) of one or both breasts. The emerging evidence is that breast implants may need removal after a period of years although the different breast implants have variable life-spans (estimates of 10% at 10 years and 14% at 8 years for two leading brands). The majority of women with implants had them done at a private facility and they should consult their private providers for advice and continuing management of their implants. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that the women had the implants done within the HSC (or equivalent) or funded by the HSC (or equivalent) • Confirm by appropriate means that the patient either has a health risk from the implant or has symptoms attributable to the implant • Not offer re-implantation unless the women currently meets the criteria in EUR Policy No 2.2.2 or the original implants were part of breast reconstruction done as part of the treatment of breast cancer.

2.2.6 Reduction of Gynaecomastia Males – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Reduction of gynaecomastia in Males
Policy and Minimum eligibility criteria	The SPPG will commission male breast reduction providing all the following criteria are met: • The gynaecomastia is of a significant degree such that *a reasonable person would be unable to tolerate the abnormality of appearance* **AND** • The patient is post-puberty **AND** • The patient has a body mass index (BMI) of less than 25kg/m^2 stable for 12 months **AND** • An endocrinological or drug-related cause for the gynaecomastia has been excluded or adequately managed. ** Where a patient has a disability that may prevent them from meeting the above criteria i.e. having a disability which affects mobility and therefore may not be able to have a BMI of less than 25 kg/m^2 they should still be referred into the service normally. An appeal will NOT be required.
Rationale	Gynaecomastia (enlarged breast tissue in males) can occur during puberty. It may resolve once puberty is complete. It may also be caused by underlying endocrine abnormalities, drug treatments or, rarely, breast cancer. These must be excluded when assessing a patient. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP should ensure that the patient meets the criteria above in particular that: • Breast cancer has been excluded if appropriate • Established causes of gynaecomastia have been excluded or managed • The patient meets the BMI criteria. The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm the degree of gynaecomastia and confirm it meets the criteria above • Confirm that there has been adequate medical management of underlying conditions and it has not resolved the gynaecomastia • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.3 ENT

2.3.1 Tonsillectomy for Recurrent Tonsillitis – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Tonsillectomy for recurrent tonsillitis
Policy and Minimum eligibility criteria	The SPPG commissions tonsillectomies in line with the 2010 Scottish Intercollegiate Guidelines Network (SIGN) guidance 117 and expects that the following criteria will be met if a decision is made to do a tonsillectomy for recurrent sore throats: ▪ sore throats are due to acute tonsillitis and ▪ the episodes of sore throat are disabling and prevent normal functioning and ▪ seven or more well documented, clinically significant, adequately treated sore throats in the preceding year or ▪ five or more such episodes in each of the preceding two years or ▪ three or more such episodes in each of the preceding three years. ▪ If appropriate following peri-tonsillar abscess.
Rationale	No study demonstrated clear clinical benefit of tonsillectomy in children. A Cochrane review showed modest benefit of tonsillectomy or adenotonsillectomy in the treatment of recurrent acute tonsillitis. Apart from adults with proven recurrent Group A streptococcal pharyngitis, evidence on which adults will benefit from tonsillectomy is not available. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP should carefully assess the patient and document the diagnosis of significant sore throats or tonsillitis. The GP should discuss the risks of tonsillectomy vs watchful waiting with the patient/parents before referral to secondary care. Information and reassurance should be provided if referral is not deemed necessary at this stage. The GP must provide sufficient clinical information to confirm that the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm the primary care assessment • Confirm that the patient fulfils the SIGN criteria above • Discuss the management options including tonsillectomy and referral back to primary care for on-going monitoring.

2.3.2 Simple Snoring excluding Obstructive Sleep Apnoea – New Criteria

Procedure Not Commissioned	
Intervention	Snoring
Policy and Minimum eligibility criteria	Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in four adults snore, as long as it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person's partner. This guidance relates to surgical procedures to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring and should not be applied to patients with diagnosed obstructive sleep apnoea. It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate. It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, that NHS are proposing that this procedure should no longer be routinely commissioned. **<u>Alternative Treatments</u>** There are a number of alternatives to surgery that can improve the symptom of snoring. These include: • Weight loss • Stopping smoking • Reducing alcohol intake • Medical treatment of nasal congestion (rhinitis) • Mouth splints (to move jaw forward when sleeping).
Rationale	In two systematic reviews of 72 primary research studies, there is no evidence that surgery to the palate to improve snoring provides any additional benefit compared to other treatments. While some studies demonstrate improvements in subjective loudness of snoring at 6-8 weeks after surgery, this is not longstanding (>2years) and there is no long-term evidence of health benefit. This intervention has limited to no clinical effectiveness and surgery carries a 0-16% risk of severe complications (including bleeding, airway compromise and death). There is also evidence from systematic reviews that up to 58-59% of patients suffer persistent side effects (swallowing problems, voice change, globus, taste disturbance & nasal regurgitation). It is on this basis the interventions should no longer be routinely commissioned. *References* 1. Franklin KA, Anttila H, Axelsson S, Gislason T, Maasilta P, Myhre KI, Rehnqvist N. Effects and side-effects of surgery for snoring and obstructive sleep apnoea-a systematic review. Sleep. 2009 Jan. 32(1):27-36 2. Main C, Liu Z, Welch K, Weiner G, Jones SQ, Stein K. Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic

	review of clinical effects and associated treatment costs. Health Technol Assess2009;13(3)https://www.ncbi.nlm.nih.gov/pubmed/19091167 3. Jones TM, Earis JE, Calverley PM, De S, Swift AC. Snoring surgery: A retrospective review. Laryngoscope. 2005 Nov 115(11): 2015-20. https://www.ncbi.nlm.nih.gov/pubmed/16319615
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must: • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

2.4 Facial Problems

2.4.1 Repair of Split Ear Lobes – Updated Criteria

Not Commissioned	
Intervention	Repair of split ear lobes
Policy and Minimum eligibility criteria	The SPPG does not commission repair of split ear lobes. ** This will be funded for primary suture trauma **at the time of trauma only**. E.g. the patient is automatically eligible for emergency treatment when he/she presents for repair at Accident and Emergency (A&E) at the time of trauma.
Rationale	The external ear lobe can be damaged partially or completely as a result of trauma or wearing ear rings. Correction of split ear lobes is not always successful and the ear lobe is a site where poor scar formation is a recognised risk.
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

2.4.2 Blepharoplasty (eyelid surgery) – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Blepharoplasty (eyelid surgery)
Policy and Minimum eligibility criteria	The SPPG will commission blepharoplasty of either the upper or the lower eyelid providing one or more of the following criteria are met. Blepharoplasty will not be commissioned for cosmetic reasons. The SPPG will only commission blepharoplasty of the upper eyelid to correct functional impairment if at least one of the following criteria are met; • The patient's vision/visual fields are impaired by the excess skin **OR** • The function of the eyelid is impaired sufficiently for the patient to demonstrate evidence of chronic compensation or symptoms that can be directly attributed to the eyelid function, evidence of impairment should be demonstrated through a visual field test. The SPPG only commissions blepharoplasty of the lower eyelid if the following criteria are met. To correct lesions where they are sufficiently severe to interfere with the normal function of the eye.
Rationale	Many people have excess skin in the upper eyelids as a normal part of the ageing process. However, surgery can be of benefit if the condition is severe enough to interfere with the function of the eye. Excessive skin in the lower lid can cause 'eyebags'. These do not affect the function of the eye and do not need to be corrected. Pathological disorders of the lids or skin disorders close to the eye may need a blepharoplasty-type procedure to correct functional defects. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that the patient meets the criteria above • Assure themselves that there is a functional impairment that is severe enough to benefit from a procedure • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.4.3 Correction of Prominent Ears – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Correction of prominent ears
Policy and Minimum eligibility criteria	The SPPG will commission correction of prominent ears providing all the following criteria are met: • The patient is a child/young person aged 5 years – 18 years • The child/young person has significant psychological distress directly related to their prominent ears • The appearance of the ears should be assessed by the clinician as being sufficiently prominent that *'a reasonable person would be unable to tolerate the abnormality on appearance'*.
Rationale	Prominent ears are very common. There are several anatomical factors that can contribute to prominent ears. Each of the factors can be addressed surgically. Prominent ears in children can lead to low self-esteem, bullying and significant psychological morbidity. Psychological distress is unlikely to have developed prior to the age of five and surgery can therefore be delayed until later. Children under the age of five are less likely to tolerate the procedure well or be compliant with dressing care. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Assess and document the degree of prominence • Assure themselves that the child has psychological morbidity directly associated with the prominent ears • Assure themselves that the child understands the procedure and wants to have surgery to correct it • Advise the patient/parents of the likely final result • The information should be recorded appropriately for future audit purposes.

2.4.4 Face Lifts/Brow Lifts – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Face lifts /brow lifts
Policy and Minimum eligibility criteria	The SPPG will commission face lift or brow lifts providing one of the following criteria are met. Face lifts or brow lifts will not be commissioned to treat the natural process of ageing. • Congenital facial abnormalities • Congenital or acquired facial palsies • Specific conditions affecting facial skin (e.g. cutis laxa; pseudoxanthoma elasticum; neurofibromatosis) • To correct the consequences of trauma • To correct deformity following surgery.
Rationale	Changes to the face develop as part of the natural ageing process. This may result in loose skin around the face, neck and eyes.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the consultant	The consultant must: • Confirm which of the criteria the patient is being considered under and record an estimate of degree of impact on the patient of the condition • Confirm that the deformity to be treated is sufficiently severe to meet *(Need to agree the scale – needs to be at the severe end of the scale)* • Confirm that the request is not to treat the normal ageing process • Inform the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.4.5 Rhinoplasty (Surgery to re-shape the nose) – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Rhinoplasty (surgery to re-shape the nose)
Policy and Minimum eligibility criteria	The SPPG will commission rhinoplasty providing all of the following criteria are met. Rhinoplasty will not be commissioned for cosmetic reasons. • The patient has problems caused directly by obstruction of the nasal airway **OR** • There is obvious nasal deformity as a result of trauma **OR** • To correct complex congenital conditions such as cleft lip or palate.
Rationale	Rhinoplasty can be of benefit to patients with limited nasal air entrance due to anatomical derangement.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the consultant	The consultant must: • Assess the severity of the patient's nasal problems and confirm that it is significant • Confirm that the problems are related to an obstruction or a deformity caused by trauma that can be corrected by surgery • Ensure that the request is not for cosmetic reasons • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.5 General Surgery

2.5.1 Varicose Veins – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Treatment of Varicose veins
Policy and Minimum eligibility criteria	The SPPG does not commission the surgical treatment of varicose veins on purely cosmetic grounds. The SPPG does not commission surgical or endovenous treatment of varicose veins unless one of the following criteria is met: • Recurrent phlebitis or • Bleeding varices • Symptomatic Grade 3 (varicose veins with associated significant or severe limb oedema), Grade 4 (varicose veins with skin changes), or Grade 5/6 (healed or active venous ulceration).
Rationale	Varicose veins are common. Many varicose veins do not cause symptoms. NICE CG168 outlines the patients that should be referred for vascular review and informs this policy. In addition NICE IPG 8 and IPG 37 support delivering interventions using minimally invasive techniques. Studies show that the outcomes are less favourable after surgical treatment of varicose veins in people with a BMI of >30, with an increased risk of recurrence. The American Venous Forum of the American Society for Vascular Surgery concluded that wound outcomes were also worse with higher BMI. It also found that BMI was a risk factor for anatomical failures which are associated with recurrence.
Responsibility of the GP	The GP should ensure that the patient has had appropriate management within primary care. The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant should: • Confirm that the varicose veins meet the criteria in this policy before adding a patient to the waiting list • Assess the extent of the problems that the patient attributes to the varicose veins. If there are concerns that the symptoms may have an alternative cause then the patient should be investigated appropriately before intervention • Assure themselves that there is a functional problem and that problem can reasonably be attributed to the varicose veins • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.6 Musculo-Skeletal Health

2.6.1 Hip Arthroscopy – New Criteria

Procedure Commissioned In Special Circumstances	
Intervention	Hip Arthroscopy
Policy and Minimum eligibility criteria	SPPG will fund open or arthroscopic hip surgery for the treatment of femoro-acetabular impingement (FAI) ONLY when patients fulfil all of the following criteria: - Diagnosis of definite femoro-acetabular impingement defined by appropriate investigations, X-rays, MRI and CT scans. - An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis. This should include discussion of each case with a specialist musculoskeletal radiologist. - Severe symptoms typical of FAI with duration of at least six months where diagnosis of FAI has been made as above. - Failure to respond to all available conservative treatment options including activity modification, pharmacological intervention and specialist physiotherapy. - Compromised function, which requires urgent treatment within a 6-8 months' time frame, or where failure to treat early is likely to significantly compromise surgical options at a future date. - Treatment with more established surgical procedures is not clinically viable. **Exclusions** 4.1 Hip arthroscopy is not routinely commissioned for any other indications or pathologies other than those outlined above. 4.2 In addition, the HSC will not fund hip arthroscopy in patients with femoro-acetabular impingement where any of the following criteria apply: - Patients with advanced Osteo-Arthritic change on preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade lll or IV). - Patients with a joint space on plain radiograph of the pelvis that is less than 2mm wide anywhere along the sourcil. - Patients who are a candidate for hip replacement. - Any patient with severe hip dysplasia or with a Crowe grading classification of 4. - Patients with generalised joint laxity especially in diseases connected with hypermobility of the joints, such as Marfan syndrome and Ehlers-Danlos syndrome. - Patients with osteogenesis imperfecta.
Rationale	In the updated NICE guidance IPG 203, 213, 408, states the treatment should be restricted to centres experienced in treating this condition and staffed by surgeons adequately trained in techniques addressing FAI. All governance and audit should be undertaken in accordance with these guidelines.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above.

Responsibility of the consultant	The consultant must: • Confirm that there has been adequate medical management of underlying conditions and it has not resolved the underlying condition • Confirm and record that the patient meets the criteria.

2.6.2 Carpal Tunnel – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Carpal Tunnel Decompression
Policy and Minimum eligibility criteria	The SPPG will commission surgical treatment for carpal tunnel syndrome providing one or more of the following criteria are met: • Chronic mild to moderate symptoms (intermittent paraesthesia / numbness / pain interfering with ADL or causing frequent night waking) that have not responded to 4 months of conservative management (activity modification / splints / injections • Severe symptoms (persistent paraesthesia / numbness / pain or weakness / wasting) • Acute severe symptoms uncontrolled by conservative treatment (or where conservative treatment is not possible) including corticosteroid injections if appropriate. (RARE – consider other pathology)
Rationale	Carpal Tunnel syndrome can be managed non-operatively with activity modification, wrist splints, non-steroidal anti-inflammatory drugs (NSAIDs) and steroid injections. There are recognised criteria where surgical release may be beneficial as stated above. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. ** Nerve conduction studies are **NOT** essential and should not delay referral** Referrals that do not provide this information or do not meet the criteria will be returned.
Responsibility of the consultant	The consultant must: • Confirm that there has been adequate medical management of underlying conditions and it has not resolved the symptoms • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.6.3 Epidural Injections (Lumbar and Caudal) for Back Pain – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Epidural Injections (Lumbar and Caudal) for Back Pain
Policy and Minimum eligibility criteria	The SPPG will commission Epidural Injections (Lumbar and Caudal) for Back Pain for the following conditions • Therapeutic epidural injections for acute severe sciatica • Diagnostic medial branch block.
Rationale	Following endorsement of NICE CG 59 by the Department of Health (DoH) in January 2017. HSC consultants, PHA and SPPG have discussed how to provide alternatives to patients with chronic back pain who have already been offered or received facet joint injections in the expectation that these will be repeated. Patients should not be subjected to initial or repeat injections but should be referred to self-supported management, psychologically enhanced physiotherapy and pain management programme interventions. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that there has been adequate medical management of underlying conditions and it has not resolved the underlying condition • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.6.4 Ganglion – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Wrist Ganglion Excision
Policy and Minimum eligibility criteria	The SPPG will commission surgery for Wrist Ganglia providing the following criteria are met: • Symptomatic (painful) Ganglia in a patient prepared to consider surgical treatment.
Rationale	Ganglia are benign fluid-filled, smooth lumps. Trans-illumination is pathognomic. They occur most commonly around the wrist, but also around the ankle and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80%). Reassurance should be the first therapeutic intervention. Aspiration / injection is rarely successful. Surgical excision is the most invasive therapy but recurrence rates of up to 40% have been reported. As well as recurrence, other complications of surgical excision include scar sensitivity, joint stiffness and distal numbness. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the criteria set out above. Referrals that do not provide this information or for patients who do not meet the criteria will be returned.
Responsibility of the consultant	The consultant must: • Confirm and record that the patient meets the criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.6.5 Hallux Valgus (Bunion) Surgery – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Bunion Surgery
Policy and Minimum eligibility criteria	The SPPG will commission treatment for bunion surgery providing one or more of the following criteria are met: • Failure of appropriate conservative measures after three months. These include trying accommodative footwear, considering orthoses and advice on patient directed approach **AND** The patient suffers from either: • Persistent pain and disability not responding to up to 12 weeks of non-surgical treatments; this time to include any treatment received in primary care **OR** • Deteriorating symptoms.
Rationale	The 2017 updated "Commissioning Guide The Painful Deformed Great Toe" sets out the guidance covering the management of the painful deformed great toe, including the roles of primary, intermediate and secondary care. The guide was sponsored by the British Orthopaedic Foot & Ankle Society, British Orthopaedic Association (BOA), Royal College of Surgeons of England (RCS Eng) and the process was accredited by NICE. https://www.boa.ac.uk/uploads/assets/8ccdae1a-c9ce-4938-8f7c61747f33f752/painful%20deformed%20great%20toe.pdf).
Responsibility of the GP	The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm that there has been adequate medical management of underlying conditions and it has not resolved the underlying condition • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes • Surgery must not be undertaken for prophylactic or cosmetic reasons.

2.7 Skin

2.7.1 Tattoo Removal – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Tattoo Removal
Policy and Minimum eligibility criteria	The SPPG does not commission the removal of tattoos unless the following criteria are met: • The tattoo cannot be concealed in a person's normal daily life, **and either** • The tattoo may put the patient's life or health at risk, **or** • The tattoo was inflicted without the patient's valid consent. Tattoo removal is not routinely commissioned for aesthetic or cosmetic purposes.
Rationale	Tattooing is becoming increasingly popular and as people change their minds about their body art or, in some cases, where it prevents them from achieving a desired life goal, then the demand for tattoo removal will also increase. There are very few clinical reasons for removing a tattoo and this procedure is therefore considered predominantly aesthetic and not routinely commissioned.
Responsibility of the GP	The GP must provide significant clinical information to confirm that in the GP'S opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.7.2 Botulinum Toxin A (Botox) for primary hyperhidrosis (excessive sweating) in adults – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Botulinum Toxin A (Botox) for primary hyperhidrosis (excessive sweating) in adults
Policy and Minimum eligibility criteria	The SPPG will commission Botox for primary hyperhidrosis in adult providing the following criteria are met: • Occurs in at least ONE of the following sites: axillae, palms, soles, or craniofacial region **AND** • Has lasted at least six months **AND** • Has no apparent cause **AND** • Hyperhidrosis Disease Severity Scale (HDSS) Score of 3 of 4. *Botox will not be made available for treatment of facial ageing or excessive wrinkles.
Rationale	Botulinum A Toxin is only licenced for use in severe axillary hyperhidrosis that is inadequately managed by/unresponsive to topical agents. Trials have shown it to be an effective treatment for axillary hyperhidrosis. However it has a limited duration of effectiveness, with trial data suggesting it wanes in the majority of people between 6 and 24 months. This means that they require repeated treatments of multiple injections of what is a relatively expensive drug. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide significant clinical information to confirm that in the GP'S opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result. • The information should be recorded appropriately for future audit purposes.

2.7.3 Dermatological Laser Treatment – New Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Dermatological laser treatment
Policy and Minimum eligibility criteria	The SPPG will commission dermatological laser treatments providing all the following criteria are met. SPPG will fund laser treatment of facial conditions that are symptomatic or are so severe they are the first thing noticeable about a patient from any distance. This will be judged using the Ulster Dermatology Group (UDG) grading system. For asymptomatic lesions to be eligible for treatment they must be UDG grade 5 (definition of UDG 5 is very severe, first thing visible/strikes observer when looking at the patient from any distance). **Benign Skin Lesions and Scarring (including acne scarring) Treated By Laser** SPPG will only commission laser treatment of benign skin lesions, including scarring, if it is symptomatic (infected) or if it is **UDG grade 5**. SPPG will fund a maximum of one course of six session treatment. **Birthmarks (including capillary haemangioma, congenital melanocytic naevi and naevus of Ota)** SPPG will commission laser treatment of suitable birthmarks if they are symptomatic or are **UDG grade 5.**
Rationale	Lasers can be used to improve the general appearance of skin, remove hair, tattoos and other pigmented lesions. The SPPG does not commission cosmetic treatments including dermatological laser treatments. When a patient's condition is so severe, the treating dermatologist believes laser treatment should be provided, an appeal should be made. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.
Responsibility of the GP	The GP must provide significant clinical information to confirm that in the GP'S opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm there has been adequate medical management of underlying conditions and it has not resolved the underlying condition • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.7.4 Hair Removal – No Change to 2006 Policy

Procedure Commissioned in Special Circumstances	
Intervention	Hair Removal
Policy and Minimum eligibility criteria	The SPPG will commission treatment for hair removal providing one of the following criteria are met: • Following reconstructive surgery leading to abnormally located hair-bearing skin **OR** • The patient is undergoing treatment for pilonidal sinus, to reduce recurrence **OR** • The patient has an underlying endocrine abnormality resulting in hirsutism (e.g. polycystic ovary syndrome - PCOS) **and** • If it causes facial disfigurement where "a reasonable person would be unable to tolerate the abnormality in appearance". HSCNI only fund a maximum of 6 sessions of hair removal treatment. *(Note: there is a separate policy for patients undergoing Gender Reassignment Surgery)*
Rationale	There are a number of ways to remove or disguise excess hair. As these are considered 'cosmetic' treatments to improve physical appearance, they are unlikely to be funded routinely by the NHS. The procedure is considered as being of limited clinical value. Patients concerned with appearance of their body and facial hair should be advised about managing their condition through conservative methods including shaving, waxing, and depilatory creams although such treatments are also not routinely commissioned or funded.
Responsibility of the GP	The GP must provide significant clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant must: • Confirm there has been adequate medical management of underlying conditions and it has not resolved the underlying condition • Confirm and record that the patient meets the other criteria • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.7.5 Removal of Clinical Benign Skin Lesions and Lipomata (fatty lumps) Not Treated By Laser – Updated Criteria

Procedure Commissioned in Special Circumstances	
Intervention	Removal of clinically benign skin lesions and Lipomata (fatty lumps) Not Treated By Laser
Policy and Minimum eligibility criteria	The SPPG will commission the removal of benign skin lesions/lumps providing all the following criteria are met: • The lesion is infected and not responding to non-invasive topical treatment. • The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this **OR** • This results in infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year **OR** • The lesion is obstructing an orifice or impairing field vision **OR** • The lesion significantly impacts on function e.g. restricts joint movements **OR** • Greater than 1 cm facial lesions that cause significant disfigurement **OR** • Congenital deformity (this does not include normal variation). **Lipomas** • The lipoma is causing symptoms and/or functional impairment that can be directly attributed to the lipoma **OR** • The lipoma is growing rapidly **OR** • The lipoma is located in an abnormal position e.g. under muscle • Lipomas that are under 5cms should be observed only unless the above applies. The SPPG expects that where there is expertise the lipomata/lesion will be removed in primary care. Any lipomata/lesion that are considered for removal in secondary care should first be assessed for their suitability for removal as an out-patient procedure, if that is not appropriate then it should be a day case procedure.
Rationale	Skin lesions are common. It is important that the lesion is appropriately examined to establish it is benign. Benign skin lesions include a wide range of skin disorders such as sebaceous cyst, dermoid cyst, skin tags, hirsutism, milia, molluscum, contagiosum, seborrhoeic keratosis (basel cell papillomata), spider naevus (telangiectasia), warts, xanthelasma, dermatofibromas, benign pigmented moles, comedones, and corn/callous. Lipoma are benign lumps of fat tissue. Many do not cause symptoms and therefore do not require removal for clinical reasons. Occasionally they do cause symptoms. Only commissioning within the above criteria will ensure that patients who will get the most clinical benefit can access services.

Responsibility of the GP	This policy only applies to benign skin lesions. If the GP assesses the lesion as suspicious of cancer then the patient should be referred for assessment through the appropriate pathway. If there is diagnostic uncertainty, skin lesions should be referred to the appropriate service for further assessment. If the GP is considering removal of lipoma/lesion they should document that the patient meets the criteria for removal as set out above. The GP must provide sufficient clinical information to confirm that in the GP's opinion the patient meets the minimum criteria set out above. Referrals that do not provide this information will be returned. Referrals will not be accepted for patients who do not meet the criteria.
Responsibility of the consultant	The consultant should: • Confirm that the lesion is benign • Assess the extent of the problems that the patient attributes to the lesion • Assure themselves that there is a functional problem and that problem can reasonably be attributed to the lesion • Advise the patient of the likely final result • The information should be recorded appropriately for future audit purposes.

2.8 Urological Genitary Problems

2.8.1 Labioplasty (Labial Reduction) and FGCS – New Criteria

Not Commissioned	
Intervention	Labiaplasty (labial reduction) and FGCS
Policy and Minimum eligibility criteria	The SPPG does not commission labiaplasty or other forms of Female genital cosmetic surgery (FGCS). *(Note: there is a separate policy for patients undergoing Gender Reassignment Surgery)*
Rationale	The Royal College of Gynaecologists (RCOG) have said that providing labiaplasty for cosmetic reasons alone is not a proper use of public resources and should not be provided by the NHS. The British Society Paediatric and Adolescent Gynaecology (BSPAG) have said FGCS should not be performed on girls under 18 years of age.
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must: • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

2.8.2 Reversal of Sterilisation Female – New Criteria

Not Commissioned	
Intervention	Reversal of Sterilisation (Female)
Policy and Minimum eligibility criteria	The SPPG does not commission reversal of sterilisation in women.
The procedure	Reversal of sterilisation is a surgical procedure to reconstruct fallopian tubes that have been interrupted by a previous sterilisation procedure.
Rationale	Sterilisation is a permanent method of contraception. It is commissioned by the SPPG when the woman (and her partner if appropriate) and her consultant consider it to be the appropriate method for her. The RCOG guidance should be followed when sterilisation is done, in particular the guidance on fully advising and counselling the patient that the procedure is intended to be permanent. In addition the consultant should advise the patient that the SPPG do not commission reversal of sterilisation. Pregnancy rates after reversal of sterilisation vary and are dependent on the type of procedure done, the length of time since the procedure, the age of the women and surgical expertise. There is a significantly lower pregnancy rate in women who have a reversal more than eight years after the original operation, compared with women who are less than eight years post-op. Reversal of sterilisation is not usually routinely commissioned by English PCTs.
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must: • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

2.8.3 Reversal of Sterilisation (Vasectomy Male) – New Criteria

Not Commissioned	
Intervention	Reversal of sterilisation (Vasectomy) (Male)
Policy and Minimum eligibility criteria	The SPPG does not commission male reversal of sterilisation.
Rationale	Male sterilisation is also known as vasectomy. Reversal of vasectomy is a surgical procedure to reconstruct the vas deferens that has been interrupted by a previous sterilisation procedure. Sterilisation is a permanent method of contraception. It is commissioned by the SPPG when the man (and his partner if appropriate) and his consultant consider it to be the appropriate method for him. The RCOG guidance should be followed when vasectomy is done, in particular the guidance on fully advising and counselling the patient that the procedure is intended to be permanent. In addition the consultant should advise the patient that the SPPG do not commission reversal of vasectomy. Pregnancy rates after reversal of vasectomy vary and are dependent on the type of procedure done, the length of time since the procedure and surgical expertise. Reversal of vasectomy is not routinely commissioned by English PCTs.
Responsibility of the GP	Referrals will not be accepted for this procedure unless there is evidence of exceptionality.
Responsibility of the consultant	The consultant must: • Not undertake these procedures unless exceptionality has been demonstrated and approved by the SPPG panel.

3.0 Freedom of Information Act 2000 – confidentiality of consultations

The Health and Social Care Board (SPPG) will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The SPPG can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the SPPG in this case. This right of access to information includes information provided in response to a consultation. The SPPG cannot automatically consider as confidential, information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances.

The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- the SPPG should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the SPPG functions and it would not otherwise be provided;
- the SPPG should not agree to hold information received from third parties "in confidence" which is not confidential in nature;
- acceptance by the SPPG of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses, please contact the Information Commissioner's Office (or see website at: http://www.informationcommissioner.gov.uk/).

GLOSSARY

A&E	**Accident & Emergency**
BMI	**Body Mass Index**
BSPAG	**British Society Paediatric & Adolescent Gynaecology**
CCG	**Clinical Communications Gateway**
DHSSPS	**Department of Health, Social Services and Public Safety**
DVT	**Deep Vein Thrombosis**
DoH	**Department of Health**
DIP	**Distal Interphalangeal Joints**
EUR	**Effective Use of Resources**
FGCS	**Female Genital Cosmetic Surgery**
GP	**General Practitioner**
GIRFT	**Getting It Right First Time**
HSC	**Health and Social Care**
SPPG	**Health and Social Care Board**
HDSS	**Hyperhidrosis Disease Severity Scale**
LCG	**Local Commissioning Group**
MTP	**Metatarsophalangeal Joint**
MDT	**Multi-disciplinary Team**
NHS	**National Health Service**
NICE	**National Institute for Health & Care Excellence**
NSAIDs	**Non-Steroidal Anti-inflammatory Drugs**
OSA	**Obstructive Sleep Apnoea**
OME	**Otitis Media with Effusion**
OP	**Out Patient**
PAS	**Patient Administration System**
PIP	**Poly Implant Prosthesis**

PCTs	**Primary Care Trusts**
PHA	**Public Health Agency**
PE	**Pulmonary Embolism**
RCOG	**Royal College of Gynaecologists**
SIGN	**Scottish Intercollegiate Guidelines Network**
UDG	**Ulster Dermatology Group**