NHS
Wakefield
Clinical Commissioning Group

NHS Wakefield CCG
Commissioning Policy

Version: 3.7

Committee Approved by: Quality, Performance & Governance Committee

Date Approved: 27 May 2021

Author: Simon Rowe, Head of Contracting & Interim Head of Acute Commissioning

Responsible Directorate: Finance, Strategy and Commissioning

Date issued: 15 June 2021

Review date: 27 November 2021

CONTENTS

Review and Amendment Log / Version Control Sheet 5

1 Introduction 8

2 Scope of the Policy 8

2.1 Aims and Objectives 9

2.2 Legal Context 10

2.3 Commissioning Principles 10

2.4 Application of the Policy 10

2.5 Adherence to this Policy 11

3 Applying this Policy 11

3.1 The circumstances for funding particular types of care 11

3.2 Access to specific treatment interventions 11

3.2.1 Exceptionality 12

3.2.2 Other 12

3.2.3 The Individual Funding Request (IFR) Process 14

3.3 Accountability and Monitoring 15

4 Equality and Quality Impact Assessments 16

5 Implementation and Dissemination 16

6 The Funding of Particular Types of Care 16

6.1 Patient Transport 16

6.2 Continuing Care, Continuing Healthcare and Funded Nursing Care 17

6.3 Reimbursement of Living Donor Expenses 18

6.4 Overseas Care 18

6.4.1 European Economic Area - Travelling 18

6.4.2 European Economic Area (EEA) – Planned Treatment 19

6.4.3 Countries Outside of the EEA 20

6.4.4 Commissioning of Services for Overseas Visitors and Asylum Seekers 20

6.4.5 Failed Asylum Seekers 21

6.4.6 Overseas Visitors Exempt from Charges, Including Refugees, Asylum Seekers and Children in Care 22

7 Clinical Commissioning Policies 22

7.1 Evidence Based Interventions 22

7.2 West Yorkshire and Harrogate Health and Care Partnership clinical commissioning policies 25

7.3 NHS Wakefield CCG clinical commissioning policies 26

7.3.1 ABDOMINOPLASTY 26

7.3.2 PROCEDURES TO TREAT ACNE SCARRING 29

7.3.3 ALLERGY TREATMENTS 31

7.3.4 BLEPHAROPLASTY 32

7.3.5 BODY CONTOURING PROCEDURES 34

7.3.6 BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS 36

7.3.7 SURGERY TO CORRECT BREAST ASYMMETRY 38

7.3.8 BREAST AUGMENTATION 40

7.3.9 BREAST AUGMENTATION (REVISION OF) 42

7.3.10 MASTOPEXY 44

7.3.11 BREAST REDUCTION FOR GYNAECOMASTIA (MALE) 46

7.3.12 CIRCUMCISION (FOR SOCIAL, RELIGIOUS OR CULTURAL REASONS) 49

7.3.13 COMPLEMENTARY AND ALTERNATIVE THERAPIES 51

7.3.14 PROCEDURES FOR CONGENITAL VASCULAR SKIN LESIONS 53

7.3.15 DIAGNOSTIC FIBREOPTIC ENDOSCOPIC EXAMINATION FOR RECTAL BLEEDING - UNDER 45 YEARS 55

7.3.16 REPAIR OF EXTERNAL EAR LOBES 58

7.3.17 FACIAL PROCEDURES (FACE LIFT/BROW LIFT) 59

7.3.18 FUNCTIONAL ELECTRICAL STIMULATION (FES) 61

7.3.19 HAIR REMOVAL 63

7.3.20 HAIR REPLACEMENT/CORRECTION OF MALE PATTERN BALDNESS 65

7.3.21 SURGERY FOR HALLUX VALGUS 67

7.3.22 HERNIA REPAIR 71

7.3.23 IN VITRO FERTILISATION (IVF) – INFERTILITY TREATMENT 76

7.3.24 LABIAPLASTY 77

7.3.25 LIPOSUCTION 79

7.3.26 LYCRA GARMENTS 81
7.3.27 MRIs- UPRIGHT/OPEN/WIDE BORE 83
7.3.28 SURGICAL CORRECTION OF BENIGN NIPPLE INVERSION 88
7.3.29 PINNAPLASTY 90
7.3.30 REVERSAL OF VASECTOMY AND FEMALE STERILISATION 92
7.3.31 SURGICAL/LASER TREATMENT OF RHINOPHYMA 94
7.3.32 RHINOPLASTY/SEPTORHINOPLASTY 96
7.3.33 SPINAL CORD STIMULATION 99
7.3.34 SPINAL INJECTIONS (THERAPEUTIC) FOR PAIN 104
7.3.35 SURGICAL SCAR REVISION/KELOIDECTOMY 108
7.3.36 SURROGACY 110
7.3.37 TATTOO REMOVAL 112
7.3.38 TREATEMENT FOR THREAD VEINS/TELANGIECTASIAS 114
Appendices 116
Appendix A: Equality and Quality Impact Assessment 116
Appendix B: Individual Funding Request Form 119
Appendix C: List of Complementary / Alternative Therapies 124
Appendix D: Yorkshire and Humber Access to Infertility Treatment Policy 127

Review and Amendment Log / Version Control Sheet

Responsible Officer:	Head of Contracting
Clinical Lead (where appropriate):	Clinical Lead for Planned Care
Author:	Simon Rowe, Head of Contracting & Interim Head of Acute Commissioning
Date Approved:	27 May 2021
Committee:	Quality, Performance & Governance Committee
Version:	3.7
Review Date:	27 November 2021

Version History

Version no.	Date	Author	Description	Circulation
1.0	10th May 2018	Phil Smedley	DRAFT V1	
2.0	6th July 2018	Phil Smedley	V2.0 Includes amendments to commissioning principles Amended NK IFR process included Amended criteria for back pain injections included	
2.1	12th July	Phil Smedley	V2.1 Format amendments	

3.0	13th July	Phil Smedley	Draft v3 Amended to Wakefield CCG only	
3.1	13th May 2019	Phil Smedley	V3.1 Amended to include National Evidence Based Interventions (Joint Committee approved Jan 2019)	
3.2	15th May 2019	Phil Smedley	V3.2 Updated to reflect alignment with North Kirklees IFR criteria. (IGC approved Dec 2018)	
3.3	16th May 2019	Phil Smedley	V3.3 Updated to reflect process change to use of Value Based Checker for prior approvals and IFR	
3.4	17th May 2019	Phil Smedley	V3.4 Updated to include Spinal policies (Joint Committee approved Mar 2019)	
3.5	3rd July 2019	Phil Smedley	V3.5 Updated to include Obesity Surgery (Joint Committee approved May 2019)	
3.6	9 July 2020	Simon Rowe	V3.6 Update to include the revised Access to	

			Treatment Policy (Quality Performance & Governance Committee approved May 2020)	
3.7	12th August 2020	Simon Rowe	V3.7 Re-write of all sections (with edit) prior to the clinical polices. Removal of all clinical policies for review and edit.	

1 Introduction

The Policy details, for the NHS Wakefield Clinical Commissioning Group ("the CCG"), where there are criteria to define the circumstances within which its patient population[1] may obtain specific types of healthcare.

Such criteria are only in-place by exception, within some of the areas of healthcare that the CCG is legally responsible for. Each criterion results from a national/regional/local NHS decision that there should – on the grounds of clinical value/cost-effectiveness - be a qualification to inform when a particular type of care/treatment can be sought. The criteria within this Policy may either define the eligible circumstances for accessing the funding for a particular type of care, or they may define a set of circumstances to ensure that an individual patient will gain a given benefit before they receive a particular clinical treatment.

2 Scope of the Policy

The CCG is responsible for the commissioning of specific types of healthcare on behalf of its patient population. The areas of healthcare that the CCG is responsible for commissioning – as defined within the standing rules for NHS Clinical Commissioning Groups - include:

- Community health services
- Maternity services
- Elective hospital care
- Rehabilitation services
- Urgent and emergency care including A&E, ambulance and out-of- hours services
- Older people's healthcare services
- Healthcare services for children
- Healthcare services for people with mental health conditions
- Healthcare services for people with learning disabilities
- Continuing healthcare
- Abortion services
- Infertility services
- Wheelchair services
- Home oxygen services
- Treatment of infectious diseases

Commissioning is the act of assessing what healthcare is required for a given population, and then being able to fund service providers to deliver this. For the CCG this concerns the needs of the patients who reside within the boundaries of the General Practices within its membership, and a fixed financial budget from NHS England.

[1] This includes individual patients who are registered to a General Practice member of the CCG, and unregistered patients, who reside within the boundary areas of its member General Practices.

The CCG has a statutory duty to ensure that the commissioning decisions it takes are commensurate to the needs of its patient population, resulting in high quality, cost-effective healthcare. Inevitably – within such a process - the CCG has to assess, and make decisions, on behalf of its patient population, concerning the cost-effectiveness (and value) of specific types of care and treatment.

The scope of this Policy is therefore to define – for the healthcare that the CCG is responsible for commissioning – where there are criteria in-place to ensure the cost-effectiveness (and value) of specific types of care and treatment.

To support its decisions on the cost-effectiveness of healthcare, the CCG engages with stakeholders at national, regional and local levels.

The CCG:

- Works to inform, and to implement criteria that is directed from NHS England;
- Works regionally, within the West Yorkshire Integrated Care System, to develop common criteria across Clinical Commissioning Groups; and,
- Works with local clinicians and patients within its population to agree criteria.

2.1 Aims and Objectives

The aims of this Policy are:

To clearly define the criteria that govern how the CCG's patient population may obtain specific types of healthcare;

To direct how the criteria should be adhered to by clinicians and providers contracted to the CCG to deliver healthcare to the CCG's patient population; and,

Should the criteria not be met, to direct how individual cases can be subsequently reviewed by the CCG to determine if there is an exception reason for a patient to access a particular type of care/treatment.

The subsequent objectives of the Policy are:

- To demonstrate how the CCG acts within its statutory duties and powers when setting criteria for the accessing of healthcare;
- To demonstrate that the criteria set within the Policy result from evidence-based decisions;
- To ensure that any decision taken, when assessing a patient's exceptionality to access a type of care/treatment, is made on the best available evidence at the time of consideration;
- To ensure there is equity of access to services, interventions and treatments for all the CCG patient population.

2.2 Legal Context

This Policy is able to define to any single patient why their access to a particular type of care/treatment has, or has not, been supported by the CCG.

This Policy clearly defines where criteria exist for the CCG's patient population to be able access to a particular type of care/treatment, and why such criteria exist.

2.3 Commissioning Principles

The CCG's setting of criteria - as detailed in this Policy - follows its process for the commissioning of healthcare. Such a process - and the CCG's setting of the criteria within this Policy - is directed by the following principles:

- Healthcare commissioning should seek to achieve the greatest possible improvement in health outcomes for the patient population of the CCG within the resources available;
- Healthcare interventions that produce the greatest benefits for patients in terms of both clinical improvement and improvement in quality of life should be prioritised;
- The commissioning of care/treatment should be from a proven clinical effectiveness, securing the greatest possible health gain from available resources;
- The commissioning of care/treatment should provide services that are safe and offer good positive experiences for patients and their carers;
- Healthcare commissioning should be committed to ensuring that there is equitable access to services for the patient population of the CCG.

2.4 Application of the Policy

The criteria described in this Policy apply to all staff (clinical and non- clinical) who are involved in any way with the commissioning, authorising of treatments or proposed clinical interventions commissioned by the CCG.

This Policy must be followed by all staff who are employed by the CCG including those on temporary, fixed-term or honorary contracts, secondments, pool staff and students. It must also be followed by any organisation contracted to commission, authorise or administer healthcare on behalf of the CCG.

Both referrers (including GP practices) and provider organisations are expected to adhere to the principles, criteria and policies set out in this Policy. Any service requested or provided outside of the funding criteria set out in this policy will be undertaken at the risk of the respective organisation.

2.5 Adherence to this Policy

It is the responsibility of the CCG to ensure that the adherence to this Policy is known, and acted upon, where necessary. In fulfilling this responsibility the CCG shall, on an annual basis, define the approach(es):

- It has taken to support the adherence to this Policy among clinicians and healthcare managers; and,
- It will use to monitor and review the adherence, among clinicians and healthcare managers, to this Policy.

3 Applying this Policy

This Policy defines the circumstances in which criteria have to be met before an individual patient, within the CCG's patient population, can obtain a stated area of healthcare.

Within the introduction to this Policy a distinction was made between:

- The criteria that are listed within the Policy to define the circumstances by which funding for a particular type of care may be accessed; and
- The criteria that are within the Policy to describe the circumstances that have to be met before a specific treatment intervention may be provided to a patient.

The application of this Policy will be specific to each of these.

3.1 The circumstances for funding particular types of care

This concerns the following:

- Patient transport;
- Continuing Care, Continuing Healthcare and Funded Nursing Care;
- Reimbursement of Living Donor Expenses;
- Commissioning of Services for Overseas Visitors and Asylum Seekers.

Subsequent sections of this Policy provide the criteria that define what shall be followed for each of these areas of care.

3.2 Access to specific treatment interventions

This concerns two broad categories.

The first of these is when an individual patient does not meet in full the criteria for a treatment intervention that is stated within this Policy. In such an event then the concerned clinician, in conjunction with the affected individual patient, has the right to apply to the CCG on the grounds of exceptionality – to make a case as to why the stated area of healthcare should be provided to the individual.

This shall be through the Individual Funding Request (IFR) process, which is described within this Policy.

The IFR process shall also be available for a number of other circumstances. These circumstances – as listed below – are wide-ranging in their nature.

The second of the two categories is therefore composed of these circumstances:

High Cost Drugs
Introduction of New Drugs or Treatments
Restricted Treatments
Rare Conditions
Drug Trials
Continuing Private Care
Inheriting decisions from other Clinical Commissioning Groups
Retrospective Payment
Co-payment
Patient Safety

3.2.1 Exceptionality

The CCG, as the responsible body for this Policy, shall consider an individual patient, who has not met in full the criteria for a treatment intervention stated within it, to have the grounds of exceptionality to it, when a case by a referring clinician can evidence:

- That the individual patient has demonstrated exceptional clinical circumstances in comparison to the cohort of other patients with the same clinical condition. (The patient is significantly different to the general population of patients with the condition in question who would normally be refused treatment.)
- That it is likely that the requested treatment will be clinically effective and there are good grounds to believe the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition.

In general, the CCG must justify the grounds upon which they are choosing to fund treatment for a patient when the treatment is unavailable to others with the condition.

3.2.2 Other

For the set of circumstances listed under section 3.2 a case may be made by the clinician concerned through the IFR process.

The following guidance should also be taken into account by the clinician concerned when they are considering making a case to the IFR process.

High Cost Drugs: Individual Funding Requests for high cost drugs. On receiving a request for high cost drug treatment the screening panel will

consider available evidence based reviews to inform the decision-making process. The request will also, be reviewed by a Medicines Management Representative to provide key information that should be considered. A representative from Medicines Management will attend the screening panel to present any information and discuss these cases as required.

Introduction of New Drugs or Treatments: Consideration of new drugs/treatments should be referred into established planning frameworks but a decision should be made as to whether an interim commissioning policy is needed to enable the clinician/patient to access treatment.

Restricted Treatments: Treatments not included in existing pathways are not routinely funded but policy statements on restricted treatments are available. Individual Funding Requests can be considered in relation to these restricted treatments to assess whether the request fits the criteria or if exceptional circumstances exist.

Rare Conditions: NHS England has the responsibility for commissioning treatments for many rare conditions as set out in the Specialised Services Manual and accompanying documents. The CCG will be the responsible commissioner where NHS England is not responsible for commissioning the service. These patients are unlikely to have treatment options covered by NICE guidance or commissioning policies and therefore, Individual Funding Requests should be considered against the commissioning principles.

Drug Trials: The CCG will not usually provide funding for individuals coming off drug trials unless prior agreement has been obtained before commencement of the trial. In accordance with the Medicines Act (2004) responsibility for an exit strategy from a trial lies with those conducting it (NHS Confederation, 2008b).

Continuing Private Care: Funding for individuals to continue care purchased privately, where an individual has exhausted their own resources or chosen to terminate a private arrangement, will not routinely be funded by the CCG. Applications for funding can be considered via the funding request process in the usual way.

Inheriting decisions from other Clinical Commissioning Groups: Patients moving into the CCG area and registering with a GP in that CCG area, become the responsibility of the CCG and therefore decisions for treatment already agreed by the previous Clinical Commissioning Group would normally be upheld as long as it is consistent with the principles in this policy and the Department of Health publication “Establishing a Responsible Commissioner”.

Retrospective Payment: The CCG would not support applications for patients who have paid for private treatment and then ask for reimbursement of these costs from the CCG because prior approval for funding should have been sought through the IFR process outlined in this policy.

Co-payment: Patients who pay for some aspects of treatment while being treated in the Public Sector. The NHS Act (2006) does not allow for recovery

of charges for healthcare and the Code of Conduct for Private Practice: Guidance for NHS Medical Staff (2003) states that patients wishing to become private patients cannot be treated as both a private and NHS patient during the same visit to an NHS Organisation. The government's current position is to rule out co-payment and it is recommended that CCGs follow this guidance because it would provide access to a treatment that the CCG were not making available to others (NHS Confederation, 2008b).

Patient Safety: The CCG have a responsibility for patient safety when being treated in healthcare settings. The Care Quality Commission (CQC) governs the suitability of providers of NHS services and therefore patients should only be referred to providers registered with the CQC.

3.2.3 The Individual Funding Request (IFR) Process

Appendix B provides the Prior Approval Funding Request Form that requires completion for any circumstance outlined in sections 3.2.1 and 3.2.2 of this Policy. The only exception to this is when an alternative pro forma is available from individual Hospital Trusts requesting high cost drugs for individual patients.

The completed form should be sent to NHS Kirklees CCG IFR Team:

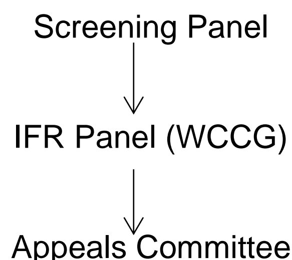
IFR Manager
Individual Funding Requests Team
NHS Kirklees Clinical Commissioning Group
Broad Lea House
Bradley Business Park
Dyson Wood Way
Bradley
Huddersfield
HD2 1GZ

Telephone: 01484 464438

Email: KIRKCCG.IFR-CKW@nhs.net

Safe Haven Fax: 01484 464062

There will be three stages to the IFR process



3.3 Accountability and Monitoring

Accountability and Responsibilities

The Chief Officer and Governing Body of the CCG are accountable for the discharge of CCG statutory duties and have a scheme of delegation in place that is set out in the CCG standing orders and standing financial instructions.

CCG Leads

The Lead Manager with the day-to-day responsibility for this maintenance of this Policy is Simon Rowe, Head of Contracting & Interim Head of Acute Commissioning.

Committee Accountability

Overall responsibility for the development and implementation of this policy and its procedures remain with the CCG Governing Body. There is an annual report which is made available to the Quality, Performance and Governance Committee and reported formally to the Governing Body of the CCG to enable them to:

- Ensure the systems in place are sufficient to meet patients' needs;
- Ensure that decisions made throughout the process are consistent and appropriate;
- Ensure positive health outcomes are being achieved as a result of the decisions made.

Delegated Responsibilities

Kirklees CCG is the host commissioner for the implementation of the Individual Funding Request process on behalf of the CCG.

Responsibility for decision making regarding Individual Funding Requests on behalf of the CCG has been delegated by the Governing Body of the CCG to:

- The IFR Panel for Wakefield CCG

Responsibility for Policy Review

The CCG formal clinical decision-making forums are responsible for the formal approval and ratification of this Policy on an annual basis to ensure continued relevance and applicability to the 5-year vision. An evidence base approach to reviewing all clinical criteria referenced within the Policy will be adopted.

The formal Clinical Decision-making forums are also responsible for recommending the approval of newly developed clinical criteria.

4 Equality and Quality Impact Assessments

The CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This policy is not intended to discriminate against any group or individual on the grounds of ethnicity, gender, age, disability, sexual orientation or religion/belief.

The CCG has a duty to conduct an Equality and Quality Impact assessment for this Policy. The completed assessment can be found in Appendix A.

5 Implementation and Dissemination

As part of the annual review and implementation process, this Policy will be shared with the CCG Locality Networks, the Local Medical Committees (LMCs), Local Optical Committees, the Local Authorities, Mid-Yorkshire Hospitals NHS Trust and all other service providers directly commissioned by the CCG.

This policy will be disseminated via the CCG intranet and website. Written copies will be made available to any member of the public on request made via the CCG's switchboard on **01924 213050**, or via the 'Contact Us' link on the CCG's website.

6 The Funding of Particular Types of Care

6.1 Patient Transport

The CCG commissions transport services in line with the terms and conditions set out in the Department of Health (DH) paper Healthcare Travel Costs Scheme – Instruction and guidance for the NHS.

DH guidelines state patients are eligible to use patient transport where their medical problems would be made worse if they used another means of transport such as a bus, taxi or their own vehicle to get to hospital or they suffer with severe mobility problems. Eligibility for transport services will be assessed against the criteria by the referring clinician at the time of the request for transport. Escorts are allowed to use patient transport with a patient who is under the age of 16 or with an adult who has been assessed as vulnerable.

6.2 Continuing Care, Continuing Healthcare and Funded Nursing Care

Continuing Care (CC) is defined as care provided over an extended period of time to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness. Continuing Healthcare (CHC) means a package of continuing care that is arranged and funded solely by the NHS.

Funded Nursing Care (FNC) is the element of care a person receives in a care home from a qualified nurse which is funded by the NHS at a nationally determined rate.

Eligibility for CC, CHC and FNC is determined by national criteria using processes and tools which are specified in the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2012b).

Eligibility is determined by need and not by diagnosis. The CCG are responsible for determining a patient's eligibility. Assessments may be undertaken by professionals within other organisations and recommendations made, but the final decision rests with the CCG as the commissioning organisation.

Eligibility will only be considered once an individual has become clinically stable and has reached their full potential. If a patient is in need of further treatment or rehabilitation, then their eligibility for CC, CHC or FNC will not be considered.

All assessments will be made with the full involvement of the individual and / or their representatives.

An individual may also cease to be eligible. This will be determined by a review of their health needs. If a patient is found to no longer be eligible, then the NHS will not continue to fund this care. The patient (and/or their representative) will be given 28 days' notice that funding will be withdrawn.

Every effort will be made to work with eligible patients to provide a package of care or placement which will meet identified need. Patient preferences will be taken into account. A final decision however, on both the service provider(s) and content of a package or placement lies with the CCG.

An individual is entitled to ask for a review of a decision made on their eligibility. This will be addressed in accordance with the National Framework and local policy. The CCG will consider each request individually via the Continuing Care Commissioning team (not through complaints processes). Where it is decided that eligibility will not be reviewed, a full explanation will be provided in writing.

Occasions may arise where a patient is transferred from an acute hospital setting into a care home bed on a temporary basis fully funded by the NHS. Unless an assessment for CHC eligibility has been undertaken, then the patient should not be considered as a CHC patient.

6.3 Reimbursement of Living Donor Expenses

The Human Tissue Act 2004 and the Human Tissue (Scotland) Act 2006 forbid the offer or payment of any inducement for the supply of a human organ. However, it does not prohibit payment of reasonable expenses to a donor for travel and accommodation and any loss of earnings incurred, if directly attributable to his/her donation of an organ.

The purpose of discretionary reimbursement is to ensure that loss of earnings or other financial disincentives does not act as a constraint on individuals wishing to act as a live transplant donor.

DH guidance states the reimbursement of living donor expenses is permitted and should be so if the live transport is permitted under the Human Tissue Act. The NHS is not legally obliged to do so, but as a live donor transplant is an option for some patients (e.g. in liver failure), payment of the cost of the donor operation and any associated donor expenses is justified.

The CCG will consider reimbursement in line with the NHS England Commissioning policy: Reimbursement of expenses for living donors.

6.4 Overseas Care

The CCG follows national policy in relation to overseas care. Please note that any changes to national policy will supersede the below.

6.4.1 European Economic Area - Travelling

The European Health Insurance Card (formerly known as E111) and the new UK Global Health Insurance Card

The European Health Insurance Card (EHIC) and, following the UK's exit from the European Union(EU), the new UK Global Health Insurance Card (GHIC) lets patients get state healthcare at a reduced cost or sometimes for free in EU countries. The EHIC and GHIC will cover patients for treatment that is needed to allow them to continue their stay until their planned return. They

also cover patients for treatment of pre-existing medical conditions and for routine maternity care, as long as they're not going abroad to give birth.

The EHIC and GHIS are valid in all EU countries, Iceland, Liechtenstein, Norway or Switzerland.

For more information about what is covered in each country see the government's country-by-country guide.

6.4.2 European Economic Area (EEA) – Planned Treatment

Department of Health Guidance, Cross Border Healthcare and Patient Mobility states that if a patient is eligible for NHS funded healthcare but plans to be treated in an EEA country, there are two ways to access NHS funding:

The S2 Route (Formerly E112)

This is a direct arrangement between the NHS and the state healthcare provider in the country of your choice. Prior approval is required.

The S2 (formerly E112) route entitles the patient to state-funded treatment in another European Economic Area (EEA) country or Switzerland. Treatment will be provided under the same conditions of care and payment as for residents of that country. This could mean the patient has to pay a percentage of the costs, however, the patient may be able to claim back some or all of the co-payment when they return to the UK.

In some countries, as in the UK, care is completely free. This means the S2 will cover 100% of the cost of care, so the patient would not be required to pay any treatment costs upfront.

The NHS would pay the treating country's contribution and the patient would be expected to pay the 'co-payment charge'. Reimbursement of this charge may be sought upon returning to the UK.

The EU Directive on Cross-Border Healthcare (or Article 56)

Generally, the patient will have to pay the costs of treatment abroad and then claim reimbursement from the NHS when they return. Depending on the treatment, it may be necessary to obtain authorisation from NHS England before receiving treatment. Types of services requiring prior authorisation are detailed in the List of the Prescribed Specialised Services Directly Commissioned by NHS England.

The EU Directive on cross-border healthcare (or Article 56) may allow a patient to obtain reimbursement of the costs of their procedure in an EEA country after paying the total cost of treatment up front.

Unlike using the S2, patients could receive this contribution to either private or state provided treatment. The treatment must be one that is available through

the NHS. Reimbursement can only be issued up to the cost of being treated locally under the NHS; there is no guarantee that a patient will receive funding.

For more information contact NHS England before arrangements are made abroad.

6.4.3 Countries Outside of the EEA

If the patient wants to be treated outside the EEA, the condition must be of a serious nature and the treatment requested must be established (not experimental), not available in the UK or the EU, and it must be likely to be of significant benefit to the patient's health. If it fulfills these criteria, the CCG will consider the request, but are not under any obligation to do so or to approve the application.

A case of this nature will be considered on an individual basis and should be submitted in line with the process outlined in the Individual Funding Request policy. Clinicians will need to demonstrate how best their patient meets the above criteria as part of the individual funding request.

6.4.4 Commissioning of Services for Overseas Visitors and Asylum Seekers

Charges to Overseas Visitors

Guidance on charges for NHS treatment and exemptions for people visiting the UK is given in the following legislation; 'The National Health Service (Charges to Overseas Visitors) Regulations 2011.' and the Guidance On Implementing the Overseas Visitors Hospital Charging Regulations.

NHS trusts have a legal obligation to identify and charge those people not entitled to free NHS hospital treatment under this legislation. NHS Trusts will make their decision in accordance with the legislation.

No charge may be made or recovered in respect of any relevant services provided to an overseas visitor which fall within the following:

a) Accident and emergency services, whether provided at a hospital accident and emergency department, a minor injuries unit, a walk-in centre or elsewhere, but not including any services provided:

    (i) After the overseas visitor has been accepted as an in-patient; or

    (ii) At an outpatient appointment;

b) Services otherwise than at, or by staff employed to work at, or under the direction of, a hospital;
c) Family planning services;

d) Treatment in respect of a disease listed in Schedule 1 of the above guidance;
e) Treatment for sexually transmitted infections, but in the case of services which relate to infection with Human Immunodeficiency Virus, only to the extent that they consist of a diagnostic test for evidence of infection with the Virus and counseling associated with that test or its result;
f) Services provided to an overseas visitor who is liable to be detained in a hospital or, received into guardianship under the Mental Health Act 1983 (7) '(the 1983 Act)' or any other enactment authorising detention in a hospital by reason of mental disorder, or subject to a community treatment order under the 1983 Act(8);
g) Treatment which is provided in circumstances where:

(i) A requirement to submit to the form of treatment concerned is imposed by, or included in, an order of a court; and

(ii) Paragraph (f) does not apply.

Further exceptions apply to the provision of NHS treatment to those that are not ordinarily resident in the UK as governed by the NHS (Charges to Overseas Visitors), Regulations 2011. Full details are available in the legislation but some specific areas are given below.

6.4.5 Failed Asylum Seekers

The CCG position on the entitlement of failed asylum seekers is in line with national guidelines 'The NHS (Charges to Overseas Visitors) Regulations 2011', as follows:

- Failed asylum seekers who have commenced a course of treatment without charge are to complete that course without charge (what constitutes a 'course of treatment' is a clinical decision);

- Treatment in A&E remains free of charge;

- Treatment which is immediately necessary, including all maternity treatment, must not be withheld, but Trusts are still obliged to seek recovery of their charges even when there is no prospect of payment being made;

- The obligation to charge for urgent and non-urgent treatment remains, but a Trust can exercise its discretion to choose to treat individuals who cannot or will not pay. Trusts can seek a deposit of the likely charge of the treatment required before the treatment is delivered.

6.4.6 Overseas Visitors Exempt from Charges, Including Refugees, Asylum Seekers and Children in Care

No charge may be made or recovered in respect of any relevant services provided to an overseas visitor who:

a) Has been granted temporary protection, asylum or humanitarian protection under the immigration rules made under section 3(2) (general provisions for regulation and control) of the Immigration Act 1971;

b) Has made an application, which has not yet been determined, to be granted temporary protection, asylum or humanitarian protection under those rules;

c) Is currently supported under section 4 or 95 of the Immigration and Asylum Act 1999; or

d) Is a child, taken into local authority care under the Children Act 1989.

7 Clinical Commissioning Policies

7.1 Evidence Based Interventions

The Evidence Based Interventions (EBI) Policy is the national policy relating to the commissioning of interventions which are clinically inappropriate or which are appropriate only when performed in specific circumstances, published by NHS England. The programme aims to prevent avoidable harm to patients, to avoid unnecessary operations, and to free up clinical time by only offering interventions on the NHS that are evidence-based and appropriate.

The programme uses clinical evidence provided by National Institute for Health and Care Excellence (NICE) guidelines, 'Choosing Wisely' recommendations, academic studies and local CCGs' work on Procedures of Limited Clinical Effectiveness (PoLCE) to identify interventions that should not be routinely commissioned or that should only be commissioned in specific clinical circumstances. The CCG is required to commission in line with these policies and compliance with the EBI programme is mandated through the NHS Standard Contract.

The full EBI programme guidance and policies can be found on the Academy of Medical Royal Colleges website.

Anaesthesia

Pre-operative electrocardiogram (ECG)

Pre-operative chest x-ray

Non Specialty Specific

Blood transfusion

Obstetrics and Gynaecology

Hysterectomy for heavy menstrual bleeding

Dilatation & curettage for heavy menstrual bleeding

Ophthalmology

Chalazia removal

Paediatrics and Child Health

Helmet therapy for treatment of positional plagiocephaly/brachycephaly in children

Cardiology

Troponin test

Exercise electrocardiogram (ECG) for screening for coronary heart disease

Diagnostic coronary angiography for low risk, stable chest pain

Liver function, creatinine kinase and lipid level tests (Lipid lowering therapy)

Dermatology

Removal of benign skin lesions

Breast Surgery

Breast reduction

ENT

Tonsillectomy for recurrent tonsillitis

Snoring surgery (in the absence of obstructive sleep apnoea)

Surgical intervention for chronic rhinosinusitis

Removal of adenoids for treatment of glue ear

Grommets for glue ear in children

Gastroenterology

Early endoscopic retrograde cholangiopancreatography (ERCP) in acute gallstone pancreatitis without cholangitis

Upper GI endoscopy

Repeat colonoscopy

Appropriate colonoscopy in the management of hereditary colorectal cancer

General Surgery

Repair of minimally symptomatic inguinal hernia

Haemorrhoid surgery

Cholecystectomy

Appendicectomy without confirmation of appendicitis

Musculo-skeletal (MSK)

Vertebral augmentation (vertebroplasty or kyphoplasty) for painful osteoporotic vertebral fractures

Trigger finger release in adults

Scans for shoulder pain and guided injections for shoulder pain

MRI scan of the hip for arthritis

Lumbar radiofrequency facet joint denervation

Lumbar discectomy

Knee MRI for suspected meniscal tears

Knee MRI when symptoms are suggestive of osteoarthritis

Knee arthroscopy for patients with osteoarthritis

Ganglion excision

Fusion surgery for mechanical axial low back pain

Dupuytren's contracture release in adults

Carpal tunnel syndrome release

Arthroscopic shoulder decompression for subacromial pain

Arthroscopic surgery for meniscal tears

Low back pain imaging

Injections for nonspecific low back pain without sciatica

Urology

Surgical intervention for benign prostatic hyperplasia

Surgical removal of kidney stones

Prostate-specific antigen (PSA) test

Cystoscopy for men with uncomplicated lower urinary tract symptoms

Vascular

Varicose veins

7.2 West Yorkshire and Harrogate Health and Care Partnership clinical commissioning policies

West Yorkshire and Harrogate Health and Care Partnership is an 'Integrated Care System'. It works in partnership with NHS organisations, councils, Healthwatch, charities and the community, voluntary & social enterprise sector to improve the health and wellbeing of local people.

A number of standardised commissioning policies have been agreed across the West Yorkshire and Harrogate, which means that access to health services, and the eligibility criteria for them, is the same for everyone, regardless of where they live in the region.

These commissioning policies reflect the most up-to-date clinical evidence, best practice and patient insight. Each commissioning policy, some patient information and any other relevant documents can be found on the West Yorkshire and Harrogate Health and Care Partnership website.

At the time of publishing the policies are as follows:

- Flash Glucose Monitoring
- Hydroxychloroquine and chloroquine retinopathy monitoring
- Liothyronine for the treatment of hypothyroidism
- Cataract surgery in adults
- Hip arthroscopy
- Hip replacement (arthroplasty)
- Knee arthroplasty (knee replacement for knee arthritis)
- Knee arthroscopy (keyhole surgery) for patients with osteoarthritis
- Shoulder pain referrals
- Routine referral for spinal surgery assessment
- Treatments for spine, ischaemic and neuropathic pain
- Obesity (bariatric) surgery for adults

7.3 NHS Wakefield CCG clinical commissioning policies

7.3.1 ABDOMINOPLASTY

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	NOT ROUTINELY COMMISSIONED
PROCEDURE/ TREATMENT	ABDOMINOPLASTY
ELIGIBILTY CRITERIA	Abdominoplasty/apronectomy is not routinely commissioned by the CCG for: • Cosmetic/aesthetic reasons, including stretch marks. • Psychological benefit without associated clinical need. Abdominoplasty/apronectomy may rarely be considered on an exceptional basis for the following groups of patients who should have achieved a stable body mass index (BMI) between 18 and 27 kg/m^2 (stable is defined as within the range detailed above **AND** at the same measurement for at least 2 years) **AND** be suffering from severe functional problems: • Those with complex scarring following trauma or previous abdominal surgery. • Those who have undergone treatment for morbid obesity and have excessive skin folds. • Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years (significant is defined as moved down two levels of the BMI Scottish Intercollegiate Guidelines Network (SIGN) guidance as shown below). • Where it is required as part of abdominal hernia correction or other abdominal wall surgery. Severe functional problems include: • Chronic and persistent skin condition (for example, intertriginous

	dermatitis, and cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. • Experiencing severe difficulties with daily living, i.e. ambulatory or urological restrictions. • Where previous post-trauma or surgical scarring (usually midline vertical or multiple) leads to very poor appearance and carries a risk of infection. • Problems associated with poorly fitting stoma bags. In addition to the above, the following will also be required: • Age over 19 years. • Documented record of all BMI measurements over the previous 2 years. • Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection. • Confirmation that the panniculus hangs below the symphysis pubis when the patient is standing normally. • For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity. BMI is referred to as per SIGN guidance where: Less than 18.5 — Underweight 18.5 -24.9 — Normal BMI 25.0 - 29.9 — Overweight 30.0 - 39.9 — Obese 40 or above — Extremely Obese **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).**

	• **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.2 PROCEDURES TO TREAT ACNE SCARRING

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>PROCEDURES TO TREAT ACNE SCARRING</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Procedures to treat facial acne scarring are not routinely commissioned by the CCG.

Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.

Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request form.

NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).

• Obesity - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
• Smoking - In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.</td></tr>
</table>

Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Head of Contracting & Interim Head of Acute Commissioning

7.3.3 ALLERGY TREATMENTS

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**ALLERGY TREATMENTS**
ELIGIBILTY CRITERIA	The CCG will support referrals being made to an NHS Specialist Allergy Centre when the condition has been thoroughly assessed and standard treatment, given by a GP or other clinician, has not improved the condition so that the condition is considered ‘resistant’ to conventional treatment. The CCG will not support referrals made to non-NHS providers.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.4 BLEPHAROPLASTY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**BLEPHAROPLASTY (SURGERY FOR DROOPING OR MISSHAPEN EYELID**
ELIGIBILTY CRITERIA	Blepharoplasty is not routinely commissioned by the CCG for cosmetic reasons. Surgery on the upper lid/s maybe considered on an exceptional basis, for example: • Impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields. • Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow. • Significant ectropion or entropion that requires correction or for the removal of lesions of the eyelid skin or lid margin. In addition to the above, the following evidence will also be required: • Results from an appropriate visual fields test. Results from tests will be required with the eyelid/s both retracted and un-retracted to rule out any pathological causes. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control

	plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.5 BODY CONTOURING PROCEDURES

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	NOT ROUTINELY COMMISSIONED
PROCEDURE/ TREATMENT	BODY CONTOURING PROCEDURES (BUTTOCK, THIGH AND ARM LIFT SURGERY)
ELIGIBILTY CRITERIA	Surgery to remove excess skin from the buttock, thighs and arms is not routinely commissioned by the CCG for cosmetic reasons. Cases may be considered on an exceptional basis for the following groups of patients who should have achieved a stable body mass index (BMI) between 18 and 27 kg/m^2 (stable is defined as within the range detailed above **AND** at the same measurement for at least 2 years) **AND** be suffering from severe functional problems. • Has an underlying skin condition, for example cutis laxa (rare inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds). • Has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living (i.e. walking, dressing and ambulatory restrictions) which have been formally assessed. In addition to the above, the following will also be required: • Age over 19 years. • Documented record of all BMI measurements over the previous 2 years. • Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection. • For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity. If it is an adjunct to another surgical procedure, then patients would be required to meet the established criteria (where applicable) for the defined

	surgical procedure being carried out. Please see the relevant applicable criteria. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a BMI greater than 30 Kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.6 BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Botulinum toxin for axillary hyperhidrosis is not routinely commissioned by the CCG.

Treatment may be considered on an exceptional basis for intractable, disabling focal primary hyperhidrosis when all of the following criteria are met:

• Topical aluminium chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; AND
• Iontophoresis has been ineffective; AND
• Unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics) if sweating is episodic; AND
• Significant disruption of life has occurred because of excessive sweating.

Exclusion

The CCG will not commission botulinum toxin to treat hyperhidrosis in people with social anxiety disorder in line withThe National Institute for Health and Care Excellence (NICE) clinical guideline CG159.

NB. For approved requests the CCG will fund a maximum of 2 treatments per year per patient, not to be repeated more frequently than every 16 weeks.</td></tr>
<tr><td>Date effective from</td><td>27 May 2021</td></tr>
<tr><td>Date published</td><td>15 June 2021</td></tr>
</table>

Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NICE CG159 - Social anxiety disorder: recognition, assessment and treatment

7.3.7 SURGERY TO CORRECT BREAST ASYMMETRY

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	NOT ROUTINELY COMMISSIONED
PROCEDURE/ TREATMENT	SURGERY TO CORRECT BREAST ASYMMETRY
ELIGIBILTY CRITERIA	Surgery to correct breast asymmetry is not routinely commissioned by the CCG for cosmetic reasons. Breast prosthesis or implants often have a limited lifespan and are likely to require replacement or revision during the patient's lifetime. Therefore, where possible, breast reduction of the larger breast should be the preferred option for patients seeking to correct breast asymmetry. Surgery may be considered on an exceptional basis when there is no ability to maintain a normal breast shape using non-surgical methods, for example where the patient: • Has developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia); **OR** • Patients with gross asymmetry (defined as a difference of 3 cup sizes) **AND** body mass index (BMI) in the range 18 – 27 kg/m$^{2.}$ • Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting. • Is aged over 19 years to allow for completion of puberty. In addition to the above, the following evidence will also be required: • Written confirmation from a professional bra fitter evidencing a difference in breast size of at least 3 cup sizes difference. Only the following cup sizes are recognised in the UK: AA | A | B | C | D | DD | E | F | FF | G | GG | H | HH | J | JJ | K | L

	NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated). • **Obesity** - Patients with a BMI greater than30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NHS England Interim Commissioning Policy: Breast Asymmetry November 2013

7.3.8 BREAST AUGMENTATION

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE /TREATMENT</td><td>BREAST AUGMENTATION (BREAST ENLARGEMENT)</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>NB. Breast augmentation which is part of reconstructive surgery after trauma or previous mastectomy or other excisional breast surgery does not go through the IFR process as it is part of the treatment pathway for those conditions.

Breast augmentation is not routinely commissioned by the CCG for:
• Cosmetic reasons, for example for ‘small’ but normal breasts or for breast tissue involution (including post-partum changes).
• Requests made for psychological benefit without associated clinical need.

Breast augmentation may be considered on an exceptional basis, for example where the patient:
• Has congenital amastia (complete absence of bilateral breast tissue); or
• Has suffered trauma to the breast during or after development; or
• Has endocrine abnormalities; or
• Has developmental asymmetry (at least 3 cup sizes); or
• Has tubular breasts – type iii with severe breast constriction with minimal breast base and hypoplasia of all four quadrants as described in Tuberous Breast: Clinical Evaluation and Surgical Treatment.

Gender re-assignment – where requests for breast augmentation are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.

In addition to the above, the following will also be required:</td></tr>
</table>

	• Age over 19 years to allow for completion of puberty. • Body mass index (BMI) within the range 18 – 27 kg/m^2 **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated)**. • Obesity - Patients with a BMI greater than 30 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.9 BREAST AUGMENTATION (REVISION OF)

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>BREAST AUGMENTATION (REVISION OF)</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Revision of breast augmentation is not routinely commissioned by the CCG.

Removal of implants (including implants inserted within the private sector) will be considered if at least one of the following criteria is met:

• Remnant breast cancer or cancer on the contralateral breast; or
• Intra or extra capsular rupture of silicone gel filled implants; or
• Implants complicated by recurrent infections; or
• Extrusion of implant through the skin; or
• Implants with Baker Class IV contracture associated with severe pain (classifications detailed below); or
• Implants with severe contracture that interferes with mammography.

Implant replacement will only be considered if the NHS commissioned the original procedure and that the patient is still eligible for breast implant/s under the CCGs current commissioning criteria.

NB. Approval will be given for implant replacement/s for any patients whose original procedure was undertaken as part of the NHS commissioned cancer pathway.

Gender re-assignment – where requests for revisional breast surgery are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.</td></tr>
</table>

	In addition to the above, the following will also be required: • Age over 19 years to allow for completion of puberty. • BMI within the range 18 – 27 kg/m^{2}. • Ultrasound scan results to evidence implant rupture and/or capsular contracture. • Evidence to support the clinical need for revisional surgery. • Evidence to support that the patient meets the current criteria for augmentation. **Baker Classification** Class I Augmented breast feels soft as a normal breast. Class II Augmented breast is less soft and implant can be palpated, but is not visible. Class III Augmented breast is firm, palpable and the implant (or distortion) is visible. Class IV Augmented breast is hard, painful, cold, tender and distorted.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

Reference	1. NHS England Interim Commissioning Policy: Breast Implant removal and re-insertion November 2013

7.3.10 MASTOPEXY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**BREAST LIFT (MASTOPEXY)**
ELIGIBILTY CRITERIA	Mastopexy is not routinely commissioned by the CCG for cosmetic reasons, for example weight loss, post lactation or age related ptosis. Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request form. Mastopexy may be included as part of the treatment to correct breast asymmetry and reduction. In this instance, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) >30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that

	people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.11 BREAST REDUCTION FOR GYNAECOMASTIA (MALE)

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**BREAST REDUCTION FOR GYNAECOMASTIA (MALE)**
ELIGIBILTY CRITERIA	Surgery to correct benign gynaecomastia is not routinely commissioned by the CCG for cosmetic reasons. The CCG will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids. Surgery may be considered on an exceptional basis, for example where the patient: • Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat); **AND** • Has a body mass index (BMI) of 25 kg/m^2 or less and stable for 12 months (stable is defined as within the range detailed above **and** at the same measurement for 12 months), unless a specific un-correctable aetiological factor is identified such as androgen therapy for prostate cancer; **AND** • Has been screened prior to referral to exclude endocrinological and medication related causes and if medication has been a factor then a period of one year since last use should have elapsed; **AND** • Has completed puberty - surgery is not routinely commissioned below the age of 19 years; **AND** • Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger. In addition to the above, the following will also be required: • BMI to have been measured within 2 months of the request being submitted. • Evidence that screening for endocrine and drug-related causes has taken place and the results

	• Documented additional information where circumstances include:
	  o Pain
	  o Gross asymmetry
	  o The gynaecomastia is iatrogenic
	
	NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).
	
	• **Obesity** - Patients with a BMI greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
	• **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.

Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee

Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	

7.3.12 CIRCUMCISION (FOR SOCIAL, RELIGIOUS OR CULTURAL REASONS)

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**CIRCUMCISION (FOR SOCIAL, RELIGIOUS OR CULTURAL REASONS)**
ELIGIBILTY CRITERIA	Circumcision for social, religious or cultural reasons is not routinely commissioned by the CCG. Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request form Cases may be considered on an exceptional basis, for example: • When an underlying medical condition means that routine surgery in the usual setting may be unsafe
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee

Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.13 COMPLEMENTARY AND ALTERNATIVE THERAPIES

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	NOT ROUTINELY COMMISSIONED
PROCEDURE/ TREATMENT	COMPLEMENTARY AND ALTERNATIVE THERAPIES
ELIGIBILTY CRITERIA	Complementary and alternative therapies are not routinely commissioned as stand-alone treatments by the CCG. See Appendix C for the list of therapies which are not routinely commissioned. The list is not exhaustive and other therapies not listed but that are considered ‘alternative’ therapies will be considered in the same way. Those complementary and alternative therapies which are an integral part of an agreed care pathway within existing contracts (supported by a service specification) are excluded from this policy.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee

Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.14 PROCEDURES FOR CONGENITAL VASCULAR SKIN LESIONS

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>PROCEDURES FOR CONGENITAL VASCULAR SKIN LESIONS</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Procedures for congenital vascular abnormalities are not routinely commissioned by the CCG for cosmetic reasons.

Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only.

Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request Form.

NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).

• Obesity - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
• Smoking - In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.</td></tr>
</table>

Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.15 DIAGNOSTIC FIBREOPTIC ENDOSCOPIC EXAMINATION FOR RECTAL BLEEDING - UNDER 45 YEARS

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**CRITERIA TO GUIDE CLINICAL JUDGEMENT**
PROCEDURE /TREATMENT	**DIAGNOSTIC FIBREOPTIC ENDOSCOPIC EXAMINATION FOR RECTAL BLEEDING - UNDER 45 YEARS**

ELIGIBILTY CRITERIA	Diagnostic fibre optic endoscopic examination of the colon and diagnostic fibre optic sigmoidoscope examination of the lower bowel with or without biopsy are NOT routinely commissioned where the patient is under 45 years of age, other than in the following circumstances:
	
	• Patients with HIV who have an increased risk of anal cancer, emergency care patients with suspected cancer.
	• Patients with any of the following symptoms over a period of six weeks should be urgently and appropriately investigated:
	    o rectal bleeding with a change in bowel habit to looseness or increased
	    o frequency
	    o rectal bleeding without anal symptoms
	    o palpable abdominal or rectal mass
	    o intestinal obstruction
	• All patients with iron-deficiency anaemia (Hb<11g/dl in men or<10g/dl in postmenopausal women) without overt cause should be thoroughly investigated for colorectal cancer. Source: SIGN 67 (2003).
	
	NB. Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances. Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request form.

	NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated). • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Summary of evidence/ rationale	
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee

Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NICE Evidence Search	rectal bleed pathway 2. Royal College of Surgeons, Rectal Bleeding Guide (2013)

7.3.16 REPAIR OF EXTERNAL EAR LOBES

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**REPAIR OF EXTERNAL EAR LOBES)(LOBULES)**
ELIGIBILTY CRITERIA	Repair of external ear lobes for cosmetic reasons is not routinely commissioned by the CCG. This procedure is only commissioned by the CCG for the repair of totally split earlobes as a result of direct trauma. Repair of external ear lobes as a result of a gauge piercing is excluded from treatment by the CCG.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.17 FACIAL PROCEDURES (FACE LIFT/BROW LIFT)

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**FACIAL PROCEDURES (FACE LIFT/BROW LIFT)**
ELIGIBILTY CRITERIA	Facial procedures and botulinum toxin for cosmetic reasons are not routinely commissioned by the CCG. Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request Form. Cases may be considered on an exceptional basis, for treatment of: • Congenital facial abnormalities. • Facial palsy (congenital or acquired paralysis). • As part of the treatment of specific conditions affecting the facial skin, e.g. cutis laxa, pseudoxanthoma elasticum, neurofibromatosis. • To correct the consequences of trauma. • To correct deformity following surgery. In addition to the above, for a brow lift procedure the following evidence will also be required: • Results from an appropriate visual fields test with eyelid un-retracted. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There

	is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.18 FUNCTIONAL ELECTRICAL STIMULATION (FES)

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	CRITERIA TO GUIDE CLINICAL JUDGEMENT
PROCEDURE/ TREATMENT	FUNCTIONAL ELECTRICAL STIMULATION (FES) – POLICY FOR FOOT DROP OF CENTRAL NEUROLOGICAL ORIGIN
ELIGIBILTY CRITERIA	The objective for this commissioning statement is to: 1. Reduce the variation in access to Functional Electrical Stimulation (FES). 2. Ensure that Functional Electrical Stimulation (FES) is commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness. 3. Promote the cost-effective use of healthcare resources. This policy is in line with the guidance in NICE IPG 278 - Functional Electrical Stimulation for drop foot of central neurological origin. **Criteria** **Inclusion** The CCG routinely commissions Functional Electrical Stimulation (FES) for drop foot, with the non-implantable device (skin surface FES - OPCS A70.7 application of transcutaneous electrical nerve stimulator), in line with NICE IPG278. Provisions for clinical, governance, consent, audit and research are fully expected to be in place for this service. • The patient must be over 18 years of age and being treated for foot drop (deficit of dorsiflexion and/or eversion of the ankle) which must be of central neurological origin, due to an upper motor neurone lesion i.e. one that occurs in the brain or spinal cord at or above the level of T12. • Upper motor neurone lesions resulting in dropped foot occur in conditions such as stroke, brain injury, multiple sclerosis, incomplete spinal cord injury at T12 or above, cerebral palsy, familial/hereditary spastic para paresis and Parkinson’s disease.

	Exclusion The following forms of FES are not routinely commissioned by the CCG: • Other forms of electrical stimulation for conditions other than foot drop. • FES for upper limb. • Implanted FES. • Wireless FES. The CCG does not routinely commission the wireless or implantable devices. Funding will only be considered for wireless or implantable devices where there are exceptional clinical circumstances. The clinician needs to submit an application to the CCG's Individual Funding Request (IFR) Panel. Clinicians can submit an IFR if they feel there is a good case for exceptionality as described in the Wakefield CCG Policy for IFR. Where the patient has previously been provided with the treatment with limited or diminishing benefit, the IFR process should be followed. **NB.** Funding for patients meeting the above criteria will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request Form. Each individual case will be reviewed via the CCG Individual Funding Request process.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.19 HAIR REMOVAL

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**HAIR REMOVAL**
ELIGIBILTY CRITERIA	Hair removal for cosmetic reasons is not routinely commissioned by the CCG. Patients concerned with the 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 by the CCG. Hair removal may be considered on an exceptional basis, for example where the patient: • Has undergone reconstructive surgery resulting in abnormally located hair bearing skin to the face, neck or upper chest (areas not covered by normal clothing). • Has a proven underlying endocrine disturbance resulting in hirsutism (e.g. Polycystic Ovary Syndrome). • Is undergoing treatment for pilonidal sinuses to reduce recurrence. In addition to the above, the following evidence will also be required: • Evidence of the underlying endocrine disturbance e.g. blood test results or ultrasound scan report. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery

	afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NHS England Interim Commissioning Policy: Hair removal (including Electrolysis and Laser Therapy) November 2013

7.3.20 HAIR REPLACEMENT/CORRECTION OF MALE PATTERN BALDNESS

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	NOT ROUTINELY COMMISSIONED
PROCEDURE/ TREATMENT	HAIR REPLACEMENT/CORRECTION OF MALE PATTERN BALDNESS
ELIGIBILTY CRITERIA	**Hair Transplantation** Hair transplantation is not routinely commissioned by the CCG for cosmetic reasons, regardless of gender. Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is required following cancer or trauma. **Correction of Male Pattern Baldness** Treatments to correct male pattern baldness are not routinely commissioned by the CCG for cosmetic reasons. This is excluded from treatment by the NHS. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound

	complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.21 SURGERY FOR HALLUX VALGUS

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**CRITERIA TO GUIDE CLINICAL JUDGEMENT**
PROCEDURE /TREATMENT	**SURGERY FOR HALLUX VALGUS**
	A bunion is a deformity of the joint connecting the big toe to the foot and is known as hallux valgus. It is characterized by medial deviation of the first metatarsal bone and lateral deviation of the hallux (big toe).
EXCLUSIONS	Where **URGENT** referral via existing diabetic foot pathway is required.
ELIGIBILTY CRITERIA	• Patient has been seen, assessed and treated within podiatry services. • All appropriate conservative measures have been tried over a 6-month period and failed to relieve symptoms, including up to 12 weeks of evidence based non-surgical treatments, i.e. Analgesics/painkillers, bunion pads, footwear modifications. • The patient suffers from o severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment interfering with Activities of Daily Living (ADLs) i.e. ability to work, attend education, ability to manage simple domestic duties, ability to manage as a carer; **OR** o Severe deformity (with or without lesser toe deformity) that causes significant functional impairment **OR** prevents them from finding adequate footwear; **OR** o Recurrent or chronic ulceration or infection. • Understands post-operative pathway including: o 6-week post-operative period with plaster cast and may involve absence from work for sedentary work of 2-6 weeks and a possible 2-3 months for physical work. o 6-8 weeks' post-operative period without driving (2 weeks if left side and driving automatic car). o Full function will be limited for approximately 4 months. o Treatment prognosis is highly variable.

	◦ 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. A patient should not be referred for surgery for prophylactic or cosmetic reasons for asymptomatic bunions. **NB.** Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances. For those patients who are not eligible for treatment under this policy, will be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed via the CCG Prior Approval Process **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Summary of evidence/ rationale	NICE Clinical Knowledge Summaries (CKS) makes clear that referral for bunion surgery is indicated for pain and is not routinely performed for cosmetic purposes[1]. Conservative treatment may be more appropriate than surgery for some older people, or people with severe neuropathy or other comorbidities affecting their ability to undergo surgery. Referral for orthopaedic or podiatric surgery consultation may be of benefit if the deformity is painful and worsening; the second toe is involved; the person has difficulty obtaining suitable shoes; or there is significant disruption to lifestyle or activities.

	If the person is referred for consideration of surgery, advise that surgery is usually done as a day case. Bunion surgery may help relieve pain and improve the alignment of the toe in most people (85%–90%); but there is no guarantee that the foot will be perfectly straight or pain-free after surgery. Complications after bunion surgery may include infection, joint stiffness, transfer pain (pain under the ball of the foot), hallux varus (overcorrection), bunion recurrence, damage to the nerves, and continued long-term pain. There is very little good evidence with which to assess the effectiveness of either conservative or operative treatments or the potential benefit of one over the other. Untreated hallux valgus in patients with diabetes (and other causes of peripheral neuropathy) may lead to ulceration, deep infection and even amputation.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officer	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NICE Clinical Knowledge Summaries Bunions 2. Royal College of Surgeons Painful deformed great toe (2013) 3. Abhishek A; Roddy E; Zhang W; Doherty M. Are hallux valgus and big toe pain associated with impaired quality of life? A cross-sectional study. Osteoarthritis Cartilage 2010 Jul;18(7):923-6

	4. Nix S; Smith M; Vicenzino B. Prevalence of hallux valgus in the general population: a systematic review and meta-analysis. J Foot Ankle Res 2010;3:21 5. NICE Surgical correction of hallux valgus using minimal access techniques. 332. London: National Institute for Health and Clinical Excellence; 2010 6. Ferrari J; Higgins JP; Prior TD. Interventions for treating hallux valgus (abductovalgus) and bunions. Cochrane Database Syst Rev 2004;(1):CD000964 7. Saro C; Jensen I; Lindgren U; Fellander-Tsai L. Quality-of-life outcome after hallux Valgus surgery. Qual Life Res 2007 Jun;16(5):731

7.3.22 HERNIA REPAIR

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**CRITERIA TO GUIDE CLINICAL JUDGEMENT**
PROCEDURE /TREATMENT	**HERNIA REPAIR - INGUINAL (IN MEN), UMBILICAL, INCISIONAL**
	Hernia repair refers to a surgical operation for the correction of a hernia (a bulging of internal organs or tissues through the wall that contains it). Hernias can occur in many places, including the abdomen, groin, diaphragm, brain, and at the site of a previous operation. This statement covers surgical treatment of inguinal hernias in adult men, and umbilical or incisional hernias in all adults.
EXCLUSIONS	It **EXCLUDES** suspected femoral hernias, inguinal hernias in women, and any irreducible hernias, which should be referred urgently due to the increased risk of incarceration/strangulation.
ELIGIBILTY CRITERIA	**N.B.** INGUINAL HERNIA is now a part of List 2 Evidence Based Interventions Policy. Please refer to the management and referral guidance in the EBI List 2 document. An approach of watchful waiting is recommended for asymptomatic or minimally symptomatic abdominal hernias. Watchful waiting is considered safe. Appropriate conservative management should also be tried first e.g. weight reduction or support from surgical appliances or underwear. Surgical treatment should only be offered when one of the following criteria are met: • Pain/discomfort interfering significantly with activities of daily living; • The hernia is difficult or impossible to reduce; • There is a risk of incarceration or strangulation of the bowel; • Comorbidity is present that will likely significantly increase the risks associated with surgery at a later date;

	AND • The patient has been a non-smoker for at least 8 weeks. Patient information leaflet – hernias **NB.** Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances. For those patients who are not eligible for treatment under this policy, will be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed via the CCG Prior Approval Process. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Summary of evidence/ rationale	The Royal College of Surgeons 2013 - High Value Care Pathway for groin hernia[1] (which includes a useful flow chart) states that GPs should refer: • All patients with an overt or suspected inguinal hernia to a surgical provider except for patients with minimally symptomatic inguinal hernias who have significant comorbidity **AND** do not want to have surgical repair (after appropriate information provided) [2, 3]. • Irreducible and partially reducible inguinal hernias and all hernias in women as urgent referrals [4, 5]. • Patients with suspected strangulated or obstructed inguinal hernia as emergency referrals [4, 5].

- All children <18 years with inguinal hernia to a paediatric surgical provider.

Watchful waiting (WW) is regarded as an acceptable option for men with minimally symptomatic or asymptomatic inguinal hernias by the European Hernia Society guidelines on the treatment of inguinal hernia in adult patients[6] (Level 1B evidence) and by a number of RCTs, concluding that it is an acceptable option for men with minimally symptomatic inguinal hernias[7]. Delaying surgical repair until symptoms increase is safe because acute hernia incarcerations occur rarely.

Analysis of 336 patients randomised to watchful waiting in the American College of Surgeons Watchful Waiting Hernia Trial found readily identifiable patient characteristics can predict those patients with minimally symptomatic inguinal hernia who are likely to "fail" watchful waiting hernia management[8]. These include pain with strenuous activities, chronic constipation and prostatism.

Higher levels of activity reduced the risk of this combined outcome but there is no mention of BMI. Consideration of these factors will allow surgeons to tailor hernia management optimally.

Another study found that with follow up over 10 years, a total of 68% of men had had elective surgery, more commonly men older than 65 years, with pain[9]. They conclude that, although WW is a reasonable and safe strategy, symptoms are likely to progress and an operation will be needed eventually.

More recently a study concluded that a commissioning policy restricting funding for elective hernia repairs (but notably across all types) had led to a significant increase in emergency hernia repairs[10]. They carried out a retrospective cohort study on around 2550 patients who underwent repair of inguinal, umbilical, incisional, femoral or ventral hernias over a 3-year period.

The number of elective hernia repairs reduced from 857 over 12 months before the funding restrictions to 606 in the same period afterwards ($p < 0.001$). Over the same time period, however, a significant rise in total emergency hernia repairs was demonstrated, increasing from 98 to 150 ($p < 0.001$). 30-day readmission rates also increased from 5.1 % before the policy introduction to 8.5 % afterwards ($p = 0.006$). They concluded that the funding restrictions introduced in 2011 were followed by a statistically significant and unintended increase in emergency hernia repairs in their trust, with associated increased risks to patient safety.

<table>
<tr><td></td><td>A “watchful waiting” approach is also supported by other CCG’s, including Leeds CCG. Their clinical guidelines commissioning position is that hernia repair is not routinely commissioned for:

• Men with an asymptomatic or a minimally symptomatic inguinal hernia (discomfort or pain that does not restrict daily activity - adopt watchful waiting).
• Men with groin pain and an ultrasound detected, but clinically impalpable, hernia (consider musculoskeletal referral).
• Post-operative follows up for low risk cases (i.e. no evidence of clinically significant haematoma, injury to the bowel or major blood vessels, deep infection, ischaemic orchitis, recurrence).</td></tr>
<tr><td>Date effective from</td><td>27 May 2021</td></tr>
<tr><td>Date published</td><td>15 June 2021</td></tr>
<tr><td>Review date</td><td>27 November 2021</td></tr>
<tr><td>Author</td><td>N/A (Taken from existing policies)</td></tr>
<tr><td>Clinical Reviewers</td><td>N/A (Taken from existing policies)</td></tr>
<tr><td>Approved by</td><td>Quality, Performance & Governance Committee</td></tr>
<tr><td>Responsible Officer</td><td>Chief Operating Officer, North Kirklees & Wakefield CCG

NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care</td></tr>
<tr><td>Reference</td><td>1. Royal College of Surgeons 2013 - High Value Care Pathway for groin hernia

2. Collaboration, I.T., Operation compared with watchful waiting in elderly male inguinal hernia patients: a review and data analysis. J Am Coll Surg, 2011. 212(2): p. 251-259 e1-4
3. Chung, L et al, Long-term follow-up of patients with a painless</td></tr>
</table>

	inguinal hernia from a randomized clinical trial. Br J Surg, 2011. 98(4): p. 596-9 4. Bay-Nielsen, M., et al., Quality assessment of 26,304 herniorrhaphies in Denmark: a prospective nationwide study. Lancet, 2001. 358(9288): p. 1124-8 5. Nilsson, H., et al., Mortality after groin hernia surgery. Ann Surg, 2007. 245(4): p. 656-60 6. Simons, M.P., et al., European Hernia Society guidelines on the treatment of inguinal hernia in adult patients. Hernia: the journal of hernias and abdominal wall surgery, 2009. 13(4): p. 343-403 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719730/ 7. Fitzgibbons (2006); Watchful waiting versus repair of inguinal hernia in minimally symptomatic men, a randomised controlled trial. JAMA: 295; 285-292 8. Sorosi G A et al A clinician's guide to patient selection for watchful waiting management of inguinal hernia. Annals of Surgery March 2011 9. Long-term results of a randomized controlled trial of a non-operative strategy (watchful waiting) for men with minimally symptomatic inguinal hernias Fitzgibbon et all Annals of Surgery 2013 10. The impact of healthcare rationing on elective and emergency hernia repair. Orchard et al Hernia.2016 Jun; 20(3):405-9. doi: 10.1007/s10029-015-1441-y. Epub 2015 Nov 23

7.3.23 IN VITRO FERTILISATION (IVF) – INFERTILITY TREATMENT

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**IVF – INFERTILITY TREATMENT**
ELIGIBILTY CRITERIA	Criteria have been agreed across the Yorkshire and Humber. (See Appendix D – separate document to this policy.) The CCG arrangements are in line with the above policy but the CCG will only fund one full cycle where the eligibility criteria are met.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.24 LABIAPLASTY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**LABIAPLASTY**
ELIGIBILTY CRITERIA	Labiaplasty is not routinely commissioned by the CCG for cosmetic reasons. Surgery may be considered on an exceptional basis, for example where the patient has: • Congenital conditions; **or** • Recurrent disease or chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment; **or** • Excess androgenic hormones. **NB.** Treatment for female genital mutilation is not considered cosmetic and does not require funding approval.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical	N/A (Taken from existing policies)

Reviewers	
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	NHS England Interim Commissioning Policy: Labiaplasty/Vaginoplasty/ Hymenorrhaphy

7.3.25 LIPOSUCTION

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>LIPOSUCTION</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Liposuction is not routinely commissioned by the CCG for cosmetic reasons or to correct the distribution of fat.

Cases may be considered on an exceptional basis, for example when:

• It may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies).
• If it is an adjunct to other surgical procedures e.g. surgery for gynaecomastia. In this instance, patients would be required to meet the established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).

• Obesity - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
• Smoking - In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.</td></tr>
</table>

Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.26 LYCRA GARMENTS

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>CRITERIA TO GUIDE CLINICAL JUDGEMENT</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>LYCRA GARMENTS</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Criteria for Funding

The patient must be on the caseload of the referring clinician.

• The patient should have cerebral palsy or similar condition with significantly abnormal postural muscle tone.
• There are no contraindications present (see below).
• Referral should identify the specific significant benefits offered by the therapy for this patient.
• Evidence provided that other therapies have been considered but were deemed to be insufficient.
• Evidence of the patient/carer’s willingness to comply with treatment (e.g. signed agreement or previous successful use).
• If the patient is over 18, successful previous use of Lycra garments and benefits evidenced.
• Requests for replacement garments should include a user or professional evaluation of benefits to add to the evidence base on this technology.

Contraindications

• Lycra garments are contraindicated when adequate monitoring and supervision are not available, there is deemed to be a lack of purposeful intent or, dependent on site of the garment, if severe epilepsy or chronic respiratory problems are present. Lycra splinting is not recommended if there is severe uncontrolled reflux or chronic skin conditions.
• Problems with comfort, reflux sickness and putting on/taking off the suit have been reported. Temperature can also be an issue, particularly in summer. These factors may all impact on compliance and motivation of</td></tr>
</table>

	the patient.
	• A study carried out with the support of Scope and Birmingham Community Health Trust from 1998 – 2000 also found that some people stop wearing the garments altogether because of:
	  o The level of support needed to get the garments on and off
	  o Toileting issues
	  o Garment took too long to dry after washing
	  o Unable to maintain the function gains achieved without continued use
	• The above considerations should be taken into account before referring for Lycra garments.
	
	NB. Funding for patients meeting the above criteria will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request Form.

Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.27 MRIs- UPRIGHT/OPEN/WIDE BORE

POLICY STATEMENT	COMMISSIONING POLICY
STATUS	CRITERIA TO GUIDE CLINICAL JUDGEMENT
PROCEDURE /TREATMENT	MRIs- UPRIGHT/OPEN/WIDE BORE
	Current upright magnetic resonance imaging (MRI) scanners generally use medium field magnets of 0.5T or 0.6T. Upright MRI (uMRI) here refers to any system of 0.5T or greater that allows for scanning in various positions, regardless of manufacturer. By comparison, the most advanced standard recumbent MRI (rMRI) scanners have magnet strength of at least 1.0T and up to 3.0T allowing for the greatest resolution generally in a shorter amount of time. With 0.6T magnets, uMRI requires more time to obtain images with lower resolution. Slower imaging times with uMRI may create difficulty for patients who are unable to remain still while in a standing or sitting position; not comfortable secondary to pain; or are unstable in such positions. Longer exam times may also decrease the overall patient flow and volume of patients that can be accommodated. The proposed advantages of uMRI are based on the ability to scan the spine (or joints) in different positions (including the position where clinical symptoms are more pronounced) and assess the effects of weight bearing, position and dynamic movement. It is theorised that such positional imaging may provide information not available from methods currently used (i.e. supine conventional MRI) and that this added information will lead to improved diagnosis, treatment and outcomes.
EXCLUSIONS	
ELIGIBILTY CRITERIA	Referral for open MRI scanning of at least 0.5T as an alternative to conventional MRI may be commissioned in the following circumstances as an exception where the following criteria is met:

	• Patients who suffer from claustrophobia where an oral prescription sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). • For the use for spinal cord compression and neural axis tumors. The use of open MRI is recommended rather than the use of a general anaesthetic as there is a lesser risk to the patient. • Patients who are obese and cannot fit comfortably in conventional MRI scanners as determined by a Radiology department policy. (The issue regarding size is how the weight is distributed). • Patients who cannot lie properly in conventional MRI scanners because of severe pain. • The purpose of the scan is a last resort to exclude larger lesions if this is clinically relevant in the brain and spine. Peripheral body parts will not normally be considered for upright MRI unless at the specific request of an acute consultant who believes this is essential to clinical management due to failed trial of single body part MRI. • The patient is registered with a GP Practice. • IN ADDITION, The CCG will only fund upright MRI of the specific anatomy requested. **NB.** Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances. For those patients who are not eligible for treatment under this policy, will be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed via the CCG Prior Approval Process. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in

	England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Summary of evidence/ rationale	
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officer	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and Treatment of Degenerative Lumbar Spinal Stenosis. 2011 2. Skelly AC, Moore E, Dettori JR. Comprehensive evidence-based health technology assessment: Effectiveness of upright MRI for evaluation of patients with suspected spinal or extra-spinal joint dysfunction. Washington State Health Care Authority. May 11, 2007. 3. Liodakis, E, Kenawey, M, Doxastaki, I, Krettek, C, Haasper, C, Hankemeier, S. Upright MRI measurement of mechanical axis and frontal plane alignment as a new technique: a comparative study with weight bearing full length radiographs. Skeletal Radiol. 2011 Jul;40(7):885-9 4. Kanno, H, Ozawa, H, Koizumi, Y, et al. Dynamic change of dural sac cross-sectional area in axial loaded magnetic resonance imaging

correlates with the severity of clinical symptoms in patients with lumbar spinal canal stenosis. Spine (Phila Pa 1976). 2012 Feb 1;37(3):207-13

5. Andreasen ML, Langhoff L, Jensen TS, et al. Reproduction of the lumbar lordosis: a comparison of standing radiographs versus supine magnetic resonance imaging obtained with straightened lower extremities. J Manipulative Physiol Ther. 2007;30(1):26-30
6. Ferreiro PA, Garcia IM, Ayerbe E, et al. Evaluation of intervertebral disc herniation and hypermobile intersegmental instability in symptomatic adult patients undergoing recumbent and upright MRI of the cervical or lumbosacral spines. Eur J Radiol. Apr 3 2007
7. Hirasawa Y, Bashir WA, Smith FW, et al. Takahashi K. Postural changes of the dural sac in the lumbar spines of asymptomatic individuals using positional stand up magnetic resonance imaging. Spine. 2007; 32(4):E136-140
8. Kanno H, Endo T, Ozawa H, et al. Axial loading during magnetic resonance imaging in patients with lumbar spinal canal stenosis: does it reproduce the positional change of the dural sac detected by upright myelography? Spine (Phila Pa 1976). 2011 Jan 20. [Epub ahead of print]
9. Karadimas EJ, Sodium M, Smith FW, et al. Positional MRI changes in supine versus sitting postures in patients with degenerative lumbar spine. J Spinal Disord Tech. 2006; 19 (7):495-500
10. Kong MH, Hymanson HJ, Song KY at al. Kinetic magnetic resonance imaging analysis of abnormal segmental motion of the functional spine unit. J Neurosurg Spine. 2009 Apr;10(4):357-65
11. Madsen R, Jensen TS, Pope M, et al. The effect of body position and axial load on spinal canal morphology: an MRI study of central spinal stenosis. Spine 2008 Jan 1; 33(1):61-7
12. Hayashida Y, Hirai T, Hiai Y, et al. Positional lumbar imaging using a positional device in a horizontally open-configuration MR unit - initial experience. Journal of Magnetic Resonance Imaging 2007 Sep; 26(3):525-8
13. Arcadias EJ, Siddiqui M, Smith FW, et al. Positional MRI changes in supine versus sitting postures in patients with degenerative lumbar spine. J Spinal Disord Tech. 2006; 19(7):495-500
14. Hailey D. Open magnetic resonance imaging (MRI) scanners. Issues in Emerging Health Technologies. Issue 92. Ottawa, Canada; Canadian Agency for Drugs and Technologies in Health (CADTH); 2006
15. Siddiqi M, Nicol M, Efthimios K, et al. The Positional Magnetic Resonance
16. Imaging Changes in the Lumbar Spine Following Insertion of a Novel Interspinous Process Distraction Device. Spine. 30(23):2677-2682, December 1, 2005
17. Kimura S, et al., Axial load-dependent cervical spinal alterations during simulated upright posture: a comparison of healthy controls and patients with cervical degenerative disease. J Neurosurg Spine, 2005. 2(2): p. 137-44

	18. Jinkins JR, Dworkin JS, Damadian RV. Upright, weight-bearing, dynamic-kinetic MRI of the spine: initial results. Eur Radiol 2005; 15(9):1815-25 19. Smith FW, Siddiqui M. Positional, Upright MRI Imaging of the Lumbar Spine Modifies the Management of Low Back Pain and Sciatica. In European Society of Skeletal Radiology (ESSR). 2005. Oxford, England

7.3.28 SURGICAL CORRECTION OF BENIGN NIPPLE INVERSION

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>SURGICAL CORRECTION OF BENIGN NIPPLE INVERSION</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Surgical correction of benign nipple inversion is not routinely commissioned by the CCG for:
• Cosmetic/aesthetic reasons.
• Psychological benefit without associated clinical need.

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded[1].

Surgical correction of nipple inversion may only be funded where it has been documented that there was an inability to breastfeed during a previous pregnancy and the patient is considering a subsequent pregnancy. In this instance all of the following criteria must be met in full:
• The nipple(s) must be non-retractable based on clinical examination; AND
• The patient is post pubertal; AND
• The inversion has not been corrected by correct use of a non-invasive suction device.

NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).
• Obesity - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
• Smoking - In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are</td></tr>
</table>

	committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1 Suspected cancer: recognition and referral, Recommendations organised by symptom and findings of primary care investigations.

7.3.29 PINNAPLASTY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**PINNAPLASTY (CORRECTION OF PROMINENT EARS)**
ELIGIBILTY CRITERIA	Surgical correction of prominent ears is not routinely commissioned by the CCG for cosmetic reasons. Cases may be considered on an exceptional basis, where the patient: • Is aged 5-19 at the time of referral and the child (not the parents alone) expresses concern; **AND** • Has very significant ear deformity or asymmetry. Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy. The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004)), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.
Date effective from	27 May 2021
Date	15 June 2021

published	
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. NHS England Interim Commissioning Policy: Pinnaplasty/Otoplasty November 2013

7.3.30 REVERSAL OF VASECTOMY AND FEMALE STERILISATION

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**REVERSAL OF VASECTOMY AND FEMALE STERILISATION**
ELIGIBILTY CRITERIA	Surgery for the reversal of a vasectomy or female sterilisation is not routinely commissioned by the CCG. Cases may be considered on an exceptional basis, for example: • The death of an existing child through accidents or illness. • There is clear evidence (over and above the patient's assertion) that the original operation had been performed under duress e.g. cases when the patient was very young when the procedure was carried out and evidence from the referring clinician shows that they did not receive any counselling. Funding is not agreed for these procedures for patients who are in a new relationship or who are not in contact with children from a previous relationship. The CCG reserve the right to decline funding where either partner has living children (this includes adopted children but not fostered) from that or any previous relationship. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature

	death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.31 SURGICAL/LASER TREATMENT OF RHINOPHYMA

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**SURGICAL/LASER TREATMENT OF RHINOPHYMA**
ELIGIBILTY CRITERIA	Surgical/laser treatment of rhinophyma is not routinely commissioned by the CCG for cosmetic reasons. The first line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered on an exceptional basis for surgery or laser treatment. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021

Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.32 RHINOPLASTY/SEPTORHINOPLASTY

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>RHINOPLASTY/SEPTORHINOPLASTY</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Septorhinoplasty and rhinoplasty is not routinely commissioned by the CCG for cosmetic reasons.

Septorhinoplasty may be considered on an exceptional basis, for example in the presence of:

• Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty associated with a bony deviation of the nose, where an operation on the nasal septum would not be effective in restoring the nasal airway without a simultaneous operation to straighten the nasal bones.
• Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy) or when done in association with cleft palate repair.

Rhinoplasty may be considered on an exceptional basis, for example:

• When it is being performed to correct a nasal deformity secondary to congenital cleft lip and/or palate.
• To correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect when all of the following criteria are met:

    o Nasal airway obstruction is causing significant symptoms (e.g. chronic rhinosinusitis, difficulty breathing); AND
    o Obstructive symptoms persist despite conservative management for three months or longer, which includes where appropriate, nasal steroids; AND
    o Airway obstruction will not respond to septoplasty and turbinectomy alone.</td></tr>
</table>

	In addition to the above, the following evidence will also be required: • Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g. Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); **AND** • Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; **AND** • Documentation of results of conservative management of symptoms. **NB.** For requests that meet the above criteria in relation to sporting/activity trauma, the CCG reserve the right to decline funding where the request is for a repeat surgical procedure in relation to trauma where it is as a direct cause of the same sport/activity. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)

Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.33 SPINAL CORD STIMULATION

POLICY STATEMENT	COMMISIONING POLICY
STATUS	CRITERIA TO GUIDE CLINICAL JUDGEMENT
PROCEDURE/ TREATMENT	SPINAL CORD STIMULATION
	Sacral nerve stimulation (SNS), also called sacral neuromodulation, is a type of medical electrical stimulation therapy. It typically involves the implantation of a programmable stimulator subcutaneously, which delivers low amplitude electrical stimulation via a lead to the sacral nerve, usually accessed via the S3 foramen. In the event that the nerves and the brain are no longer communicating effectively, resulting in a bowel/bladder disorder, this type of treatment is designed to imitate a signal sent via the central nervous system. One of the major nerve routes is from the brain, along the spinal cord and through the back. This is commonly referred to as the sacral area. This area controls the everyday function of the pelvic floor, urethral sphincter, bladder and bowel. By stimulating the sacral nerve (located in the lower back), a signal is sent that manipulates a contraction within the pelvic floor. Over time these contractions rebuild the strength of the organs and muscles within it. This effectively alleviates all symptoms of urinary/faecal disorders, and in many cases, eliminates them completely. (**NB**. In line with National Institute for Health and Care Excellence (NICE) recommendations this policy has separate eligibility criteria and care pathways for men and women).
ELIGIBILTY CRITERIA	**SNS for Bowel and Bladder Disorders** **Women** SNS for urinary incontinence, urgency-frequency syndrome or non-

	obstructive urinary retention in women is not routinely commissioned unless the patient meets the following criteria:
	
	• Symptoms are refractory to lifestyle modification (caffeine reduction, modification of fluid intake, weight loss if body mass index (BMI) is greater than 30 kg/m^2).
	
	BMI is an established measure of weight though it is recognised that muscular people will have a higher BMI that is not thought to be a risk to health (muscle is denser than fat).
	
	Waist Circumference
	
	Obesity can be measured by waist measurements but it is not yet established in UK clinical practice. NHS Choices website states individuals have a higher risk of health problems if waist size is more than 80cm (31.5 inches).
	
	Patients can be reconsidered for a referral if they fulfil ALL the following criteria
	
	• They have undertaken a self-managed or supervised weight reduction programme and have lost at least 5% weight.
	• Symptoms are refractory to behavioural interventions: a minimum of 6 weeks of bladder retraining **OR** 3 months of pelvic floor muscle training (in mixed UI only, where there is some stress incontinence as well as OAB).
	• Symptoms are refractory to 4 weeks of anticholinergic medication to a maximal tolerated dose (a number of drugs may be tried in accordance with NICE CG171) **OR** Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects (NICE TA290).
	• They have been referred to secondary care, reviewed by an MDT and a diagnosis of detrusor over activity has been confirmed by urodynamic assessment.
	• Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall (only in patients willing and able to perform clean intermittent catheterisation). (**NB**. If Botox has not been tried, the IFR should include a valid clinical explanation for this).
	• Symptoms are refractory to behavioural and lifestyle modification (diet, weight management, modification of fluid intake):
	    o Bladder retraining
	    o Bladder catheterisation

	○ The woman has a confirmed diagnosis defined by urodynamic assessment and has been reviewed by a Urology MDT **Men** Requests for SNS from a Consultant Urologist for men with overactive bladder (OAB) caused by detrusor over activity who fulfil ALL the following criteria: • Symptoms are refractory to conservative management lifestyle advice, advice on fluid intake, supervised bladder training and use of containment products (pads, sheaths, etc.). • Symptoms are refractory to 4-6 weeks of anticholinergic medication **OR** Mirabegron, in people for whom anticholinergic drugs are contraindicated or clinically ineffective, or have unacceptable side effects (NICE TA290). • They have been referred to secondary care for specialist assessment and a diagnosis of detrusor over activity has been confirmed. • Symptoms are refractory to injections of Botulinum Toxin Type A into the bladder wall (only in patients willing and able to self-catheterise). (**NB**. If Botox has not been tried, the IFR should include a valid clinical explanation for this). Before a temporary SNS device is fitted, ALL prospective patients must be: • Able to record voiding diary data so that clinical results of the implantation can be evaluated. • Fully informed of the risks and benefits of the procedure and, therefore, able to make an appropriate choice and consent to treatment. Before a permanent SNS device is fitted, **ALL** prospective patients must have been approved for and have undergone a positive trial period (2-3 weeks) of temporary stimulation resulting in a 50% or greater improvement in voiding function based on the results of a voiding diary. SNS will not be commissioned for patients with: • Stress incontinence, the most common type of urinary dysfunction. • Urinary retention due to obstruction (e.g. from benign prostatic hypertrophy, cancer, or urethral stricture). • Urge incontinence due to psychological or neurological conditions, such as diabetes with peripheral nerve involvement, MS, stroke or spinal cord injury (see NICE CG148).

	SNS for Chronic Neuropathic Pain Spinal cord stimulation is recommended as a possible treatment for adults with chronic pain of neuropathic origin if they: • Continue to experience chronic pain (measuring at least 50 mm on a 0-100 mm visual analogue scale) for at least 6 months despite standard treatments, and • Have had a successful trial of spinal cord stimulation as part of an assessment by a specialist team. • Treatment with spinal cord stimulation should only be given after the person has been assessed by a specialist team experienced in assessing and managing people receiving treatment with spinal cord stimulation. The CCG does not routinely fund high frequency stimulators. Re-chargeable batteries for implantable pulse generators will be funded where this avoids the need for further surgery. It is expected that where there are different systems of equal effectiveness, the least costly system is used. The CCG does not commission Spinal Cord Stimulation as a treatment option for adults with chronic pain of ischaemic origin. **NB.** Funding for patients not meeting the above criteria will only be made available in clinically exceptional circumstances. For those patients who are not eligible for treatment under this policy, will be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed via the CCG Prior Approval Process. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a BMI greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the

	leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin https://www.nice.org.uk/guidance/ta159 2. Low back pain in adults: early management https://www.nice.org.uk/guidance/cg88 3. Royal College of Anaesthetists - Guidance on competencies for Spinal Cord Stimulation

7.3.34 SPINAL INJECTIONS (THERAPEUTIC) FOR PAIN

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>CRITERIA TO GUIDE CLINICAL JUDGEMENT</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>SPINAL INJECTIONS (THERAPEUTIC) FOR PAIN RELATED TO THE LUMBAR SPINE</td></tr>
<tr><td></td><td>Spinal Therapeutic Injections

This commissioning policy:

• Is applicable to non-specific low back pain. This is defined as low back pain not attributable to a recognisable, known specific pathology.
• Addresses therapeutic use of spinal injections. It does not address diagnostic indications.
• Does not apply to Radiofrequency Denervation or Medial Branch Blocks.

NICE Guidance NG59 clearly states: Do not offer spinal injections for treating low back pain. This refers to:

1. Epidural Steroid Injections

Epidural steroid injections for sciatica and spinal stenosis have an unclear therapeutic effect, but may help reduce pain for a short time in some people.

2. Facet Joint Injections

A cervical, thoracic or lumbar facet joint injection involves injecting a small amount of local anaesthetic (numbing agent) and/or steroid medication into one or more facet joints. The therapeutic effect is also unclear but they may help reduce pain for a short time in some people.

3. Selective Nerve Root Block Injections (SNRB)

Primarily used to diagnose the specific source of nerve root pain (such as a facet joint medial branch block) and secondarily for temporary therapeutic relief of low back pain and/or leg pain, such as during</td></tr>
</table>

<table>
<tr><td></td><td>surgical procedures.</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>

Spinal therapeutic injections in the lumbar spine are not routinely commissioned for patients with chronic (defined as more than 3 months duration) non-specific low back pain with or without sciatica.
Spinal therapeutic injections in the lumbar spine should not be routinely commissioned for patients with acute (defined as less than 3 months duration) episodes of back pain.

Exceptions

Following the November 2016 NICE Guideline NG 59 for the management of low back pain and sciatica in the over 16s, the CCG routinely commission a single injection only for acute and severe sciatica of less than 3 months duration for people who would be considered for surgery.

Repeat Spinal Injections

Repeat injections should not be routinely provided as there is a lack of high quality supporting evidence for long term benefit and clinical advice suggests diminishing returns with increased risk of adverse events.

Repeat injections may be commissioned only following a specialist multi-disciplinary pain management team assessment which concludes that:

Benefits outweigh harm to the patient.
There is documented evidence from the patient’s previous medical history of substantial and sustained benefit; for example if there has been a more than 50% reduction in symptoms for more than 12 weeks with documented evidence of improved health function in physical activity/role and emotional and social role function.
Where it is considered by a pain management clinician that a repeat injection or a single series of injections such as trigger point injections may break the cycle of pain and muscle disuse and support patients to engage with rehabilitation and self-management strategies.
Pain self-management is more challenging due to coexisting physical or mental illness or frailty.

</td></tr>
</table>

	Referrals On referral to the specialist multidisciplinary pain management service, patients must be informed that the referral is for assessment and development of a pain management plan by the service with focus on multimodal self-management approach. For people where there is clear documented evidence of a pre-existing chronic, persistent or long term pain (more than 3 months duration) it should be made clear that the emphasis will be on supporting their confidence and skills to self-manage their condition. Patients should not be under the impression that the decision to provide an injection has already been made or that repeat injections are routinely available. **NB.** Funding for patients not meeting the above criteria will be considered on an individual basis where their consultant has completed the necessary Individual Funding Request form. Each individual case will be reviewed via the CCG's Individual Funding Request process **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** NICE Guidance (NG59) clearly states that the decision to refer a person for a surgical opinion **should not** be influenced by their body mass index (BMI), smoking status or psychological distress. However, the following should be considered: • **Obesity** - Patients with a BMI greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.

Summary of evidence/ rationale	
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	1. Low back pain and sciatica in over 16s: assessment and management (Nov 2016) 2. Non-specific low back pain and sciatica: management – NICE 3. NICE Evidence Search | Spinal injections 4. NICE Evidence Search | facet joint injections 5. NICE Evidence Search | lumbar spine injections 6. NICE Evidence Search | epidural guidelines 7. NICE Evidence Search | spinal stenosis treatments 8. NICE Evidence Search | epidural steroid injection - NHS Evidence 9. NICE Evidence Search | epidural steroid injection - NHS Evidence 10. British Pain Society Guidelines for Pain Management Programmes Adults 2013

7.3.35 SURGICAL SCAR REVISION/KELOIDECTOMY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**SURGICAL SCAR REVISION/KELOIDECTOMY**
ELIGIBILTY CRITERIA	Revision surgery for scars including keloid scars is not routinely commissioned by the CCG for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • Has significant deformity; • Has severe functional problems, or needs surgery to restore normal function; • Causes significant pain requiring chronic analgesic medication; • Bleeding; • Obstruction of orifice or vision; • Has a scar resulting in significant facial disfigurement. **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound

	complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.36 SURROGACY

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**SURROGACY**
ELIGIBILTY CRITERIA	Criteria have been agreed across the Yorkshire and Humber: (See Appendix D– separate document to this policy.) Surrogacy arrangements will not be funded, but we will fund treatment (IVF component and storage) in identified (fertile) surrogates, where this is the most suitable treatment for a couple infertility problem and the eligibility criteria are met.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

7.3.37 TATTOO REMOVAL

POLICY STATEMENT	**COMMISSIONING POLICY**
STATUS	**NOT ROUTINELY COMMISSIONED**
PROCEDURE/ TREATMENT	**TATTOO REMOVAL**
ELIGIBILTY CRITERIA	Tattoo removal is not routinely commissioned by the CCG. Cases may be considered on an exceptional basis, for example where the patient: • Has suffered a significant allergic reaction to the dye and medical treatments have failed. • Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo"). • Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial functioning.) **NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).** • **Obesity** - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery. • **Smoking** - In line with 'Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who

	smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.
Date effective from	27 May 2021
Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care
Reference	NHS England Interim Commissioning Policy: Tattoo Removal November 2013

7.3.38 TREATEMENT FOR THREAD VEINS/TELANGIECTASIAS

<table>
<tr><td>POLICY STATEMENT</td><td>COMMISSIONING POLICY</td></tr>
<tr><td>STATUS</td><td>NOT ROUTINELY COMMISSIONED</td></tr>
<tr><td>PROCEDURE/
TREATMENT</td><td>TREATEMENT FOR THREAD VEINS/TELANGIECTASIAS</td></tr>
<tr><td>ELIGIBILTY CRITERIA</td><td>Treatment for thread veins and telangiectasia is not routinely commissioned by the NHS for cosmetic reasons.

Funding for patients will be considered on an individual basis where their GP or consultant has completed the necessary Individual Funding Request Form.

NB. Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated).

• Obesity - Patients with a body mass index (BMI) greater than 30 kg/m^2 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.
• Smoking - In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.</td></tr>
<tr><td>Date effective from</td><td>27 May 2021</td></tr>
</table>

Date published	15 June 2021
Review date	27 November 2021
Author	N/A (Taken from existing policies)
Clinical Reviewers	N/A (Taken from existing policies)
Approved by	Quality, Performance & Governance Committee
Responsible Officers	Chief Operating Officer, North Kirklees & Wakefield CCG NHS North Kirklees CCG & NHS Wakefield CCG GP Leads Planned Care

Appendices

Appendix A: Equality and Quality Impact Assessment

Title of policy	NHS Wakefield CCG Commissioning Policy	
Names and roles of people completing the assessment	Louise Horsfield, Interim Senior Transformation Manager (Contractor)	
Date assessment started/completed	11/05/2021	11/05/2021

1. Outline	
Give a brief summary of the policy	The policy details, for NHS Wakefield CCG, where there are criteria to define the circumstances within which its patient population may obtain specific types of healthcare.
What outcomes do you want to achieve	To clearly document and make available the types of healthcare which are subject to criteria or not routinely commissioned, and to ensure that the commissioned and delivered healthcare for the CCG's population is in line with the latest national, regional and local policies.

2.Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations			
	Are there any likely	Are these negative	What action will be taken to address any negative

	impacts? Are any groups going to be affected differently? Please describe.	or positive?	impacts or enhance positive ones?
Age	No		
Carers	No		
Disability	No		
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	No		
Gender reassignment	No		
Pregnancy and maternity	No		
Marriage and civil partnership	No		
Other relevant	No		

group			

If any negative/positive impacts were identified are they valid, legal and/or justifiable? Please detail.	N/A

4. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	This EIA will be reviewed as part of the wider policy in 6 months' time.		
Lead Officer	Simon Rowe, Head of Contracting & Interim Head of Acute Commissioning	Review date:	Tbc (6 months)

5.Sign off			
Lead Officer			
Director		Date approved:	

Once complete please forward to the CCG's Equality lead

Appendix B: Individual Funding Request Form

Confidential

Individual Funding Request (IFR) - Referral Form

This form should be completed by the clinician with the most knowledge of the intervention / procedure that is being requested and the most knowledge of the patient that it is being requested for.

NHS Number:	DOB:
DETAILS OF REQUEST AND SUPPORTING INFORMATION **Please ensure that all relevant information is included in this form or is attached to ensure that requests are processed in a timely manner**	
Individual Funding Request for intervention/procedure;	
Is the requested intervention required to be performed within a strict time-frame? If YES, please provide further evidence; Would undue delay result in a real and imminent risk of harm? If YES, please provide further evidence;	

Clinical Information to support the request (including BMI measurement where relevant);
Have you checked the CCG's Commissioning Policy? **Yes/No**
Are you aware of the CCG's eligibility criteria relating to this procedure? **Yes/No**
Where eligibility criteria exist, does the patient meet the eligibility criteria outlined in the policy? **Yes/No** If yes, please provide relevant information relating to each of the eligibility criteria;

Detail standard interventions and alternative options tried providing evidence to support why this procedure/treatment is the most appropriate treatment option for this patient?
Evidence base to support the request (including clinical opinion & NICE etc):
Evidence to support that this individual is exceptional when compared to other individuals with the same clinical presentation;
Expected outcomes (including duration of treatment and frequency if relevant & proposals for monitoring success):

Details of the proposed provider including costs of the requested treatment:

For equipment requests, please ensure that 3 comparable quotes are attached

I confirm that I have discussed this referral with the patient and in line with GDPR have informed the patient how their information will be processed. The patient has given consent for their information to be shared with the IFR Team at Greater Huddersfield CCG.

Signed: Date:

Please print name:

Position & address of referring clinician (Practice stamp) & GP Practice if different:

Details of where to send this form **(Please mark as CONFIDENTIAL)**

Individual Funding Requests Team

NHS Kirklees Clinical Commissioning Group

2nd Floor

Norwich Union House

Market Street

Huddersfield,

HD1 2LF

Telephone: 01484 464438
Safe Haven email: KIRKCCG.IFR-CKW@nhs.net

Appendix C: List of Complementary / Alternative Therapies

Active release technique
Acupressure
Acupuncture
Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries) technique
Alexander technique
AMMA therapy
Antineoplaston Therapy and Sodium Phenylbutyrate
Apitherapy
Applied kinesiology
Aromatherapy
Art therapy
Aura healing
Autogenous lymphocytic factor
Auto urine therapy
Bioenergetic therapy
Biofield Cancell (Entelev) cancer therapy
Bioidentical hormones
Brain integration therapy
Carbon dioxide therapy
Cellular therapy
Chakra healing
Chelation therapy for Atherosclerosis
Chung Moo Doe therapy
Coley's toxin
Colonic irrigation
Colour therapy
Conceptual mind-body techniques
Craniosacral therapy
Crystal healing
Cupping
Dance/Movement therapy
Digital myography
Ear Candling
Egoscue method
Electrodermal stress analysis
Electrodiagnosis according to Voll (EAV)
Equestrian therapy - Hippotherapy
Essential Metabolics Analysis (EMA)
Essiac
Feldenkrais method of exercise therapy (also known as awareness through movement)
Flower essence
Fresh cell therapy
Functional intracellular analysis
Gemstone therapy
Gerson therapy
Glyconutrients
Graston technique
Greek cancer cure
Guided imagery
Hair analysis
Hako-Med machine (electromedical horizontal therapy)
Hellerwork
Hoxsey method

Human placental tissue
Hydrolysate injections
Humor therapy
Hydrazine sulfate
Hydrogen peroxide therapy
Hypnosis
Hyperoxygen therapy
Immunoaugmentive therapy
Infratronic Qi-Gong machine
Insulin potentiation therapy
Inversion therapy
Iridology
Iscador
Juvent platform for dynamic motion therapy
Kelley/Gonzales therapy
Laetrile
Live blood cell analysis
Macrobiotic diet
Magnet therapy
MEDEK therapy
Meditation/transcendentalmeditation
Megavitamin therapy (also known as orthomolecular medicine)
Meridian therapy
Mesotherapy
Moxibustion
MTH-68 vaccine
Music therapy
Myotherapy
Neural therapy
NUCCA procedure
Ozone therapy
Pfrimmer deep muscle therapy
Polarity therapy
(Poon's) Chinese blood cleaning
Primal therapy
Psychodrama
Purging
Qigong longevity exercises
Ream's testing
Reflexology (zone therapy)
Reflex Therapy
Reiki
Remedial massage
Revici's guided chemotherapy
Rife therapy/Rife machine
Rolfing (structural integration)
Rubenfeld synergy method (RSM)
Sarapin injections
Shark cartilage products
Telomere testing
Therapeutic Eurythmy-movement therapy
Therapeutic touch
Thought field therapy (TFT) (Callahan Techniques Training)
Trager approach
Traumeel preparation

Vascular endothelial cells (VECs) therapy
Vibrational essences
Visceral manipulation therapy
Whitcomb technique
Wurn technique/clear passage therapy
Yoga

Appendix D: Yorkshire and Humber Access to Infertility Treatment Policy

Access to Infertility Treatment

Commissioning Policy Document

Yorkshire and Humber

adopted by

NHS Wakefield CCG

May 2020 – March 2023

Document Title:	Access to Infertility Treatment Commissioning Policy Document Yorkshire and Humber
Author/Lead Name: Job Title:	Michelle Thompson Assistant Director North East Lincolnshire CCG
Version No:	v11
Latest Version Issued On	February 2020
Supersedes:	All previous Access to infertility treatment policies
Date of Next Review:	April 2023
Completion Equality Impact Statement Name: Job Title: Date:	Philippa Doyle Hempsons Solicitors August 2018 (updated based on notes)
Target Audience:	Public
Dissemination:	CCG Bulletin, Internet & Intranet

APPROVAL RECORD		
	Committees / Groups / Individual	**Date**
Consultation:	Yorkshire and Humber Expert Fertility Panel	2 March 2017 31 January 2018 25 June 2018 25 January 2019
	Hempsons Solicitors	August 2018
Ratified by Committees:	CCG Senior Leadership Team	March 2020

CHANGE RECORD			
Version	**Author**	**Nature of Change**	**Uploaded**
v11.1	Tracy Morton	Added CCG details and funded cycles	March 2020

Any locally held old paper copies must be destroyed.

When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on the CCG website.

Commissioning Policy Statement

Commissioning

This document represents the commissioning policy of NHS Wakefield CCG for the clinical pathway that provides access to specialist fertility services. This commissioning policy has been developed in partnership with the Yorkshire and Humber Expert Fertility Panel. It is intended to provide a framework for the commissioning of services for those couples who are infertile and require infertility interventions.

The policy was developed jointly by Clinical Commissioning Groups in the Yorkshire and Humber area and provides a common view of the clinical pathway and criteria for commissioning services which have been adopted by NHS Wakefield CCG.

Funding

The policy on funding of specialist fertility services for individual patients is a policy of NHS Wakefield CCG and is not part of the shared policy set out in the rest of this document. The number of full IVF cycles currently funded by NHS Wakefield CCG for patients who meet the access criteria set out in the shared policy is one. This is unchanged from the previous commissioning policy. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

Immigration Health Surcharge; Right to Assisted Conception Services

Amendments to the NHS (Charges to Overseas Visitors) Regulations 2015 were introduced into Parliament on 19 July 2017. As a result, from 21 August 2017, assisted conception services are no longer included in the scope of services.

However, the October 2019 Guidance on Implementing Overseas Visitors Regulations says that: *'Where two people are seeking assisted conception services with NHS funding, and one of the two people is covered by health surcharge arrangements and the other is ordinarily resident in the UK and therefore not subject to charge, the services required by the health surcharge payer will be chargeable. Any services required by the ordinarily resident person will continue to be freely available, subject to the established local or national commissioning arrangements'.*

Our eligibility criteria for access to assisted conception services relates to couples rather than individuals. Therefore in light of this guidance, to enable the ordinarily resident person to have freely available access to services, where at least one partner is eligible for these services, the couple will be considered as eligible for services.

Working group membership and Conflicts of Interest

See appendices E and F

For Further Information about this policy.

Please contact your local Clinical Commissioning Group.

CONTENTS

1. Aim of Paper

2. Background

3. Clinical Effectiveness

4. Cost Effectiveness

5. Description of Treatment

5.1 Principles of Care

5.2 The Care Pathway for Fertility Investigation and Referral (Fig.1)

5.3 Definition of a Full Cycle

5.4 Frozen Embryo

5.5 Abandoned Cycles

5.6 IUI and DI

5.7 Gametes and Embryo Storage

5.8 HIV / Hep B / Hep C

5.9 Surrogacy

5.10 Single Embryo Transfer

5.11 Counselling and Psychological Support

5.12 Sperm Washing and Pre-Implantation Diagnosis

5.13 Service Providers

6. Eligibility Criteria

6.1 Application of Eligibility Criteria

6.2 Overarching Principles

6.3 Existing Children

6.4 Female Age

6.5 Pre-Referral Requirements for Assisted Conception

6.6 Reversal of Sterilisation

6.7 Previous NHS Funded Cycles

6.8 Length of Relationship

6.9 Welfare of the Child

Appendix A Abbreviations

Appendix B Terms

Appendix C Equality Impact Assessment

Appendix D Version Control

Appendix E Panel Members

Appendix F Relevant Conflicts of Interest

1. AIM OF PAPER

1.1 This document represents the commissioning policy for specialist fertility services for adults registered with a Clinical Commissioning Group (CCG) in the Yorkshire and Humber region.

1.2 The policy aims to ensure that those most in need in keeping with current eligibility, are able to benefit from NHS funded treatment and are given equitable access to specialist fertility services across the Yorkshire and Humber Area, by identifying the clinical care pathway and relevant access criteria.

2. BACKGROUND

2.1 On April 1st, 2013 Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy[2]. In February 2013 NICE published revised guidance[3] which was reviewed and updated in 2016.

2.2 CCGs across the Yorkshire and the Humber agreed to work collaboratively to update the existing policy in light of the new NICE guidance and changing commissioning landscape.

2.3 In this policy document infertility is defined as:

> ***Definition of Infertility***
>
> *The inability to conceive through regular sexual intercourse for a period of 2 years in the absence of known reproductive pathology, or less than 2 years if there is a specific reproductive pathology identified.*
>
> *Where attempting to conceive by regular sexual intercourse is not possible (for example for people with a physical disability, people with psychosexual disorders or transgender and same sex couples) this will be considered as inability to conceive for the purposes of this policy.*

2.4 Fertility problems are common in the UK and it is estimated that they affect 1 in 7 couples with 80% of couples in the general population conceiving within 1 year, if:

- The woman is aged under 40 years and
- They do not use contraception and have regular sexual intercourse (NICE 2013)

Of those who do not conceive in the first year about half will do so in the second year (cumulative pregnancy rate is 90%).

The remaining 10% of couples will be unable to conceive without medical intervention and are therefore considered infertile.

[2] Yorkshire and the Humber Commissioning Policy for Fertility Services, 2010.

[3] Fertility: Assessment and treatment for people with fertility problems 2012, NICE Clinical Guideline 156.

2.5 In 25% of infertility cases, the cause cannot be identified. However, it is thought that in the remaining couples about 30% of cases are due to the male partner being unable to produce or ejaculate sufficient normal sperm, 30% are due to problems found with the female partner such as failure to ovulate or blockage to the passage of the eggs, and 10% are due to problems with both partners.

2.6 The most recent Department for Health (DH) costing tool estimates that there are 98 attendances at a fertility clinic for every 10,000 head of population. In Yorkshire and the Humber, this could range between 4000 and 5000 attendances per year which would result in approximately 1450 couples likely to be assessed as eligible for IVF treatment.

2.7 Specialist fertility services include IUI, ICSI and IVF. They may also include the provision of donor sperm and donor eggs. The majority of treatment in the UK is statutorily regulated by the Human Fertility and Embryo Authority (HFEA)[4]. All specialist providers of fertility services must be licensed with the HFEA in order to be commissioned under this policy.

2.8 NICE Clinical Guidelines 156 (2013) covering infertility recommends that:

> *Up to three full cycles of IVF will be offered to eligible couples where the woman is aged between 18 and 39 and one cycle for eligible couples where the woman is aged 40 – 42.*

NHS Wakefield CCG will fund one full cycle of IVF treatment. Where an individual feels that they have exceptional circumstances that would merit consideration of an additional cycle being funded by the NHS they should speak to their doctor about submitting an individual funding request to their local CCG.

2.9 In addition to commissioning effective healthcare, CCGs are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore, CCGs will need to exercise discretion as to the number of cycles of IVF that they will fund up to the maximum recommended by NICE.

3. CLINICAL EFFECTIVENESS

It is considered to be clinically effective by NICE to offer up to 3 stimulated cycles of IVF treatment to couples where the woman is aged between 18 – 39 and 1 cycle where the woman is aged between 40 – 42 and who have an identified cause for their infertility or who have infertility of at least 2 years duration.

4. COST EFFECTIVENESS

4.1 Evidence shows (NICE, 2013) that as the woman gets older the chances of successful pregnancy following IVF treatment falls. In light of this, NICE has

[4] https://www.hfea.gov.uk/

recommended that the most cost-effective treatment is for women aged 18 – 42 who have known or unknown fertility problems.

4.2 As research within this field is fast moving, new interventions and new evidence needs to be considered on an on-going basis to inform commissioning decisions.

4.3 Risks **-** Fertility treatment is not without risks. A summary of potential risks is outlined below:

Risks

- There are risks of multiple pregnancies during fertility treatment, which is associated with a higher morbidity and mortality rate for mothers and babies
- Women who undergo fertility treatment are at a slightly higher risk of ectopic pregnancy
- Ovarian hyper-stimulation, which is a potentially fatal condition, is also a risk. The exact incidence of this has not been determined but the suggested number is between 0.2 – 1% of all assisted reproduction
- A possible association between ovulation induction therapy and ovarian cancer in women who have undergone treatment is uncertain
- Further research is needed to assess the long-term effects of ovulation induction agents

5. DESCRIPTION OF THE TREATMENT

5.1 Principles of Care

5.1.1 Couples who experience problems in conceiving should be seen together because both partners are affected by decisions surrounding investigation and treatment.

5.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

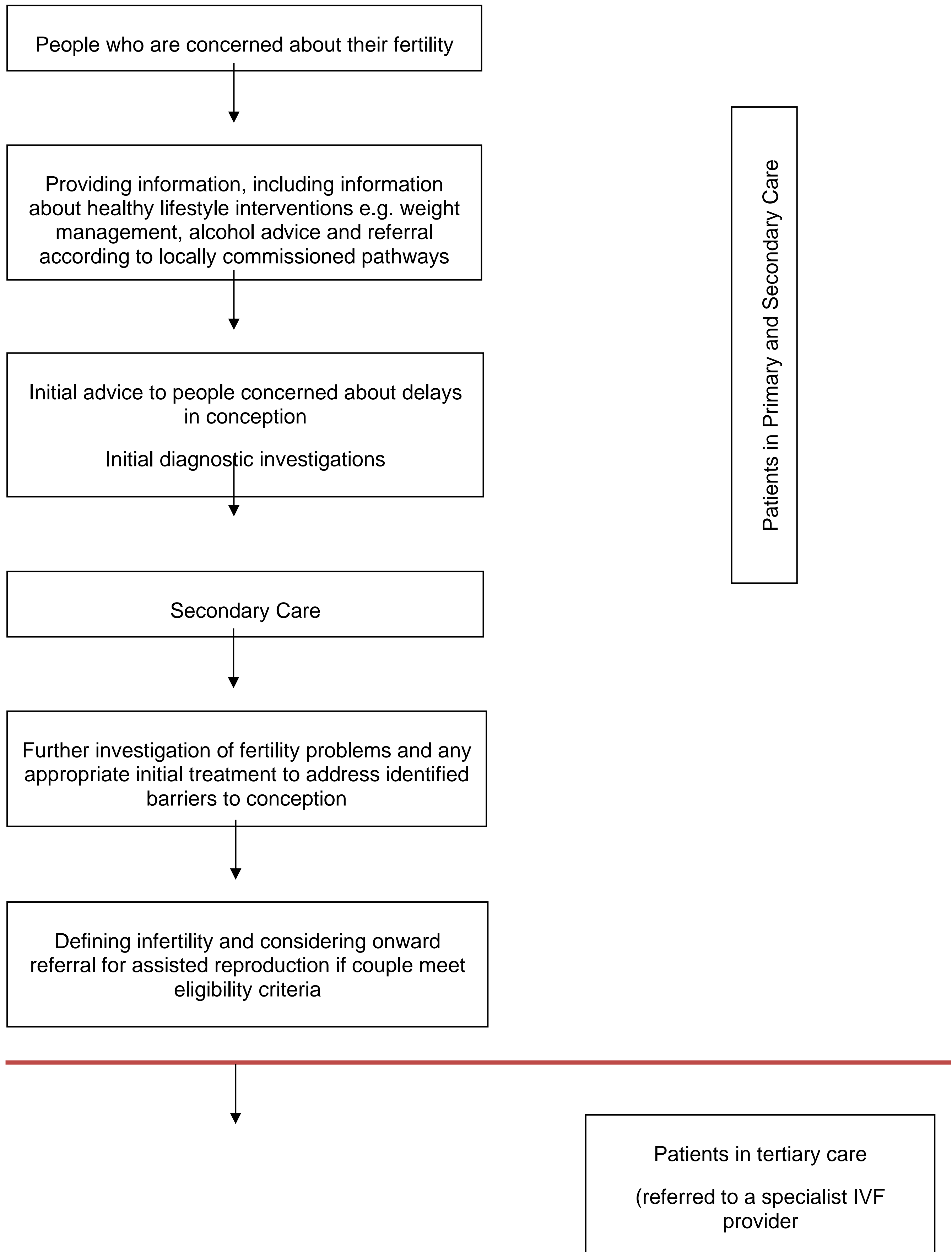
Information should be provided in the following formats:

- Face to face discussion with couples
- Written information and advice
- Culturally sensitive
- Sensitive to those with additional needs e.g. physical, cognitive, or those for whom English is not their first language

5.1.3 As infertility and infertility treatments have a number of psychosocial effects on couples, access to psychological support prior to and during treatment should be considered as integral to the care pathway.

5.2 The Care Pathway for fertility investigation and referral

Figure 1: The Care Pathway for fertility investigation and referral



Assisted Reproduction

The Care pathway for fertility investigation and referral will take account of NICE guidance.

5.2.1 Treatment for infertility problems may include counselling, lifestyle advice, drug treatments, surgery and assisted conception techniques such as IVF.

- Providers of specialist fertility services are expected to deliver appropriate interventions to support lifestyle behaviour changes which are likely to have a positive impact on the outcome of assisted conception techniques and resulting pregnancies. Recommendations covering screening, brief advice and onward referral are outlined in NICE Public Health Guidance (PH49) and, specifically in relation to fertility and pre-conception, smoking (PH 26, PH48), weight management (PH27, PH53), healthy eating and physical activity (PH11, NG7) and alcohol (PH24).
- Use any appointment or meeting as an opportunity to ask women and their partners about their general lifestyle including smoking, alcohol consumption, and physical activity and eating habits. If they practice unhealthy behaviours, explain how health services can support people to change behaviour and sustain a healthy lifestyle.
- Offer those who would benefit from this, a referral to local wellbeing services and/or locally commissioned lifestyle services. For those that are unable or do not want to attend support services direct them to appropriate self-help information such as the national 'One You' website or local websites.
- Record this in the hand-held record or accepted local equivalent.
- The care pathway (Figure 1) begins in primary care, where the first stage of treatment is general lifestyle advice and support to increase a couple's chances of conception without the need for medical intervention.

  If primary care interventions are not effective, initial assessment such as semen analysis will take place. Following these initial diagnostics, it may be appropriate for the couple to be referred to secondary care services where further investigation and potential treatments will be carried out, such as hormonal therapies to stimulate ovulation. It may be appropriate at this stage for the primary care clinician to consider and discuss the care pathway and potential eligibility for IVF. It may also be appropriate for healthy lifestyle interventions to be further discussed.

  If secondary care interventions are not successful and the couple fulfils the eligibility criteria in section 6.0, they may then be referred through to specialist care for assessment for assisted conception techniques, such as IVF, DI, IUI, and ICSI.

5.2.2 IVF involves:

- Controlled ovarian stimulation
- Monitoring the development of the eggs in the ovary
- Ultrasound guided egg collection from the ovary
- Processing of sperm
- Production of a fertilized embryo from sperm and egg cells in the laboratory
- Culture of embryos to blastocyst (*if clinically appropriate*)
- Single embryo transfer (subject to multiple birth minimisation policy)

- Use of progesterone to make the uterus receptive to implantation
- Transfer of selected embryos and freezing of those suitable but not transferred

The panel will review annually, following the HFEA[5] annual review via their traffic light report, any other emerging technologies which may then need consideration for incorporation in this policy.

5.3 Definition of a full cycle

Full cycle is the term used to define a full IVF treatment; it should include one episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s) (NICE, 2013). Or

The definition of a single full treatment cycle is the replacement of a fresh embryo and subsequent sequential replacement of all frozen embryos derived from the cycle until pregnancy is successful or harvested embryos have been exhausted.

Adherence in this way to the NICE guidelines would encourage and not disadvantage patients agreeing to single embryo transfer.

5.4 Frozen Embryo

Embryos that are not used during the fresh transfer should be quality graded using the UK NEQAS embryo morphology scheme and may be frozen for subsequent use within the cycle.

All stored and viable embryos should be used before a new cycle commences. This includes embryos resulting from previously self-funded cycles.

5.5 Abandoned Cycles

An abandoned IVF/ICSI cycle is defined as the failure of egg retrieval, usually due to lack of response (where less than three mature follicles are present) or excessive response to gonadotrophins; failure of fertilisation and failure of cleavage of embryos. Beyond this stage, a cycle will be counted as complete whether or not a transfer is attempted. One further IVF/ICSI cycle only will be funded after an abandoned cycle. Further IVF/ICSI cycles will not be offered after any subsequent abandoned cycles.

5.6 IUI and DI

IUI and DI are separate from IVF treatment; however, the couple may then access IVF treatment if appropriate.

5.6.1 People with physical disabilities, psychosexual problems, or other specific conditions with infertility (as defined in section 2.3 Definition of Infertility): Where a medical condition exists, such as physical disability up to 6 cycles of IUI may be funded,

[5] https://www.hfea.gov.uk/

followed by further assisted conception if required. In some circumstances, IUI may be impractical and so is not a requirement for further fertility treatment.

5.6.2 IUI and DI in same-sex relationships:

Up to 6 cycles of IUI will be funded as a treatment option for people in same-sex relationships, followed by further assisted conception if required.

5.6.3 People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse:

IUI either with or without ovarian stimulation will not be funded routinely (exceptional circumstances may include, for example, when people have social, cultural or religious objections to IVF), instead couples should try to conceive for a total of 2 years (this can include up to 1 year before their fertility investigations) before IVF will be considered, in keeping with current NICE guidance.

5.6.4 Gonadotrophin Therapy - for women with anovulatory infertility, ovulation induction with gonadotrophin therapy should be funded for up to 6 cycles, with or without IUI depending on the circumstances of the couple.

5.6.5 Donor Gametes including azoospermia:

Patients who require donor gametes will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria are still met. If it is anticipated that there will be difficulty finding a suitable donor exceptionality would need to be considered. At this point consideration may need to be given to sourcing from alternative providers via IFR.

Donor Sperm

Where clinically indicated up to six cycles of donor insemination will be offered. This is dependent on the availability of donor sperm which is currently limited in the UK.

The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG.

Donor Eggs

Patients eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on the waiting list for treatment with donor eggs. Unfortunately, the availability of donor eggs remains severely limited in the UK. There is, therefore, no guarantee that eligible patients will be able to proceed with treatment.

5.7 Gametes and Embryo Storage

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG. Storage will be funded by the CCG for a maximum of 3

years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.

Any embryos frozen prior to implementation of this policy will be funded by the CCG to remain frozen for a maximum period of 3 years from the date of policy adoption.

Any embryo storage funded privately prior to the implementation of this policy will remain privately funded.

5.8 HIV / Hep B / Hep C

People undergoing IVF treatment should be offered testing for HIV, hepatitis B and hepatitis C (NICE, 2013). People found to test positive for one or more of HIV, hepatitis B, or hepatitis C should be offered specialist advice and counselling and appropriate clinical management (NICE, 2013).

5.9 Surrogacy

Any costs associated with use of a surrogacy arrangement will not be covered by funding from CCGs. We will, however, fund provision of fertility treatment (IVF treatment and storage) to identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the couple meets the eligibility criteria for specialist fertility services set out in this policy.

5.10 Single Embryo Transfer

Please refer to 5.3 for the definition of a full cycle.

Multiple births are associated with greater risk to mothers and children and the HFEA[6] therefore recommends that steps are taken by providers to minimize them. This is currently achieved by only transferring a single embryo for couples who are at high risk.

We support the HFEA guidance on single embryo transfer and will be performance monitoring all specialist providers to ensure that HFEA targets are met. All providers are required to have a multiple births minimisation strategy. The target for multiple births should now be an upper limit of 10% of all pregnancies.

We commission ultrasound guided embryo transfer in line with NICE Fertility Guideline.

5.11 Counselling and Psychological Support

As infertility and infertility treatment has a number of negative psychosocial effects, access to counselling and psychological support should be offered to the couple prior to and during treatment.

5.12 Sperm washing and pre-implantation diagnosis

---

[6] https://www.hfea.gov.uk/

Sperm washing and pre-implantation genetic diagnosis are not treatments for infertility and fall outside the scope of this policy. Prior approval is required.

5.13 Service Providers

Providers of fertility treatment must be HFEA registered and comply with any service specification drawn up by Yorkshire and the Humber Clinical Commissioning Groups.

6.0 ELIGIBILITY CRITERIA FOR TREATMENT

6.1 Application of Eligibility Criteria

Eligibility criteria should apply at the point at which patients are referred to specialist care (with the exception of 6.10, which should be undertaken within specialist care). Couples must meet the definition of infertility as described in section 2.3.

6.2 Overarching Principles

6.2.1 All clinically appropriate individuals/couples are entitled to medical advice and investigation. Couples may be referred to a secondary care clinic for further investigation.

6.2.2 Assisted conception is only funded for those couples who meet the eligibility criteria.

6.2.3 Treatment limits are per couple and per individual. Referrals should be as a couple and include demographic information for both partners in heterosexual and same-sex couples.

6.3 Existing Children

Neither partner should have any living children (this includes adopted children but not fostered) from that or any previous relationship.

6.4 Female Age

Age as a criterion for access to fertility treatments is applied in line with the NICE Clinical Guideline on Fertility which is based on a comprehensive review of the relationship between age and the clinical effectiveness of fertility treatment.

The woman intending to become pregnant must be between the ages of 18 – 42 years. No new cycle should start after the woman's 43rd birthday. Referrers should be mindful of the woman's age at the point of referral and the age limit for new cycles.

Women aged 40–42 years who meet the eligibility criteria for infertility in Section 2.3, will receive 1 full cycle of IVF, with or without ICSI, provided the following criteria are fulfilled:

- they have never previously had IVF treatment and there is no evidence of low ovarian reserve (defined as FSH 9 IU/l or more (using Leeds assay); OR antral follicle count of 4 or less; OR AMH of 5 pmol/l or less
- there has been a discussion of the additional implications of IVF and pregnancy at this age
- where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, women aged between 40-42 should be referred directly to a specialist team for IVF treatment

6.5 Pre – Referral Requirement for Specialist Care

6.5.1 Female BMI

The female patient's BMI should be between 19 and 30 prior to referral to specialist services. Patients with a higher BMI should be referred for healthy lifestyle interventions including weight management advice. Patients should not be re-referred to specialist services until their BMI is within the recommended range.

6.5.2 Smoking Status

GP should discuss smoking with couples prior to referral to secondary care; support their efforts in stopping smoking by referring to a smoking cessation programme.

People should be informed that maternal and paternal smoking can adversely affect the success rates of assisted reproduction procedures, including IVF treatment.

6.6 Reversal of Sterilisation

We will not fund IVF treatment for patients who have been sterilised or have unsuccessfully undergone reversal of sterilisation.

6.7 Previous Cycles

Previous cycles whether self-funded or NHS funded will be taken into consideration when assessing a couple's ability to benefit from treatment and will count towards the total number of cycles that may be offered by the NHS. This includes where either person has had a previous cycle with a previous partner.

6.8 Length of Relationship

The stability of the relationship is very important with regards to the welfare of children; as such couples must have been in a stable relationship for a minimum of 2 years and currently co-habiting to be entitled to treatment.

6.9 Welfare of the child

HFEA guidance concerning the welfare of the child should be followed.

Appendix A

Abbreviations

BMI	Body Mass Index
CCG	Clinical Commissioning Group
DI	Donor Insemination
GP	General Practitioner
HFEA	Human Fertilisation and Embryology Authority
ICSI	Intracytoplasmic sperm injection
IUI	Intrauterine insemination
IVF	Invitro Fertilisation
NICE	National Institute for Health and Care Excellence

Appendix B

Contents

Term	Definition	Further Information
BMI	The healthy weight range is based on a measurement known as the Body Mass Index (BMI). This can be determined if you know your weight and your height. This is calculated as your weight in kilograms divided by the square of your height in metres. In England, people with a body mass index between 25 and 30 are categorised as overweight, and those with an index above 30 are categorised as obese.	BBC Healthy Living http://www.bbc.co.uk NHS Direct http://www.nhsdirect.nhs.uk
ICSI	**Intra Cytoplasmic Sperm Injection (ICSI)**: Where a single sperm is directly injected into the egg.	Glossary, HFEA http://www.hfea.gov.uk
IUI	**Intra Uterine Insemination (IUI)**: Insemination of sperm into the uterus of a woman.	As above
IVF	*In Vitro* **Fertilisation (IVF)**: Patient's eggs and her partner's sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the female patient.	As above
DI	**Donor Insemination (DI)**: The introduction of donor sperm into the vagina, the cervix or womb itself.	As above

Appendix C

Equality Impact Assessment

Title of policy	Fertility Policy	
Names and roles of people completing the assessment	Philippa Doyle Hempsons Solicitors	
Date of Assessment from – to Review date	Aug 2018 Nov 2019	Feb 2021 April 2023

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the relevant CCG to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about the fertility policy. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for specialist fertility treatment.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

2. Evidence, data or research	
Give details of evidence, data or research used to inform the analysis of impact	NICE fertility guidance https://www.nice.org.uk/guidance/cg156 (accessed 3/3/17)

3. Consultation, engagement

Give details of all consultation and engagement activities used to inform the analysis of impact	Discussion with panel of experts in Yorkshire and Humber representing commissioners and providers. All changes from the previous policy are in line with NICE guidelines which have had extensive engagement and consultation. See https://www.nice.org.uk/guidance/cg156/history

4. Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to eliminate unlawful discrimination; advance equality of opportunity; foster good relations.			
	Are there any likely impacts? Are any groups going to be affected differently? **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	Yes. IVF is only available to women aged between 18 and 42. As a woman ages the chances of successful pregnancy fall.	Both	Action cannot be taken to prevent this it is therefore incumbent simply to ensure clear age limitations are identified
Carers	No		
Disability	Yes. The policy has been enhanced to offer funding to couples who by reason of disability cannot conceive naturally	positive	The fact of this new change and opportunity to such couples can be publicised
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	Yes. The policy has been enhanced to offer funding to couples in a same sex relationship without having to demonstrate they have self-funded other trials	positive	The fact of this new change and opportunity to such couples can be publicised
Gender reassignment	Yes	positive	Gender reassignment is specifically referenced in the definition of infertility
Pregnancy and maternity	Yes. The policy enhances the ability to access fertility treatment and the potential to achieve pregnancy	positive	
Marriage and civil partnership	No		
Other relevant group			

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Each CCG to monitor individual funding requests for this procedure and identify if there are issues with the policy which require a policy refresh.		
Lead Officer	NHS Wakefield CCG	**Review date:**	April 2023

6.Sign off on behalf of the local CCG			
Lead Officer	NHS Wakefield CCG		
Lead Director		**Date approved:**	21 July 2020

Appendix D Version Control

VERSION	DATE	AUTHOR	STATUS	COMMENT
V11	Feb 19	H Lewis and M Thompson		Changes to page 3 – immigration health surcharge – reworked following updated advice Moved list of panel members to Appendix for easier access to contents of document
V10	November 2019	M Thompson on behalf of Panel		Changes to: - Page 2 & 3 – Immigration Health Surcharge – sentences reworded - 6.5.2 – Smoking Status – sentences reworded - 6.7 – Previous Self-funded Cycles – titles changed to Previous Cycles - sentences reworded - 6.8 – Previous Self-Funded Cycles - sentence removed - 6.10 – Welfare of the Child - sentence reworded
V9	January 2019	M Thompson on behalf of Panel	Draft	Changes to: - Funding - Immigration health surcharge – sentence added - 1.2 - sentence reworded - 2.3 – change of order in sentence in brackets - 5.2 – sentence included after pathway - 5.2.1 – third bullet point, wording changed - 5.2.2 – first two bullet points replaced with Controlled Ovarian Stimulation - 5.4 – heading changed to Frozen Embryo - 5.6.1 – sentence reworded - 5.6.3 – link to mild male factor infertility removed - 5.6.3 – wording added - 5.6.4 – spelling corrected - 5.6.5 – new paragraph inserted - 5.6.5 - Donor Sperm - sentence reworded - 5.7 – sentence reworded - 6.2.1 and 6.2.2 - swopped around

				and reworded - 6.5.2 – title changed - 6.5.2 – sentence reworded - 6.9 – sentence reworded
v8	June 2018	M. Thompson on behalf of Panel	Draft	Changes to:- - 2.3 Definition of Infertility - 5.2.2. – IVF involves – additional bullets added - 5.3 – Definition of cycles – removed sentence in brackets - 5.6.4 - Gonadotrophin Therapy added - 5.6.5 – renumbered – added "all couples" where this is a clinical requirement (to replace the reference to male azoospermia) added limited to UK Added additional sentence - 6.5 – title updated to – Pre-referral requirement to specialist care - 6.5.2 – non-smokers section added. - 6.9 – Updated to include the stability of the relationship
v7	Jan 2018	M. Thompson on behalf of Panel	Draft	- Changes to 5.2 pathway - Changes to funding – adding refugees and asylum seekers - Removal of summary of CCGs - 2.3 – clarification of definition of infertility - 6.7 updated to NHS Funded full cycles - 6.10 – added section - Change tertiary to specialist throughout the policy.
Review 2017	22.2.17	F Day on behalf of panel	Final draft	- changes to the definition of infertility for same sex and patients with psychosexual issues and disabilities to be more clear - the addition of public health requirements for providers in line with NICE guidance - clarification of the definition of an abandoned cycle - sections on intrauterine insemination and also egg donation updated in line with NICE guidance - Addition of People with unexplained infertility, mild endometriosis or mild male factor infertility, who are having regular unprotected sexual intercourse in line with NICE guidance - wording changed in various sections based on patient feedback to be more clear, not

				materially changed in content - embryo transfer wording updated to reflect NICE guidance - Addition of definition of low ovarian reserve (previously undefined)

Appendix E

Panel Members: (March 2017)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Chris Edward	Accountable Officer - Rotherham CCG
Dr Steve Maguiness	Medical Director - The Hull IVF Unit, Hull Women and Children's Hospital and honorary contract with HEY
Dr John Robinson	Scientific Director - IVF Unit, Hull and East Yorkshire Hospitals FT
Prof Adam Balen	Professor of Reproductive Medicine and Surgery - Leeds Teaching Hospitals NHS Trust
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Richard Maxted	Service Manager, Directorate of Obstetrics, Gynaecology and Neonatology - Sheffield Teaching Hospital NHS Trust
Dr Margaret Ainger	Clinical Director for Children, YP and Maternity - NHS Sheffield CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Dr Clare Freeman	Medical Advisor to IFR Panel - South Yorkshire and Bassetlaw CCGs

Panel Members (amendments January 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Dr Bruce Willoughby	Lead for Planned Care - NHS Harrogate and Rural District CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Karen Thirsk	Fertility Policy Manager – NHS England
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG.

Clare Freeman Lead Medical Advisor – Sheffield CCG.

Panel Members (amendments June 2018)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Dr Fiona Day	Consultant in Public Health Leeds and Associate Medical Director Leeds CCG
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Brigid Reid	Chief Nurse – NHS Barnsley CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Dr Bryan Power	(GP) - NHS Leeds CCG
Adam Balen	(Consultant) - Leeds Fertility
Clare Freeman	Lead Medical Advisor – Sheffield CCG

Panel Members (amendments January 2019)

Dr Virginia Beckett	Consultant in Obstetrics and Gynaecology - Bradford Teaching Hospital FT
Jonathan Skull	Consultant in Reproductive Medicine & Surgery – Sheffield Teaching Hospital NHSFT
Michelle Thompson	Assistant Director, Women's and Children's Services - NHS North East Lincolnshire CCG
Martine Tune	Acting Chief Nurse – NHS Barnsley CCG
Liz Micklethwaite	Business Manager IFR - NHS Leeds CCG

Commissioner Final Proof Read Panel (Amendments November 2019)

Michelle Thompson	Assistant Director, Women's and Children's Services – NHS North East Lincolnshire CCG
Helen Lewis	Head of Planned Care – NHS Leeds CCG
Clare Freeman	Lead Medical Advisor – Sheffield CCG
Karen Leivers	Head of Strategy and Delivery, Planned Care - Doncaster CCG

Debbie Stovin	Commissioning Manager – Elective Care – Sheffield CCG

Appendix F Relevant Conflicts of Interest Declared:

Dr Steve Maguiness:

IVF in Hull is provided by a private company (ERFS Co Ltd), of which I am a Director and employee.

Prof Adam Balen:

NHS Consultant in Reproductive Medicine and Clinical lead for the Leeds Centre for Reproductive Medicine, which performs all fertility treatments funded by the NHS. Partner in Genesis LLP, the private arm of the Leeds Centre for Reproductive Medicine, which performs self-funded fertility treatments using identical protocols to the NHS. Chair, British Fertility Society. Chair, NHS England IVF Pricing Development Expert Advisory Group. Chair World Health Organisation Expert Working Group on Global Infertility Guidelines: Management of PCOS. Chair, British Fertility Society. Consultant for ad hoc advisory boards for Ferring Pharmaceuticals, Astra Zeneca, Merck Serono, Gideon Richter, Uteron Pharma. Research funding received in the past. Pharmasure / IBSA- Key note lecture at ESHRE 2016 & hospitality to attend meetings. OvaScience- Member of international ethics committee. Clear Blue National medical advisory board. IVI, UK- Chair, Clinical Board

Virginia Beckett FRCO:

I have a private practice where I see fertility patients.

I have received sponsorship from Pharmasure, Ferring & Serono to attend conferences.