West Yorkshire
Health and Care Partnership

West Yorkshire
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 3 May 2022	Agenda item: 06/22		
Report title:	**Harmonisation of West Yorkshire Commissioning Policies (Tranche 1)**		
Joint Committee Sponsor:	Jo Webster		
Clinical Lead	Dr James Thomas		
Report author:	Catherine Thompson, Gaynor Goodman (Improving Planned Care)		
Presenter:	Catherine Thompson		
Purpose of report: (why this is being brought to the Committee?)			
Decision	✓	Comment	
Assurance			

Executive summary

The Health and Care Bill 2021 following the Department of Health and Social Care's published White Paper on *Integrated care: next steps to building strong and effective integrated care systems across England,* is currently progressing through Parliament and sets out plans to put integrated care systems on a statutory footing. The new legislation will transfer the core functions from clinical commissioning groups to the new statutory Integrated Care Board (ICB) on 1 July 2022 (subject to parliament approval) for it to become a single commissioning entity.

The West Yorkshire Health and Care Partnership (WY HCP) Improving Planned Care programme addresses clinical thresholds and criteria for clinical procedures, including standardisation of clinical pathways and commissioning policies. The purpose of the clinical thresholds workstream is to review and harmonise the clinical thresholds for these policies across the five Clinical Commissioning Groups (CCGs) of West Yorkshire (WY). This will reduce variation in access to care across WY and ensure that care is evidence based.

In preparation for the new ICB, the clinical thresholds across WY need to be harmonised and disparities worked through. This is a significant amount of work, with the WY clinical thresholds working group and the senior leadership of the ICS agreeing to bundle policies together and undertaking a combined robust Quality and Equality Impact Assessment (QEIA) to ensure we consider patients and the public in undertaking this harmonisation work.

The WY HCP improving planned care programme has been working on two bundles of these policies that form tranche 1 of these harmonised clinical thresholds/commissioning policies.

There are a total of 19 commissioning policies in this tranche 1 divided as follows:

Bundle 1 policies (9 in total):

- Allergy
- Circumcision

- Cryopreservation
- Infertility treatment and Surrogacy
- Labial reduction and cosmetic vaginal procedures
- Lycra garments
- Pinnaplasty
- Repair of external ear lobes
- Reversal of vasectomy and female sterilisation

Bundle 2 policies (10 in total):

- Breast Policy
- Breast reduction for Male Gynaecomastia
- Laser treatments not covered elsewhere
- Mastopexy
- Rhinophyma
- Scar revision (inc acne) and Keloidectomy
- Surgical correction of Benign nipple inversion
- Tattoo removal
- Thread veins (Telangiectasia)
- Vascular skin lesions

Bundle 1 of the commissioning policies/clinical thresholds was presented at the WY Planned Care Alliance Board on 13 December 2021, and bundle 2 on 11 April 2022 to ensure representation and agreement from all five CCGs within WY prior to recommendation to the Joint Committee.

In prioritising the harmonisation of the WY clinical thresholds consideration has been given to the number of individual funding requests (IFRs) made by patients across WY in the 12 months prior to November 2021 to ensure the most effective interventions for patients, which could contribute to most of the disparity across Places with cosmetic procedures and fertility interventions contributing significantly to the number of IFRs in the 12 months prior to November 2021.

Recommendations and next steps

The Improving Planned Care programme team and the WY Clinical Thresholds Working Group continue to work on further clinical interventions across the remaining commissioning policies that exist across our five West Yorkshire Places with the intention to bring a subsequent and final tranche (2) of commissioning policies/clinical thresholds for the approval of the WY Joint Committee.

The WY Joint Committee is asked to **approve** the attached nineteen harmonised WY commissioning policies/clinical thresholds, being the first tranche of policies, for approval pending the transferring of core functions from the five WY clinical commissioning groups to the new statutory ICB on 1 July 2022 (subject to parliamentary approval).

Delivering outcomes: describe how the report supports the delivery of ICS outcomes (Health and wellbeing, care and quality, finance and efficiency)

Health and Wellbeing: Clinical thresholds and criteria are for procedures which provide benefit to only a limited number of people, or which should only be offered after other treatment options have been tried. The harmonisation of WY's commissioning policies and their respective clinical thresholds aims to improve the health outcomes of the people of WY and their experiences of care in addressing the variation of care across WY.

Care and Quality: Harmonising the WY commissioning policies and their respective clinical thresholds will achieve the Joint Committee's aim of reducing the variation in treatment offered to people across our region and ensure the care they receive is evidence based. **Finance and Efficiency:** Harmonising the WY clinical thresholds will contribute towards addressing the variation in care that exists across the five WY Places when the WY ICS becomes a statutory organisation on 1 July 2022 (subject to parliamentary approval).	
Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	See paragraphs 4 to 16, and appendices 2 through to 6
Public involvement:	See paragraphs 5 to 10, appendices 5 and 6
Finance:	See paragraphs 12 to 16, and appendices 1, 5 and 6
Risk:	See paragraph 8 to 17, and appendices 1, 3, 4, 5 and 6
Conflicts of interest:	Dr James Thomas: Medical Director (Designate) for West Yorkshire ICB, GP Bradford and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Jo Webster: Chief Officer of Wakefield CCG, Director of Adult Services at Wakefield Metropolitan District Council, Director of Adult Community Services, Mid Yorkshire Hospital Trust Catherine Thompson: None, Gaynor Goodman: None

West Yorkshire Joint Committee of Clinical Commissioning Groups
3 May 2022

Harmonisation of West Yorkshire Commissioning Policies (tranche 1)

Introduction

1. The West Yorkshire Improving Planned Care programme addresses clinical thresholds and criteria for clinical procedures, including standardisation of clinical pathways. The purpose of the clinical thresholds workstream is to review and harmonise the clinical thresholds for these policies across the five Clinical Commissioning Groups of West Yorkshire (WY). This will reduce variation in access to care across WY and ensure that care is evidence based.

2. The Improving Planned Care programme of the West Yorkshire Health and Care Partnership (WY HCP) has considered the harmonisation of the commissioning policies across WY with the Health and Care Bill 2021 putting Integrated Care Systems on a statutory footing and the transferring of core functions from clinical commissioning groups to the new statutory Integrated Care Board on 1 July 2022 (subject to parliamentary approval), and what this means in addressing variation across the five Places within WY. The Improving Planned Care programme have standardised clinical pathways for a range of conditions and harmonised the clinical thresholds for policies within these pathways. A number of these policies and pathways have been approved by the WY HCP Joint Committee of CCGs (Joint Committee), namely the MSK pathway for WY&H and the range of MSK policies to support implementation of that pathway.

3. As part of the Improving Planned Care Programme governance process to support decision making through the Joint Committee as set out in the scheme of delegation appended to the WY&H Memorandum of Understanding. This has been discussed and agreed through clinical engagement. Each policy or pathway during its development is mapped against the current pathway and policy in each of the five WY CCGs and the WY Quality and Equality Impact Assessment (agreed at the January 2019 Joint Committee) is completed to identify barriers and levers to implementation across WY.

Harmonisation of West Yorkshire Commissioning Policies

4. The MSK workstream of the Improving Planned Care programme established a Clinical Threshold Working Group to work collaboratively in a team of teams approach with each of the five CCGs of WY in developing the WY&H MSK pathway. That working group continues its work on clinical thresholds for commissioning policies across WY. In preparation for the new statutory WY ICB the WY Clinical Threshold Working Group in prioritising the work needing to be undertaken in harmonising the clinical thresholds across WY have done so by capturing the Individual Funding Requests (IFRs) activity across WY in the 12 months prior to November 2021 **(Appendix 1),** to highlight where disparities may exist across the five Places within WY. Addressing these disparities is critical in reducing variation in care across the most effective interventions for patients, and offering the most effective use of clinical time, particularly during recovery of Planned Care services in response to the Covid 19 pandemic.

5. **Appendix 1,** summary of IFR activity, highlights that in the 12 months prior to November 2021 across the five Places within WY the following category of interventions had a high number of requests:

    - Cryopreservation
    - Infertility treatment and Surrogacy
    - Labial reduction and cosmetic vaginal procedures
    - Pinnaplasty
    - Cosmetic procedures for skin, facial, body and breasts
    - Botox
    - Open/Upright MRI
    - Insulin pumps
    - Glucose monitoring
    - Hair removal
    - Neuro placements

    The WY Clinical Thresholds Working Group have been working with colleagues across all five Places, supported by the WY Improving Planned Care programme, to harmonise these categories of interventions, and undertaking the collation of data and completion of robust quality and equality impact assessments (QEIA), as well as the required clinical engagement, to identify and address disparities, thus ensuring we consider patients and the public in undertaking this harmonisation work.

6. The nineteen commissioning policies and their harmonised clinical thresholds are presented for approval by the West Yorkshire Joint Committee and are attached. Engagement with the West Yorkshire Health and Care Partnership's Diabetes Programme and the Medicines Optimisation Leads across the five West Yorkshire Places has established that new NICE Guidance around Insulin pumps and Glucose monitoring was published on 31 March 2022 (Overview | Type 2 diabetes in adults: management | Guidance | NICE and Overview | Type 1 diabetes in adults: diagnosis and management | Guidance | NICE) and as such, said Programme and Leads are managing the harmonisation of these policies across West Yorkshire and they will be addressed separately from the work being undertaken by the West Yorkshire Planned Care Alliance and the WY HCP Improving Planned Care programme.

7. Engagement is currently ongoing with the Yorkshire Imaging Collaborative regarding harmonisation of the Open/Upright MRI commissioning policy to ensure that in addressing any identified disparities these are considered within the recovery of diagnostic services across West Yorkshire in response to the Covid 19 pandemic. Cosmetic procedures for face and body, and hair removal together with neuro placements are currently being worked on in the third bundle and the final tranche (tranche 2) of these policies, with the plan to bring them to the WY Joint Committee for approval on 7 June 2022. Botox policies are currently subject to review by the Medicines Optimisation Leads across the five WY Places.

Engagement and Consultation

8. Engagement and/or consultation has been carried out with primary care and secondary care colleagues at Place, with the GP Planned Care Leads across West Yorkshire, and with the WY Public and Patient Involvement Assurance Group in harmonising the nineteen attached WY commissioning policies and their respective clinical thresholds (**Appendix 2**). The mapping and gapping documents (**Appendix 3** (bundle 1) **and Appendix 4** (bundle 2)) highlight that in harmonising the clinical thresholds across the five Places within WY there has not been a significant change in the clinical criteria from that detailed within these policies when they were initially approved and implemented across Place, with there being no change, or minimal change for patients, or an improvement for patients where a Place didn't already have a commissioning policy. The separate Acne Scarring, Cosmetic skin procedures and conditions not covered elsewhere, and Skin hypopigmentation and skin resurfacing policies will be removed as part of this harmonisation work as detailed on the mapping and gapping document **(Appendix 4** (bundle 2)**)** with these interventions covered in other commissioning policies and are as such, currently duplicated across several policies.

9. In harmonising cosmetic breast procedures, in engaging with secondary colleagues it was identified there was duplication in criteria across these procedures with a recommendation to provide clarity for patients and clinicians in establishing a single WY Breast policy for Breast Augmentation, Breast Reconstruction, Reduction Mammoplasty, Revision Breast Augmentation and Breast Asymmetry rather than having a separate commissioning policy for each.

10. On 20 January 2022, NHS England and NHS Improvement published consultation of List 3 of its Evidenced Based Interventions programme (EBI) on the Academy of Medical Royal Colleges website EBI List 3 consultation - aomrcebi. That consultation closed on 31 March 2022. The following interventions that are included in tranche 1 of the harmonisation of the WY clinical thresholds and are attached were included in that consultation: -

    - Breast surgery
    - Male gynaecomastia reduction surgery
    - Breast prosthesis removal
    - Corrective surgery for congenital breast asymmetry

    In harmonising the clinical thresholds for these four WY commissioning policies detailed above and taking into consideration the national consultation on EBI List 3, secondary care clinicians were able to provide clarity on the criteria for the four interventions for the benefit of clinical colleagues and patients. At such time, the consultation on EBI List 3 is published the West Yorkshire Health and Care Partnership and the West Yorkshire Planned Care Alliance will consider what this will mean for the clinical interventions subject to that consultation.

Quality and Equality Impact Assessment

11. The Quality and Equality Impact Assessments (QEIA), (**see Appendix 5** (bundle 1) and **Appendix 6** (bundle 2) demonstrate that harmonising these nineteen WY commissioning policies and their respective clinical thresholds this will have a positive impact on patients in reducing the variation in care and access to care that exists across WY. A key consideration of the WY Improving Planned care Programme is equitable access to appropriate, evidence-based interventions. By harmonising the WY clinical thresholds, we aim to reduce variation and inequalities in health outcomes for the population of West Yorkshire by systematically offering the most up-to-date clinically proven treatments and making the most effective use of NHS resources.

Impact of Implementation

12. Harmonising the clinical thresholds for the commissioning polices in bundle 1 will be an improvement for patients and clinicians in adding greater detail on clinical criteria and reference to clinical evidence for the following interventions: Male Circumcision, Reversal of Vasectomy and Sterilisation, Lycra Garments and Labial Reduction and Cosmetic Vaginal Procedures; with added reference to patient information from the Royal College of Obstetrics and Gynaecology for the latter intervention. No commissioning policy currently exists for Cryopreservation in Calderdale, Kirklees and Wakefield and the policy in Bradford and Craven only covers males. This policy has been aligned to NICE guidance across all five Places in West Yorkshire to cover males and females. Pinnaplasty has been aligned to the national commissioning policy to cover children and young people across West Yorkshire aged 5 to 18 years. This is a 1 year age reduction across Calderdale, Kirklees and Wakefield where it currently is up to the age of 19 years but is an increase in Leeds where it's currently 16 years of age. Repair of External Ear Lobes remains the same across all West Yorkshire Places apart from Leeds where a 2 year limit for repair of ear due to injury is removed.

13. The combined WY Breast policy removes duplication of criteria and applies consistency of terminology and clinical interventions. There is one significant change being the adoption of a BMI threshold of 30 across all WY five Places where it currently stands at 27 with Leeds being the exception in having a threshold of 30. It should be noted that in the national EBI List 3 consultation that closed on 31 March 2022 (see paragraph 11) that a BMI threshold of 30 and lower is proposed. For Breast Asymmetry reference to 'a letter from a bra fitter' is replaced with measurement criteria to reflect clinical criteria. The Laser treatments not covered elsewhere commissioning policy is currently a 'Leeds only' policy with the recommendation for it to be adopted across all five WY Places. Only Bradford & Craven currently don't have a Breast Reduction for Male Gynaecomastia commissioning policy with a recommendation for Bradford & Craven to adopt this policy. Similarly, this is the case with the Rhinophyma commissioning policy, which exists across the four remaining WY Places and following engagement with secondary care clinicians recommends introducing access to treatment without prior approval with clinical criteria aligned to the dermatology life quality index added to the WY wide commissioning policy.

14. In lowering (making less stringent) the threshold for some clinical interventions and implementing a commissioning policy in a Place that currently doesn't have one there is potential for an increase in the number of interventions performed each year. As with previous similar pieces of work there is no correlation between presence or absence of a policy, or stringency of a policy with the number of interventions undertaken in that Place. Thus, it is difficult to predict at this time to what extent patient demand for these interventions will change as a result of these proposed harmonisations of policy. As a result there is a potential financial risk from the implementation of these policies, but it is not possible to estimate what this might be. Similarly, the impact that potential changes in demand will have on planned care referrals into secondary care and recovery of waiting lists across WY cannot currently be modelled.

15. In completing the QEIA for this tranche of policies, it is proposed to capture the impact on the demand for IFRs and planned care activity at both the 6 month stage and 12 month stage after implementation of the WY harmonised commissioning policies, when it would be possible to extrapolate any increase in demand for the nineteen clinical interventions presented here, and the remaining interventions that will be presented to the WY Joint Committee on 7 June 2022 for approval. Consequently, how any such increase in demand may impact on the planned care waiting list activity and financial resource on each of the five WY Places and the WY ICB would also be measured.

16. It is further proposed in the absence of any available data by protected group for applicants and successful applicants who make/have made individual funding requests (IFRs) to undertake engagement with patients and IFR applicants on the changes to the WY commissioning policies/clinical thresholds, to capture the impact said changes have on addressing health inequalities across West Yorkshire and each protected group of people.

Summary and Recommendations

17. The WY Joint Committee is asked to approve the harmonisation of these nineteen WY commissioning policies and their respective clinical thresholds pending the transferring of core functions from the five WY clinical commissioning groups to the new WY statutory ICB on 1 July 2022 (subject to parliamentary approval).

List of Appendices:

1. **Details of Individual Funding Requests made in each WY CCG over the 12 months prior to November 2021**

2. **Nineteen WY Commissioning Policies:**

   Nine Policies harmonised in December 2021 (bundle 1)

   - Allergy
   - Male Circumcision
   - Cryopreservation
   - Infertility treatment and Surrogacy
   - Labial reduction and cosmetic vaginal procedures
   - Lycra garments
   - Pinnaplasty
   - Repair of external ear lobes
   - Reversal of vasectomy and female sterilisation

   Ten Policies harmonised in April 2022 (bundle 2)

   - Breast Policy
   - Breast reduction for Male Gynaecomastia
   - Laser treatments not covered elsewhere
   - Mastopexy
   - Rhinophyma
   - Scar revision (inc acne) and Keloidectomy
   - Surgical correction of Benign nipple inversion
   - Tattoo removal
   - Thread veins (Telangiectasia)
   - Vascular skin lesions

3. **Mapping and Gapping document - bundle 1**
4. **Mapping and Gapping document - bundle 2**
5. **Quality and Equality Impact Assessment – bundle 1**
6. **Quality and Equality Impact Assessment – bundle 2**

Appendix 1

West Yorkshire Health and Care Partnership Individual Funding Requests in the last 12 months – November 2021

IFR numbers

Intervention	**Bradford & Craven**	**Calderdale & Kirklees**	**Leeds**	**Wakefield**
Botox	14		9	
Diabetic monitors***	6	34		40
Equipment	10	9		32
IVF/Fertility	10	5	7	2
IVF donor eggs or sperm			1	
IVF – Embryo donation		1	1	
IVF surrogacy		1	1	
Continuation of egg freezing			1	
Cryopreservation of Eggs		1	2	
Continuation of sperm storage		1	2	1
Reversal of sterilisation		1	1	
Laser Hair removal	6	9	5	7
Laser treatment for other reasons (verrucae and laser therapy)		1	9	5
Open MRI	36	31	13	24
Neuro placements	11	3		1
Bariatric Surgery (gastric band and procedures relating to significant weight loss*	12	86 (for Tier 4 MDT)	8	1
Abdominoplasty	9	7	5	9
Breast Augmentation	4	13	7	5
Removal of supernumerary nipples			1	
Pinnaplasty	1	3	9	

Intervention	Bradford & Craven	Calderdale & Kirklees	Leeds	Wakefield
Blepharoplasty	3	10	2	
Breast Reduction	34	33	33	22
Breast surgery (male)			1	
Breast Mastopexy			2	
Breast Asymmetry	4	8		4
General plastics (lumps, bumps, scar revision etc)**	24		23	
Gynaecomastia	12	12	7	10
Revision of breast implants	3			
Labia reduction	11	2	10	1
Rhinoplasty (incl septorhinoplasty)	6		16	
Varicose Veins**	6	124 (intervention not surgery)		2
Liposuction		3		2
Cosmetic filler revision			1	
Continuous Glucose monitor***		21	4	23
Wheelchair services		3	8	1

* WYH Bariatric Policy

** Evidenced Based Intervention

*** To be reviewed under WYH Flash Glucose Monitoring Policy and in response to NICE Guidance published on 31 March 2022 by WY HCP Diabetes Programme

Appendix 2 (bundle 1)

West Yorkshire Health and Care Partnership					
Policy	**Allergy Treatments at a specialist allergy centre**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			
Policy exclusions					
The ICB will not support referrals made to non-NHS providers.					
Policy inclusion criteria					
The ICB 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 Clinician has not improved the condition and that the condition is considered "resistant" to conventional treatment. Patients with problems with allergies should be referred initially to the specialist services most appropriate to their needs, e.g. , people who have an emergency treatment for suspected anaphylaxis.					
Summary of evidence / Rationale	NICE Anaphalaxis quality standard (QS119) states; People who have had emergency treatment for suspected anaphylaxis (a severe, life-threatening allergic reaction) are offered an appointment at a specialist allergy service. This is to find out the cause of the reaction and to get advice on what to do in the future.				
Reference	1. NICE Anaphalaxis quality standard [QS119] (March 2016) https://www.nice.org.uk/guidance/qs119				

<table>
<tr><th colspan="6">West Yorkshire Health and Care Partnership</th></tr>
<tr><td>Policy</td><td colspan="3">Male Circumcision</td><td>X ICB Ref</td><td></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3">West Yorkshire Health and Care Partnership
Planned Care Programme Team</td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
<tr><td colspan="6">Policy exclusions</td></tr>
<tr><td colspan="6">• Circumcision will NOT be routinely commissioned for physiological phimosis nor for non medical reasons such as social, religious or cultural reasons.</td></tr>
<tr><td colspan="6">Policy inclusion criteria</td></tr>
<tr><td colspan="6">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:

• Pathological phimosis
• Recurrent episodes of balanoposthitis

Relative Indications for circumcision are:
• Prevention of urinary tract infection in patients with an abnormal urinary tract
• Recurrent paraphimosis
• Trauma (e.g. zipper injury)
• Tight foreskin causing pain on arousal/interfering with sexual function
• Congenital abnormalities

Referral to Secondary Care
• Physiological phimosis should be managed in primary care
• If there is concern that pathology is evident or diagnostic uncertainty then referral to secondary care is appropriate.</td></tr>
<tr><td>Summary of evidence / Rationale</td><td colspan="5"></td></tr>
<tr><td>Reference</td><td colspan="5">1. The Royal College of Surgeons Commissioning Guide: Foreskin Conditions (2013) criteria for surgical interventions: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/foreskin-conditions/]

2. circumcision (2).pdf</td></tr>
</table>

West Yorkshire
Health and Care Partnership

West Yorkshire Health and Care Partnership					
Policy	**Cryopreservation for both men and women where the usual fertility policy does not apply**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

- Testicular tissue freezing is considered experimental and will not be funded.
- Ovarian tissue storage is considered experimental and will not be funded

Policy inclusion criteria

One circumstance which is not covered by the fertility policy is the provision of cryopreservation for an individual who is expected to undergo a medically necessary procedure or intervention which may impact on their future fertility, for example but not limited to, chemotherapy and radiotherapy.

Patients requesting cryopreservation must satisfy all of the following criteria:

- Patient is due to commence chemotherapy, radiotherapy or other medical or surgical treatment which the treating clinician believes is likely to affect their future fertility.

- The impact of the treatment on the patient's fertility has been discussed between the patient and the treating clinician as soon as clinically possible, including any impact of the process of gamete harvesting on the patient's health.

- The patient can make an informed choice to undertake gamete harvesting and cryopreservation of semen, oocytes or embryos for an initial period of 10 years.

- The patient is aware that funding for gamete harvesting and cryopreservation of material does not guarantee future funding of assisted conception or fertility treatment. If the patient requests an estimate of the current costs of privately funded fertility treatment then details of how to find a clinic should be given, along with information on the current local commissioning position for NHS fertility treatment, recognising this may be subject to change.

- **In line with the NICE guidelines, the usual local eligibility criteria for fertility treatment will NOT apply at the time of gamete harvesting and cryopreservation. Approval of cryopreservation does NOT guarantee future funding of assisted conception or fertility treatment at which time the local eligibility criteria for fertility treatment will apply.**

Age

- There are no specific age limits to this policy for males or females. The decision to attempt to preserve fertility is a clinical decision.

Duration of Storage

- People who preserve their fertility should be offered follow up after an appropriate interval following treatment for their medical condition, this would generally be around one year following conclusion of treatment. A discussion with a clinician should take place at this follow up regarding the need to continue storage based on whether their fertility has been affected or could reasonably be expected to be affected in the future. NHS funded storage should only be continued if fertility has been affected by the medical treatment or if the medical treatment is likely to cause future fertility problems.

- The legal duration of storage is governed by statutory HFEA legislation and regulations; the ICB will routinely fund storage of gametes or embryos for an initial 10-year period. If storage is desired for longer than ten years then an application should be made as an exceptional request to the Individual Funding Request panel, and each case will be considered on its own merit and in line with the HFEA legislation. (Note that statutory storage periods for gametes and embryos permit patients to store for a maximum of 10 years, and regulations for extending storage periods up to a maximum of 55 years).

Cryopreservation in Males

- The ICB will align to clinical evidence and clinical guidance at the time as to the number of semen samples to be collected over the recommended period of time and stored before treatment for cancer. The ICB will commission the number of samples of semen that is considered sufficient to provide future fertility.

Cryopreservation in Females

- The ICB will align to clinical evidence and clinical guidance at the time as to the number of recommended cycles of egg retrieval, with or without fertilisation. If insufficient eggs are retrieved following this first cycle of egg retrieval, then one further cycle can be offered.

Summary of evidence / Rationale	
Reference	1. NICE (CG156 Fertility Problems: assessment and management) (2013) https://www.nice.org.uk/guidance/cg156/chapter/Recommendations#people-with-cancer-who-wish-to-preserve-fertility 2. Quality statement 9: Cryopreservation before cancer treatment | Fertility problems | Quality standards | NICE 3. Royal Colleges of Physicians, Radiologists and Obstetricians and Gynaecologists: The Effects of Cancer Treatment on Reproductive Functions (2007) https://www.rcr.ac.uk/sites/default/files/publication/Cancer_fertility_effects_Jan08.pdf

	4. HFEA legislation and regulations: https://www.hfea.gov.uk/ 5. The HTA guidelines: https://www.hta.gov.uk/

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West Yorkshire Health and Care Partnership					
Policy	**Infertility Treatment and Surrogacy**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			
Policy exclusions					
• Criteria have been agreed across the Yorkshire and Humber: (See Appendix A below)					
Policy inclusion criteria					
• Criteria have been agreed across the Yorkshire and Humber: (See Appendix A below) • 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.					
Summary of evidence / Rationale	(See Appendix A below)				
Reference	1. Yorkshire and Humber Access to Infertility Treatment Policy (May 2020-March 2023) (See Appendix A below)				

Appendix A: Yorkshire and Humber Access to Infertility Treatment Policy

Access to Infertility Treatment

Commissioning Policy Document

Yorkshire and Humber

adopted by

WEST YORKSHIRE HEALTH AND CARE PARTNERSHIP

JULY 2022 – 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 Wakefield CCG	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 WY HCP website.

Commissioning Policy Statement

Commissioning

This document represents the commissioning policy of West Yorkshire Health and Care Partnership 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 West Yorkshire Health and Care Partnership.

Funding

The policy on funding of specialist fertility services for individual patients is a policy of West Yorkshire Health and Care Partnership 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 West Yorkshire Health and Care Partnership 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 the West Yorkshire Health and Care Partnership.

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 West Yorkshire Health and Care Partnership 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[1]. In February 2013 NICE published revised guidance[2] 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. This policy was adopted by the West Yorkshire Health and Care Partnership when the West Yorkshire Integrated Care System became a statutory body on 1 July 2022.

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.

2.5 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

[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.

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)[3]. 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.

The West Yorkshire Health and Care Partnership 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 the West Yorkshire Health and Care Partnership.

2.9 In addition to commissioning effective healthcare, Integrated Care Boards are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore, ICBs 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 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] https://www.hfea.gov.uk/

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.

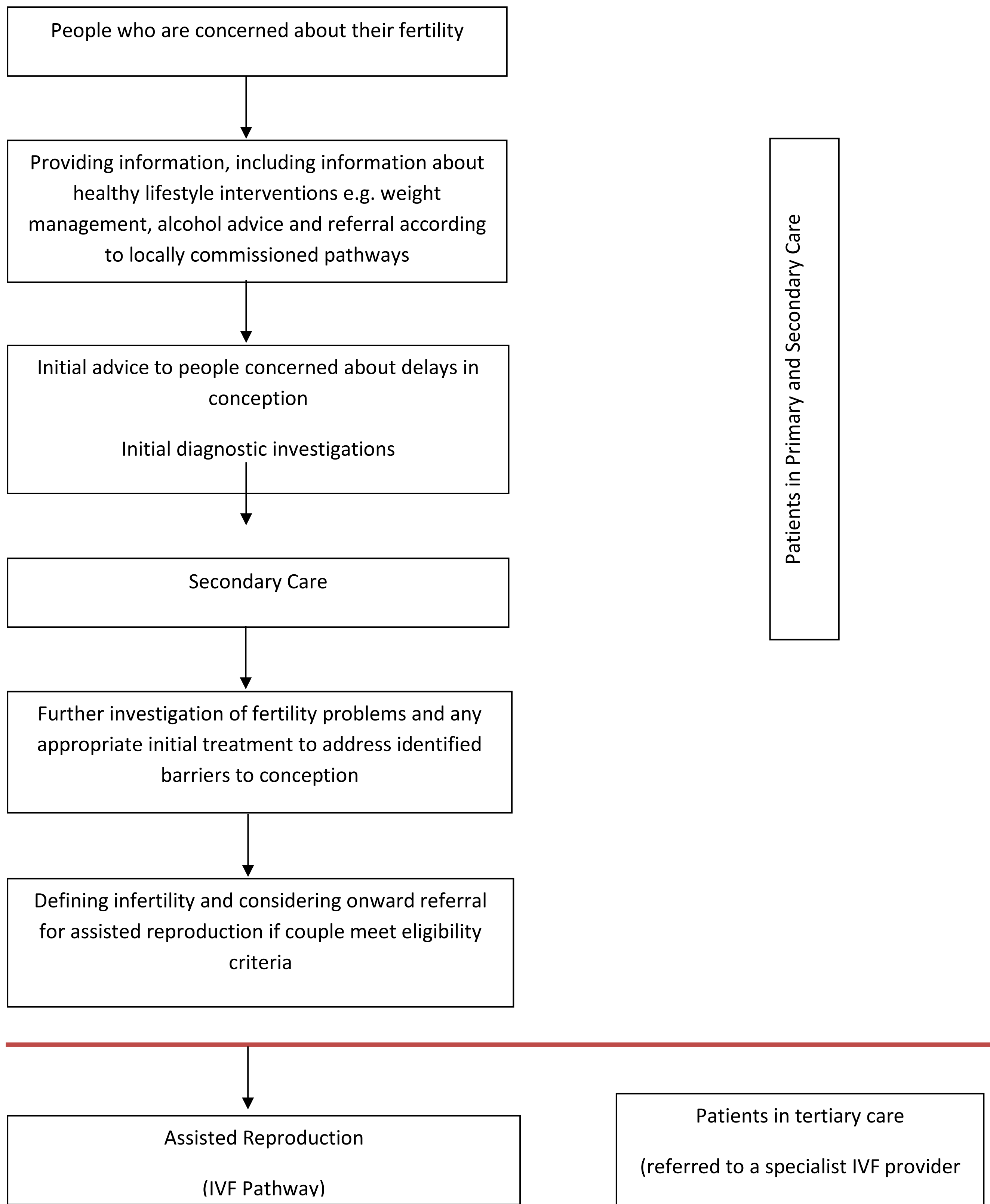
Information should be provided in the following formats:

- 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



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

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 ICB.

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 ICB 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 ICB 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 ICB. 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[5] 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

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 ICB.

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

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

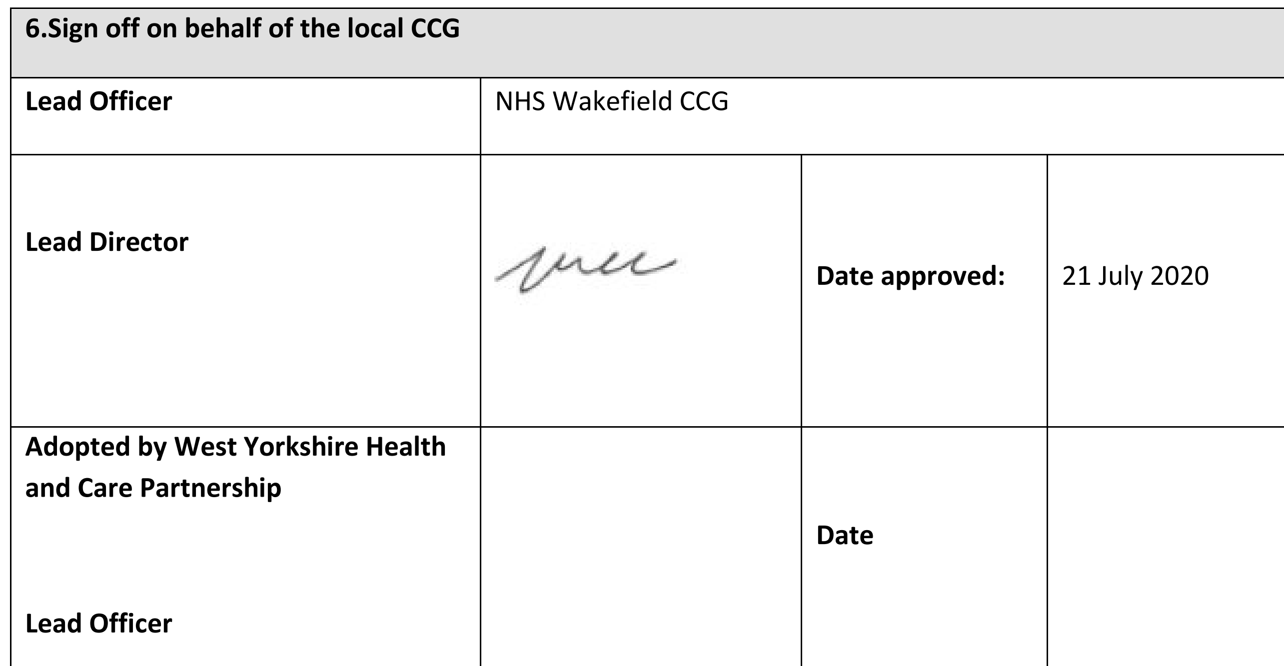
1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the relevant ICB to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general 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 ICB. 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 ICB 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	[signature]	**Date approved:**	21 July 2020
Adopted by West Yorkshire Health and Care Partnership **Lead Officer**		**Date**	

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.

<table>
<tr><td colspan="6">West Yorkshire Health and Care Partnership</td></tr>
<tr><td>Policy</td><td colspan="2">Labial Reduction and Cosmetic Vaginal Procedures/Labiaplasty</td><td>X ICB Ref</td><td colspan="2"></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3">West Yorkshire Health and Care Partnership
Planned Care Programme Team</td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
</table>

Policy exclusions

Labial reduction and cosmetic vaginal procedures are not routinely commissioned.

Policy inclusion criteria

- In the case of congenital/pathological abnormalities of the external genitalia, the ICB to consider treatment medically necessary only where the American College of Obstetricians and Gynaecologists Committee Opinion on cosmetic vaginal procedures indicate it is medically necessary.

- Medical indications for surgical procedures for labial hypertrophy or asymmetric labial growth include:
    - congenital conditions; 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

- Treatment for female genital mutilation is not considered cosmetic and does not require prior approval.

Summary of evidence / Rationale	
Reference	1. NHSE Interim Commissioning Policy on Labiaplasty, Vaginoplasty and Hymenorrhaphy, 2013 2. Joint RCOG/BritSPAG release: Issues surrounding women and girls undergoing female genital cosmetic surgery explored 3. RCOG/BritSPAG: New booklet empowers young people to understand normal vulva appearance

West Yorkshire Health and Care Partnership					
Policy	**Lycra Garments**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Lycra garments are not routinely commissioned by the ICB.

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 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:

  - The level of support needed to get the garments on and off
  - Toileting issues
  - Garment took too long to dry after washing
  - Unable to maintain the function gains achieved without continued use

The above considerations should be taken into account before referring for Lycra garments.

Policy inclusion criteria

Cases may be considered on an exceptional basis for example;

- The patient should have cerebral palsy or similar condition with significantly abnormal postural muscle tone.
- There are no contraindications present (see above).
- 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.

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.	
Summary of evidence / Rationale	
Reference	1. The Use of Lycra Garments in Children with Cerebral Palsy: a Report of a Descriptive Clinical Trial (bobath.org.uk)

West Yorkshire Health and Care Partnership

Policy	**Pinnaplasty (Correction of Prominent Ears)**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Surgical correction of prominent ears is not routinely commissioned by the ICB for cosmetic reasons.

Policy inclusion criteria

Cases may be considered on an exceptional basis, for example where the patient:

- Must be aged 5-18 at the time of referral and the child (not the parents alone) expresses concern **AND**
- Has very significant ear deformity or asymmetry

- 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.

- 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.

Summary of evidence / Rationale	
Reference	1. NHS England Interim Commissioning Policy: Pinnaplasty/Otoplasty (November 2013) https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC027.pdf

West Yorkshire Health and Care Partnership					
Policy	**Repair of external ear lobes (Lobules)**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

- Repair of external ear lobes will not be routinely commissioned by the ICB for cosmetic reasons.
- Repair of external ear lobes as a result of a gauge piercing is excluded from treatment by the ICB.

Policy inclusion criteria

This procedure is only commissioned by the ICB for the repair of totally split earlobes as a result of direct trauma.

Summary of evidence / Rationale	
Reference	1. Cosmetic procedures - Ear correction surgery - NHS (www.nhs.uk)

<table>
<tr><th colspan="7">West Yorkshire Health and Care Partnership</th></tr>
<tr><td>Policy</td><td colspan="3">Reversal of Vasectomy and Female Sterilisation</td><td>X ICB Ref</td><td colspan="2"></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td colspan="2"></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="4">West Yorkshire Health and Care Partnership
Planned Care Programme Team</td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="4"></td></tr>
<tr><td colspan="7">Policy exclusions</td></tr>
<tr><td colspan="7">• Surgery for the reversal of a vasectomy or female sterilisation is not routinely commissioned by the ICB.
• 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 ICB 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.</td></tr>
<tr><td colspan="7">Policy inclusion criteria</td></tr>
<tr><td colspan="7">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.
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>Summary of evidence / Rationale</td><td colspan="6"></td></tr>
<tr><td>Reference</td><td colspan="6">1. Can I get a sterilisation reversal on the NHS? - NHS (www.nhs.uk)
2. Can I get a vasectomy reversed? - NHS (www.nhs.uk)</td></tr>
</table>

Bundle 2 Policies

West Yorkshire Health and Care Partnership					
Policy	**Breast Policy**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

This policy is intended to cover all breast related procedures (Breast Augmentation, Breast reconstruction, Reduction Mammoplasty, Revision Breast Augmentation and Breast Asymmetry). This policy **does not** include Male Gynaecomastia and Benign Nipple Inversion and Mastopexy – Please see separate WY ICB policies on these conditions for guidance.

Any breast surgery without medical necessity is considered cosmetic. Breast Surgery will not be commissioned for cosmetic reasons.

Cosmetic reasons include, but are not limited to;

- weight loss.
- post lactation or age related ptosis.
- Breast augmentation/reconstructive surgery to enhance breast size or correct breast asymmetry (including changes following pregnancy and child birth).
- Requests for surgery for patients with "small" but normal breasts or for breast tissue involution.
- Requests made for breast surgery for psychological benefit without clinical need (as per criteria set out in the policy)
- The natural ageing process whereby there is a loss of volume or tissue elasticity.

For those cases of revision breast surgery that are not medically necessary, the following applies;

- 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 ICB current commissioning criteria – as detailed in the main policy body
- Removal of ruptured saline-filled breast implants is not considered medically necessary for patients who have previously undergone cosmetic breast augmentation mammoplasty.

The reinsertion of implants will not be funded unless the patient meets criteria as set out within this policy.

NB; Surgery relating to trauma or Breast Cancer (to reconstruct the breast, correct significant deformity, and/or to correct asymmetry) is excluded from this policy and does not require prior approval. Any Surgery relating to trauma or Breast Cancer where Breast Augmentation was undertaken, any subsequent surgery relating to this is excluded from this policy and does not require prior approval.

Policy inclusion criteria

Breast surgery (for conditions/procedures set out above) may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding

Request form and can demonstrate that the below criteria have been met for the procedure being applied for;

Breast Augmentation;

- Patient must be at least aged 19 in order to have reached the completion of puberty.

AND

- Body Mass Index (BMI) <30 NB if request is related to weight loss, this must have been maintained (with documentation) for a minimum period of 2 years.

AND

- If body scan report indicates a breast to torso ratio within the bottom 5% of the normal distribution.

Breast Asymmetry;

- One or both breasts must be malformed.

AND

- Have developmental/congenital asymmetry of at least 250g **OR** 3 cup sizes as estimated by a specialist (breast surgeon).

OR

- tuberous breasts type iiii or type 4v (iv) using grolleau and/or Himberg classification, with severe breast constriction with minimal breast base and hypoplasia of all four quadrants.

OR

- Developmental/Congenital conditions, which may include, but are not limited to, macromastia, Poland syndrome, tuberous breasts, unilateral or asymmetric hypoplasia, amazia (unilateral/bilateral) congenital symmastia and treatment to be supported by a plastic surgeon. (ie Poland Syndrome) resulting in unilateral absence of breast tissue (unilateral congenital amastia)

AND

- Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting.

Breast Reduction (Mammoplasty);

The ICS will only provide breast reduction for women (for male patients please see WY ICB Male Gynaecomastia Policy) if **ALL** of the following criteria are met:

- The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain.
- Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps).
- Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes.
- Body mass index (BMI) is <27 and stable for 12 months.
- Photographic evidence of the condition is required by the IFR panel – only photographs taken by medical photography will be accepted

Removal/Revision Breast Augmentation;

- 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.

Requests for the removal of breast implants for any of the following indications is subject to a case by case review of the exceptional circumstances:

- Breast malposition

OR

- Baker Class II contracture

OR

- Baker Class III contracture that does not follow a medically necessary mastectomy

OR

- Removal of breast implant due to patient's anxiety about developing an autoimmune disease

OR

- Implant removal for biopsy of breast mass that has not been proven to be cancerous

OR

- Implant removal for a mastectomy or lumpectomy that cannot be performed with the implant in place.
- Silicone Implant Removal for Autoimmune Disease – this is not considered medically necessary unless accompanied by complications such as recurrent infection, Intra or extra capsular rupture of silicone gel filled implants, Implants with severe contracture that interferes with mammography **NB** IgG testing in connection with silicone implants (the development of IgG antibodies is neither specific to silicone implants nor indicative of autoimmune disorders) and will not be undertaken for this purpose.

NB 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 WY ICS current commissioning criteria. Where a patient is eligible for implant removal due to a problem associated with a single implant, bilateral implant removal should be offered.

For requests relating to 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.

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. Reconstructive breast surgery is medically necessary after a mastectomy or lumpectomy that result in a significant deformity (i.e., mastectomy or lumpectomy for treatment of or prophylaxis for breast cancer and mastectomy or lumpectomy performed for chronic, severe fibrocystic breast disease, also known as cystic mastitis, unresponsive to medical therapy). Procedures include mastopexy, insertion of breast prostheses, the use of tissue expanders, or reconstruction with a transverse rectus abdominis myocutaneous (TRAM) flap, deep inferior epigastric perforator (DIEP) flap, or similar procedure. The WY ICS also consider associated nipple and areolar reconstruction and tattooing (camouflage) of the nipple area medically necessary. Reduction (or some cases augmentation) mammoplasty and related reconstructive procedures on the unaffected side for symmetry are also considered medically necessary.

Summary of evidence / Rationale	1. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 2. Cosmetic procedures - When it's on the NHS - NHS (www.nhs.uk) 3. Breast reduction on the NHS - NHS (www.nhs.uk) 4. https://www.aomrc.org.uk/ebi/wp-content/uploads/2022/01/EBI_List_3_cinical_guidance_Proposals.pdf
Reference	

West Yorkshire Health and Care Partnership					
Policy	**Breast reduction for (Male) Gynaecomastia**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Gynaecomastia (enlargement of breast tissue in males) reduction is not routinely funded. Surgery to correct benign gynaecomastia without medical necessity is considered cosmetic and will not be funded.

NB This policy does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.

The ICB will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids.

Policy inclusion criteria

Gynaecomastia surgery may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Gynaecomastia caused by medical treatments may be considered only by prior approval **AND** where the following criteria apply;

- Body Mass Index (BMI) must be 25 kg/m^2 or less and stable (having the same measurement) for 12 months, unless a specific uncorrectable aetiological factor is identified such as androgen therapy for prostate cancer - However BMI should be 30 kg/m^2 or less in these cases.

AND

- Should be for true gynaecomastia and not pseudo-gynaecomastia.

AND

- Has been screened prior to referral to exclude endocrinological and drug related (non recreational) causes or if drugs have been a factor then a period of one year since last use should have elapsed.

AND

- Must be at least 19 years of age to allow for completion of puberty.

AND

- Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger.

AND

- Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat)

AND

- The presence of an obvious unilateral lump, causing pain (specifically related to the gynaecomastia) that has failed to respond to analgesia.

AND

- Conservative treatments have been considered, tried or have been unsuccessful and are documented.

AND

- Resection should be for Simon grade 2B or above (grade 2B is moderate breast enlargement with minor skin redundancy, grade 3 is gross breast enlargement with skin redundancy that simulates a pendulous female breast)

OR

- The presence of unilateral gynaecomastia or marked asymmetry and meets the requirements set out in the WY Breast Policy for breast asymmetry.

In addition to the above criteria, the following must accompany any IFR request;

- Photographic evidence of the condition – only photographs taken by a medical photographer will be accepted.

AND

- BMI to have been measured within the last 2 months (prior to IFR submission)

AND

- Documented additional information to support IFR where circumstances include: Pain, Gross Asymmetry, the Gynaecomastia is related to/caused by other medical treatment undertaken by the patient.

Summary of evidence / Rationale	5. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2 6. What is gynaecomastia? - NHS (www.nhs.uk) 7. https://www.aomrc.org.uk/ebi/wp-content/uploads/2022/01/EBI_List_3_cinical_guidance_Proposals.pdf
Reference	

West Yorkshire Health and Care Partnership

Policy	**Laser treatments not covered elsewhere**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

This policy relates to those circumstances where laser treatments may be required, but that are not covered in other policies.

Laser treatments for certain conditions are routinely commissioned. Laser treatments other than outlined within this policy or other WY ICB policies are considered cosmetic and will not be funded.

Policy inclusion criteria

Some conditions requiring treatment with medical laser are routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Medical laser treatment may be offered to patients in the following circumstances;

Inflammatory or infiltrated dermatoses unresponsive to alternative therapy to include:

- Extensive xanthomata
- Amyloidosis

Symptomatic viral warts ONLY associated with immunodeficiency states including organ transplant patients with severe symptomatic viral warts should be referred to a Dermatologist in secondary care for assessment, although any recommended treatment may be provided in the community. Exludes Asymptomatic viral warts or viral warts in the absence of an immunodeficiency state.

NB Laser treatment is considered cosmetic and/ or experimental in the following indications and will not be routinely funded except following exceptionality approval, *where the condition is severe and debilitating, and where standard treatments are considered ineffective or contraindicated. This would be after assessment from at the advice of a specialist Laser Dermatology Consultant and would only be considered in patients with DLQI >10 where it is felt any potential risks from the treatment would outweigh the benefits*

- Atopic dermatitis
- Lichen sclerosus
- Morphea (scleroderma of the skin)
- Mycosis fungoides
- Onychomycosis
- Prurigo nodularis
- Vulval intraepithelial neoplasia
- Localised severe psoriasis or eczema

Summary of evidence / Rationale	
Reference	

<table>
<tr><td colspan="6">West Yorkshire Health and Care Partnership</td></tr>
<tr><td>Policy</td><td colspan="3">Mastopexy</td><td>X ICB Ref</td><td></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3">West Yorkshire Health and Care Partnership
Planned Care Programme Team</td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
<tr><td colspan="6">Policy exclusions</td></tr>
<tr><td colspan="6">Mastopexy (surgery to correct breasts that sag or droop) without medical necessity is considered cosmetic and will not be funded.

Cosmetic reasons include, but are not limited to; weight loss, post lactation or age related ptosis.</td></tr>
<tr><td colspan="6">Policy inclusion criteria</td></tr>
<tr><td colspan="6">Mastopexy may be considered on an individual, exceptional basis, where the 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 in the treatment of breast reduction. In these instances, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria within the WY Breast Policy.</td></tr>
<tr><td>Summary of evidence / Rationale</td><td colspan="5">1. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
2. Breast reduction on the NHS - NHS (www.nhs.uk)</td></tr>
<tr><td>Reference</td><td colspan="5"></td></tr>
</table>

West Yorkshire Health and Care Partnership					
Policy	**Rhinophyma**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Rhinophyma is a progressive skin condition that affects the nose. The condition is mainly seen in those who have rosacea, a rash that can affect the cheeks, forehead and nose (British Association of Dermatologists get-file.ashx (bad.org.uk))

Treatments/interventions for the treatment of Rhinophyma are not routinely commissioned.

Patients who have regular, well documented episodes of eruptions of foul smelling discharge and or bleeding with a Dermatology Life Quality Index of >10 do not need to seek prior approval for treatment.

Policy inclusion criteria

Treatment for Rhinophyma is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. These treatments may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.

Rhinophyma with very significant phymatous change (where isotretinoin unlikely to be effective), laser treatment, shave excision or shave diathermy may be funded by prior approval or on an exceptional basis where all the below are met:

- There is photographic evidence of significant distortion.

AND

- A Dermatology Life Quality Index (DLQI) score >=10

AND

- *Condition has not responded to first line treatment of rosacea*

AND

- Following recommendation from a Consultant Dermatologist.

Summary of evidence / Rationale	1. A nationally produced information leaflet on Rhinophyma from the British Association of Dermatologists; https://www.skinhealthinfo.org.uk/wp-content/uploads/2018/11/Rhinophyma-Update-February-2018-Lay-reviewed-Janauary-2018.pdf 2. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Reference	

West Yorkshire Health and Care Partnership

Policy	Scar Revision (including Acne Scarring) and Keloidectomy			X ICB Ref	
First Issue Date		Current version:	1	Last reviewed:	
Review date		Contact	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Review er		Approved by			

Policy exclusions

Treatment for Scarring (including acne scarring) and Keiloidectomy is not routinely funded, except in specific circumstances.

Policy inclusion criteria

Scar Revision, treatment for scarring related to acne and Keloidectomy treatment is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Treatments for Scarring (Including Keloid scars) may be considered on an individual, exceptional basis.

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 from scar site;
- Obstruction of orifice or vision;
- Has a scar resulting in significant facial disfigurement.

Keloid and hypertrophic scars;
Can be considered for excision if scar is symptomatic – i.e. resulting in physical impairment due to contractures, tethering, severe pain/pruritus or recurrent breakdown.

Skin Resurfacing Techniques
All resurfacing techniques including laser, dermabrasion and chemical peels are considered experimental and are not routinely funded. However, they may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled, and exceptionality has been demonstrated

Summary of evidence / Rationale

1. Acne vulgaris: management NICE guideline [NG198] Published: 25 June 2021; https://www.nice.org.uk/guidance/ng198/chapter/Recommendations#information-and-support-for-people-with-acne-vulgaris
2. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

Reference

West Yorkshire Health and Care Partnership					
Policy	**Surgical correction of Benign Nipple Inversion**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Surgical correction of benign nipple inversion is not routinely commissioned by the ICB for;

- Cosmetic/aesthetic reasons.
- Psychological benefit without associated clinical need.

NB Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded, this policy does not relate to those cases where there is malignancy.

Policy inclusion criteria

Surgical correction of benign nipple inversion is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Surgical correction of nipple inversion may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.

Surgical correction of nipple inversion may only be funded where it has been well documented that there was an inability to breastfeed during a previous pregnancy due to the nipple inversion and the patient is considering a subsequent pregnancy (but is not yet pregnant). 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 (Aged 19 or over).

AND

- The inversion has not been corrected by correct use of a non-invasive suction device

Photographic evidence of the condition is also required by the IFR panel to support the request – only photographs taken by medical photography will be accepted.

Summary of evidence / Rationale	8. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
Reference	

<table>
<tr><td colspan="6">West Yorkshire Health and Care Partnership</td></tr>
<tr><td>Policy</td><td colspan="3">Tattoo Removal</td><td>X ICB Ref</td><td></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3">West Yorkshire Health and Care Partnership
Planned Care Programme Team</td></tr>
<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
<tr><td colspan="6">Policy exclusions</td></tr>
<tr><td colspan="6">Tattoo removal is not routinely commissioned.

The treatment of decorative tattoos is considered cosmetic and will not be funded.</td></tr>
<tr><td colspan="6">Policy inclusion criteria</td></tr>
<tr><td colspan="6">Treatment for the removal of Tattoo/s is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Tattoo removal may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.

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).
• Tattoos placed for radiotherapy
• Traumatic tattoos, secondary to inadequate wound cleansing from abrasions, fires and explosions.</td></tr>
<tr><td>Summary of evidence / Rationale</td><td colspan="5">9. Information for Commissioners of Plastic Surgery Services. Referrals and Guidelines in plastic surgery (PDF); http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2</td></tr>
<tr><td>Reference</td><td colspan="5">Cosmetic procedures - Tattoo removal - NHS (www.nhs.uk)</td></tr>
</table>

West Yorkshire Health and Care Partnership					
Policy	**Thread Veins/Telangiectasia**			**X ICB Ref**	
First Issue Date		**Current version:**	1	**Last reviewed:**	
Review date		**Contact**	West Yorkshire Health and Care Partnership Planned Care Programme Team		
Clinical Reviewer		**Approved by**			

Policy exclusions

Treatment for Telangiectasia (Thread Veins) is not routinely commissioned.

Patients suffering with well documented, functional problems related to the condition (e.g. large disfiguring spider angiomas or those which bleed profusely or affect vision), with a DLQI >10 do not need prior approval for treatment.

Policy inclusion criteria

Treatment for Telangiectasia is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. These treatments may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.

Funding may be considered in the following cases;

Hereditary haemorrhagic telangiectasia (HHT) - NHS (www.nhs.uk) where visible at conversational distance and causing disfigurement sufficient to score 10 or more on Dermatology Life Quality Index (DLQI) and limited to 4 treatments at each affected skin site to include:

- Telangiectasia associated with chronic inflammatory dermatoses (including rosacea, rhynophyma, lupus erythematosus, scleroderma, granuloma faciale, sarcoidosis and chronic radiation dermatitis).
- Extensive or severe telangiectasia as seen in progressive ascending arborising telangiectasia and essential telangiectasia.
- Telangiectasia associated with severe scarring as seen following large surgical wounds and burns.
- Spider angiomas in children.

Telangiectasia of all types generally will respond to four treatments to each affected site. The number of treatments offered to each skin site will therefore be restricted to four.

The following are considered cosmetic and will not be funded;

Minor telangiectasia or minor acquired vascular lesions in adults which are asymptomatic to include**:**

- Minor forms of telangiectasia not visible at conversational distance or insufficient to score 10 or more on DLQI.
- Spider Angiomas in adults
- Cherry angiomas or Campell de Morgan spots
- Telangiectasia of legs due to or associated with varicose veins
- Rosacea including mild to moderate telangiectasia & rhinophyma

Summary of evidence / Rationale	1.Hereditary haemorrhagic telangiectasia (HHT) - NHS (www.nhs.uk) 2. Full evidence summary | Facial erythema of rosacea: brimonidine tartrate gel | Advice | NICE
Reference	

<table>
<tr><th colspan="6">West Yorkshire Health and Care Partnership</th></tr>
<tr><td>Policy</td><td colspan="3">Vascular skin lesions</td><td>X ICB Ref</td><td></td></tr>
<tr><td>First Issue Date</td><td></td><td>Current version:</td><td>1</td><td>Last reviewed:</td><td></td></tr>
<tr><td>Review date</td><td></td><td>Contact</td><td colspan="3">West Yorkshire Health and Care Partnership
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<tr><td>Clinical Reviewer</td><td></td><td>Approved by</td><td colspan="3"></td></tr>
<tr><td colspan="6">Policy exclusions</td></tr>
<tr><td colspan="6">Procedures for congenital vascular abnormalities are not routinely commissioned.</td></tr>
<tr><td colspan="6">Policy inclusion criteria</td></tr>
<tr><td colspan="6">Treatments for congenital vascular lesions are not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Treatment for congenital vascular abnormalities may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.

Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only and in the following circumstances;

Laser treatable naevi (congenital and late onset) or genetically determined skin tumours at all skin sites;
in children
in adults with a Dermatology Life Quality Index (DLQI) >10 to include:
Vascular and lymphatic malformations and tumours
All naevoid lesions that cause either functional problems (such as bleeding, pain, or secondary infection). Many naevi and genetically determined tumours develop in late childhood or early adult life and many will undergo changes throughout life which result in increasing functional problems.</td></tr>
<tr><td>Summary of evidence / Rationale</td><td colspan="5">1. Intralesional photocoagulation of subcutaneous congenital vascular disorders in September 2004 - Overview | Intralesional photocoagulation of subcutaneous congenital vascular disorders | Guidance | NICE</td></tr>
<tr><td>Reference</td><td colspan="5"></td></tr>
</table>

Appendix 3

Harmonisation of West Yorkshire Commissioning Policies

Bundle 1 – December 2021: Mapping and Gapping

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
Allergy Treatments at a specialist allergy centre The CCGs 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 Clinician has not improved the condition and that the condition is considered "resistant" to conventional treatment. The CCGs will not support referrals made to non-NHS providers. Patients with problems with allergies should be referred initially to the specialist services most appropriate to their needs, e.g., people who have an emergency treatment for suspected anaphylaxis. Reference to relevant NICE guidance added to policy.	No material change	Same	Leeds has no commissioning policy relating to Allergies. Harmonisation of a policy will provide clarity to patients and clinicians.	Same
Male Circumcision 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: • Pathological phimosis • Recurrent episodes of balanoposthitis Relative Indications for circumcision are: • Prevention of urinary tract infection in patients with an abnormal urinary tract	No material change. The addition of clinical criteria will provide clarity for patients and clinicians.	No material change. The addition of clinical criteria will provide clarity for patients and clinicians.	Same	No material change. The addition of clinical criteria will provide clarity for patients and clinicians.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
• Recurrent paraphimosis • Trauma (e.g. zipper injury) • Tight foreskin causing pain on arousal/interfering with sexual function • Congenital abnormalities Referral to Secondary Care • Physiological phimosis should be managed in primary care • If there is concern that pathology is evident or diagnostic uncertainty, then referral to secondary care is appropriate. • Circumcision will NOT be routinely commissioned for physiological phimosis nor for non-medical reasons such as social, religious, or cultural reasons.				
Cryopreservation for both men and women where the usual fertility policy does not apply One circumstance which is not covered by the fertility policy is the provision of cryopreservation for an individual who is expected to undergo a medically necessary procedure or intervention which may impact on their future fertility, for example but not limited to, chemotherapy and radiotherapy. **Patients requesting cryopreservation must satisfy all of the following criteria:** • Patient is due to commence chemotherapy, radiotherapy or other medical or surgical treatment which the treating clinician believes is likely to affect their future fertility. • The impact of the treatment on the patient's fertility has been discussed between the patient and the treating clinician as soon as clinically possible, including any impact of the process of gamete harvesting on the patient's health. • The patient is able to make an informed choice to undertake gamete harvesting and cryopreservation of semen, oocytes or embryos for an	B&C policy only applies to males. There is no policy for females. Current policy is for Sperm Freezing prior to cytotoxic therapy and the recommendation that the NHS should fund this intervention. Any subsequent fertility intervention should be subject to CCG policies. Harmonisation of a policy will provide clarity to patients and clinicians.	No additional policy. Harmonisation of a policy will provide clarity to patients and clinicians.	Same	No additional policy. Harmonisation of a policy will provide clarity to patients and clinicians.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
initial period of 10 years. • The patient is aware that funding for gamete harvesting and cryopreservation of material does not guarantee future funding of assisted conception or fertility treatment. If the patient requests an estimate of the current costs of privately funded fertility treatment then details of how to find a clinic should be given, along with information on the current local commissioning position for NHS fertility treatment, recognising this may be subject to change. • **In line with the NICE guidelines, the usual local eligibility criteria for fertility treatment will NOT apply at the time of gamete harvesting and cryopreservation.** **Approval of cryopreservation does NOT guarantee future funding of assisted conception or fertility treatment at which time the local eligibility criteria for fertility treatment will apply.** **Age** • There are no specific age limits to this policy for males or females. The decision to attempt to preserve fertility is a clinical decision. **Duration of Storage** • People who preserve their fertility should be offered follow up after an appropriate interval following treatment for their medical condition, this would generally be around one year following conclusion of treatment. A discussion with a clinician should take place at this follow up regarding the need to continue storage based on whether their fertility has been affected, or could reasonably be expected to be affected in the future. NHS funded storage should only be continued if fertility has been affected by the medical treatment or if the medical treatment is likely to cause future fertility problems. • The legal duration of storage is governed by statutory HFEA legislation and regulations; the ICS will routinely fund storage of gametes or embryos for an initial 10 year period. If storage is desired for longer than				

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
ten years then an application should be made as an exceptional request to the Individual Funding Request panel, and each case will be considered on its own merit and in line with the HFEA legislation. (Note that statutory storage periods for gametes and embryos permit patients to store for a maximum of 10 years, and regulations for extending storage periods up to a maximum of 55 years). **Cryopreservation in Males** • The ICS will align to clinical evidence and clinical guidance at the time as to the number of semen samples to be collected over the recommended period of time and stored before treatment for cancer. The ICS will commission the number of samples of semen that is considered sufficient to provide future fertility. **Cryopreservation in Females** • The ICS will align to clinical evidence and clinical guidance at the time as to the number of recommended cycles of egg retrieval, with or without fertilisation. If insufficient eggs are retrieved following this first cycle of egg retrieval, then one further cycle can be offered. **Policy exclusions:** • Testicular tissue freezing is considered experimental and will not be funded. • Ovarian tissue storage is considered experimental and will not be funded Reference made to NICE guidance, and relevant clinical standards.				
Infertility Treatment and Surrogacy • Surrogacy arrangements will not be funded, but the ICS 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. • NICE Clinical Guidelines 156 (2013) covering infertility recommends that: *Up to three full cycles of IVF will be offered to eligible couples where the*	Criteria has been agreed across the Yorkshire and Humber	Criteria has been agreed across the Yorkshire and Humber	Criteria has been agreed across the Yorkshire and Humber	Same. Policy amended from Wakefield CCG policy to reflect WY ICS Policy.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
woman is aged between 18 and 39 and one cycle for eligible couples where the woman is aged 40 – 42. • The West Yorkshire Health and Care Partnership 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 the West Yorkshire Health and Care Partnership. • In addition to commissioning effective healthcare, Integrated Care Systems (ICSs) are required to ensure that resources are allocated equitably to address the health needs of the population. Therefore, ICSs will need to exercise discretion as to the number of cycles of IVF that they will fund up to the maximum recommended by NICE.				

Labial Reduction and Cosmetic Vaginal Procedures/Labiaplasty
• Labial reduction and cosmetic vaginal procedures are not routinely commissioned.
• In the case of congenital/pathological abnormalities of the external genitalia, the ICS to consider treatment medically necessary only where the American College of Obstetricians and Gynecologists Committee Opinion on cosmetic vaginal procedures indicate it is medically necessary.
• Medical indications for surgical procedures for labial hypertrophy or asymmetric labial growth include:
  • congenital conditions; or
  • chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment); or
	The Policy states that all such cases are referred to the vulval specialist Consultant at BTHT for an opinion before an IFR is sent requesting funding for surgery.
	Harmonisation of a policy will provide clarity to patients and clinicians, with this criteria removed for patients in Bradford.
		No material change.
		The addition of clinical criteria will provide clarity for patients and clinicians.
			Same	No material change.
				The addition of clinical criteria will provide clarity for patients and clinicians.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
excess androgenic hormones • Treatment for female genital mutilation is not considered cosmetic and does not require prior approval.				
Lycra garments Lycra garments are not routinely commissioned by the ICS. Cases may be considered on an exceptional basis for example; • 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	No material change	Same	No policy in place. Harmonisation of a policy will provide clarity to patients and clinicians.	Same

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
summer. These factors may all impact on compliance and motivation of 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: - The level of support needed to get the garments on and off - Toileting issues - Garment took too long to dry after washing - Unable to maintain the function gains achieved without continued use The above considerations should be taken into account before referring for Lycra garments. 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.				
Pinnaplasty (Correction of Prominent Ears) Surgical correction of prominent ears will not be routinely commissioned by the ICS for cosmetic reasons. Cases may be considered on an exceptional basis, for example where the patient: • Must be aged 5-18 at the time of referral and the child (not the parents alone) expresses concern **AND** • Has very significant ear deformity or asymmetry • 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	No material change	Policy is for ages 5-19 years. Minor change to policy to reduce the age to 5 -18 with reference to the most recent NHS national commissioning policy.	Policy is for children under the age of 16. Minor change to policy to increase the age to 5 -18 with reference to the most recent NHS national commissioning policy.	Policy is for 5-19 years. Minor change to policy to reduce the age to 5 -18 with reference to the most recent NHS national commissioning policy.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
decisions and again this should be taken into consideration prior to referral. • 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.				
Repair of external ear lobes (Lobules) Repair of external ear lobes will not be routinely commissioned by the CCGs for cosmetic reasons. This procedure is only commissioned by the ICS 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 ICS.	No material change	Same	Leeds policy includes Repair of a traumatic tear is considered medically necessary within 2 years of injury and prior approval is not required. Harmonisation of a policy will provide clarity to patients and clinicians in removing the reference to 2 years.	Same
Reversal of Vasectomy and Female Sterilisation Surgery for the reversal of a vasectomy or female sterilisation is not routinely commissioned by the ICS. 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 ICS 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. Cases may be considered on an exceptional basis, for example:	No material change	Policy includes considering in event of the death of a child. Harmonisation of a policy will provide clarity to patients and clinicians.	No material change	Policy includes considering in event of the death of a child. Harmonisation of a policy will provide clarity to patients and clinicians.

Intervention	Bradford and Craven	Calderdale and Kirklees	Leeds	Wakefield
• 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. **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.				

Appendix 4

Harmonisation of West Yorkshire Commissioning Policies

Bundle 2 – February to April 2022: Mapping and Gapping

Cosmetic Breast and Skin Procedures

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
Acne Scarring This now comes under “Scar Revision” Policy				
Breast Policy – to include all breast related procedures; Breast Augmentation, Breast reconstruction, Mastopexy, Reduction Mammoplasty, Revision Breast Augmentation and Breast Asymmetry This policy is intended to cover all breast related procedures (Breast Augmentation, Breast reconstruction, Reduction Mammoplasty, Revision Breast Augmentation and Breast Asymmetry). This policy **does not** include Male Gynaecomastia and Benign Nipple Inversion and Mastopexy – Please see separate WY ICS policies on these conditions for guidance. Any breast surgery without medical necessity is considered cosmetic. Breast Surgery will not be commissioned for cosmetic reasons. Cosmetic reasons include, but are not limited to; • weight loss. • post lactation or age related ptosis.	By merging a lot of the policies together into one policy there is easier access to the information for clinicians and patients. The BMI threshold for Breast Augmentation will be increased from <27 to <30 which will give greater access to patients.	By merging a lot of the policies together into one policy there is easier access to the information for clinicians and patients. The BMI threshold for Breast Augmentation will be increased from <27 to <30 which will give greater access to patients.	By merging a lot of the policies together into one policy there is easier access to the information for clinicians and patients. There is no change to the Leeds patients with regards to the BMI threshold for Breast Augmentation	By merging a lot of the policies together into one policy there is easier access to the information for clinicians and patients. The BMI threshold for Breast Augmentation will be increased from <27 to <30 which will give greater access to patients. No change

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
• Breast augmentation/reconstructive surgery to enhance breast size or correct breast asymmetry (including changes following pregnancy and child birth). • Requests for surgery for patients with "small" but normal breasts or for breast tissue involution. • Requests made for breast surgery for psychological benefit without clinical need (as per criteria set out in the policy) • The natural ageing process whereby there is a loss of volume or tissue elasticity. For those cases of revision breast surgery that are not medically necessary, the following applies; • 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 ICS current commissioning criteria – as detailed in the main policy body • Removal of ruptured saline-filled breast implants is not considered medically necessary for patients who have previously undergone cosmetic breast augmentation mammoplasty. The reinsertion of implants will not be funded unless the patient meets criteria as set out within this policy. **NB**; Surgery relating to trauma or Breast Cancer (to reconstruct the breast, correct significant deformity, and/or to correct asymmetry) is excluded from this policy and does not require prior approval. Any Surgery relating to trauma or Breast Cancer where Breast Augmentation was undertaken, any subsequent surgery relating to this is excluded from this policy and does not require prior approval.	For Breast Augmentation the requirement for a body scan and for a patients' results to be a breast to torso ratio within the bottom 5% of the normal distribution has also been removed as criteria, this should reduce unnecessary referrals to a costly out of area service and give some enhanced access to the treatment There is greater clarity around the thresholds for surgery and guidance around conservative measures, this should provide better support to clinicians and patients. No change to this element of the policy	No change There is greater clarity around the thresholds for surgery and guidance around conservative measures, this should provide better support to clinicians and patients. Within the Breast Asymmetry element to the policy the acceptance of a letter from a Bra fitter has been removed and replaced with	No change There is greater clarity around the thresholds for surgery and guidance around conservative measures, this should provide better support to clinicians and patients. No change to this element of the policy	No change There is greater clarity around the thresholds for surgery and guidance around conservative measures, this should provide better support to clinicians and patients. Within the Breast Asymmetry element to the policy the acceptance of a letter from a Bra fitter has been removed and replaced with

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
Breast surgery (for conditions/procedures set out above) may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form and can demonstrate that the below criteria have been met for the procedure being applied for; **<u>Breast Augmentation;</u>** • Patient must be at least aged 19 in order to have reached the completion of puberty. **AND** • Body Mass Index (BMI) 30kg/m2 or less – NB if request is related to weight loss, this must have been maintained (with documentation) for a minimum period of 2 years. **<u>Breast Asymmetry;</u>** • One or both breasts must be malformed. **AND** • Have developmental/congenital asymmetry of at least 250g **OR** 3 cup sizes as estimated by a specialist (breast surgeon). **OR** • tuberous breasts type iiii or type 4v (iv) using grolleau and/or Himberg classification, with severe breast constriction with minimal breast base and hypoplasia of all four quadrants. **OR** • Developmental/Congenital conditions, which may include, but are not limited to, macromastia, Poland syndrome, tuberous breasts, unilateral or asymmetric hypoplasia, amazia (unilateral/bilateral) congenital symmastia and treatment to be supported by a plastic surgeon. (ie Poland Syndrome) resulting in unilateral absence of breast tissue (unilateral congenital amastia)		measurement criteria only to be assessed by a specialist (breast surgeon). This should provide equitable measurements based on expert opinion and experience.		measurement criteria only to be assessed by a specialist (breast surgeon). This should provide equitable measurements based on expert opinion and experience.

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
AND • Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting. **<u>Breast Reduction (Mammoplasty);</u>** The ICB will only provide breast reduction for women (for male patients please see WY ICS Male Gynaecomastia Policy) if **ALL** of the following criteria are met: • The woman has received a full package of supportive care from their GP such as advice on weight loss and managing pain. • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Breast reduction planned to be 500gms or more per breast or at least 4 cup sizes. • Body mass index (BMI) is <27 and stable for 12 months. • Photographic evidence of the condition is required by the IFR panel – only photographs taken by medical photography will be accepted **<u>Removal/Revision Breast Augmentation;</u>** • 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)				

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
OR • Implants with severe contracture that interferes with mammography. Requests for the removal of breast implants for any of the following indications is subject to a case by case review of the exceptional circumstances: • Breast malposition **OR** • Baker Class II contracture **OR** • Baker Class III contracture that does not follow a medically necessary mastectomy **OR** • Removal of breast implant due to patient's anxiety about developing an autoimmune disease **OR** • Implant removal for biopsy of breast mass that has not been proven to be cancerous **OR** • Implant removal for a mastectomy or lumpectomy that cannot be performed with the implant in place. • Silicone Implant Removal for Autoimmune Disease – this is not considered medically necessary unless accompanied by complications such as recurrent infection, Intra or extra capsular rupture of silicone gel filled implants, Implants with severe contracture that interferes with mammography **NB** IgG testing in connection with silicone implants (the development of IgG antibodies is neither specific to silicone implants nor indicative of autoimmune disorders) and will not be undertaken for this purpose.				

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
NB 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 WY ICS current commissioning criteria. Where a patient is eligible for implant removal due to a problem associated with a single implant, bilateral implant removal should be offered. **For requests relating to 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. **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. Reconstructive breast surgery is medically necessary after a mastectomy or lumpectomy that result in a significant deformity (i.e., mastectomy or lumpectomy for treatment of or prophylaxis for breast cancer and mastectomy or lumpectomy performed for chronic, severe fibrocystic breast disease, also known as cystic mastitis, unresponsive to medical therapy). Procedures include mastopexy, insertion of breast prostheses, the use of tissue expanders, or reconstruction with a transverse rectus abdominis myocutaneous (TRAM) flap, deep inferior epigastric perforator (DIEP) flap, or similar procedure. The WY ICB also consider associated nipple and areolar reconstruction and tattooing (camouflage) of the nipple area medically necessary. Reduction (or some cases augmentation) mammoplasty and related reconstructive procedures on the unaffected side for symmetry are also considered medically necessary.				

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
Breast reduction for Male Gynaecomastia Gynaecomastia (enlargement of breast tissue in males) reduction is not routinely funded. Surgery to correct benign gynaecomastia without medical necessity is considered cosmetic and will not be funded. **NB** This policy does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer. The ICS will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids. Gynaecomastia surgery may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Gynaecomastia caused by medical treatments may be considered only by prior approval **AND** where the following criteria apply; • Body Mass Index (BMI) must be 25 kg/m^2 or less and stable (having the same measurement) for 12 months, unless a specific uncorrectable aetiological factor is identified such as androgen therapy for prostate cancer - However BMI should be 30 kg/m^2 or less in these cases. **AND** • Should be for true gynaecomastia and not pseudo-gynaecomastia. **AND** • Has been screened prior to referral to exclude endocrinological and drug related (non recreational) causes or if drugs have been a factor then a period of one year since last use should have elapsed.	Bradford & Craven has no commissioning policy for Male Gynaecomastia. Harmonisation of a policy will provide clarity to patients and clinicians.	No change	No change	No change

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
AND • Must be at least 19 years of age to allow for completion of puberty. **AND** • Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger. **AND** • Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat) **AND** • The presence of an obvious unilateral lump, causing pain (specifically related to the gynaecomastia) that has failed to respond to analgesia. **AND** • Conservative treatments have been considered, tried or have been unsuccessful and are documented. **AND** • Resection should be for Simon grade 2B or above (grade 2B is moderate breast enlargement with minor skin redundancy, grade 3 is gross breast enlargement with skin redundancy that simulates a pendulous female breast) **OR** • The presence of unilateral gynaecomastia or marked asymmetry and meets the requirements set out in the WY Breast Policy for breast asymmetry. In addition to the above criteria, the following must accompany any IFR request; • Photographic evidence of the condition – only photographs taken by a medical photographer will be accepted. **AND** • BMI to have been measured within the last 2 months (prior to IFR submission) **AND**				

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
• Documented additional information to support IFR where circumstances include: Pain, Gross Asymmetry, the Gynaecomastia is related to/caused by other medical treatment undertaken by the patient.				
Cosmetic skin procedures and conditions not covered elsewhere Policy to be removed – not required as conditions/interventions are mentioned within other policies				
Laser treatments not covered elsewhere This policy relates to those circumstances where laser treatments may be required, but that are not covered in other policies. Laser treatments for certain conditions are routinely commissioned. Laser treatments other than outlined within this policy or other WY ICS policies are considered cosmetic and will not be funded. Some conditions requiring treatment with medical laser are routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Medical laser treatment may be offered to patients in the following circumstances; **Inflammatory or infiltrated dermatoses** unresponsive to alternative therapy to include: • Extensive xanthomata • Amyloidosis **Symptomatic viral warts ONLY associated with immunodeficiency states including organ transplant patients with severe symptomatic viral warts** should be referred to a Dermatologist in secondary care	Bradford & Craven has no commissioning policy relating to Laser Treatments for use in the conditions outlined. Harmonisation of a policy will provide clarity to patients and clinicians.	Calderdale & Kirklees has no commissioning policy relating to Laser Treatments for use in the conditions outlined. Harmonisation of a policy will provide clarity to patients and clinicians.	Enhancement to treatment access with the inclusion of Dermatologist opinion of the benefits outweighing the risks for treatment.	Wakefield has no commissioning policy relating to Laser Treatments for use in the conditions outlined. Harmonisation of a policy will provide clarity to patients and clinicians.

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
for assessment, although any recommended treatment may be provided in the community. Exludes Asymptomatic viral warts or viral warts in the absence of an immunodeficiency state. **NB Laser treatment is considered cosmetic and/ or experimental in the following indications and will not be routinely funded except following exceptionality approval, *where the condition is severe and debilitating, and where standard treatments are considered ineffective or contraindicated. This would be after assessment from at the advice of a specialist Laser Dermatology Consultant and would only be considered in patients with DLQI >10 where it is felt any potential risks from the treatment would outweigh the benefits*** • Atopic dermatitis • Lichen sclerosus • Morphea (scleroderma of the skin) • Mycosis fungoides • Onychomycosis • Prurigo nodularis • Vulval intraepithelial neoplasia • Localised severe psoriasis or eczema				
Mastopexy Mastopexy (surgery to correct breasts that sag or droop) without medical necessity is considered cosmetic and will not be funded. Cosmetic reasons include, but are not limited to; weight loss, post lactation or age related ptosis. Mastopexy may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
Mastopexy may be included as part of the treatment to correct breast asymmetry and in the treatment of breast reduction. In these instances, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria within the WY Breast Policy.				
Rhinophyma Rhinophyma is a progressive skin condition that affects the nose. The condition is mainly seen in those who have rosacea, a rash that can affect the cheeks, forehead and nose (British Association of Dermatologists get-file.ashx (bad.org.uk)) Treatments/interventions for the treatment of Rhinophyma are not routinely commissioned. Patients who have regular, well documented episodes of eruptions of foul smelling discharge and or bleeding with a Dermatology Life Quality Index of >10 do not need to seek prior approval for treatment. Treatment for Rhinophyma is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. These treatments may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Rhinophyma with very significant phymatous change (where isotretinoin unlikely to be effective), laser treatment, shave excision or shave diathermy may be funded by prior approval or on an exceptional basis where all the below are met: • There is photographic evidence of significant distortion.	Bradford & Craven has no commissioning policy for Rhinophyma. Harmonisation of a policy will provide clarity to patients and clinicians.	A minor change/enhancement to allow Patients who have *regular, well documented episodes of eruptions of foul smelling discharge and or bleeding with a Dermatology Life Quality Index of >10* to be able to access treatment without seeking prior approval	A minor change/enhancement to allow Patients who have *regular, well documented episodes of eruptions of foul smelling discharge and or bleeding with a Dermatology Life Quality Index of >10* to be able to access treatment without seeking prior approval	A minor change/enhancement to allow Patients who have *regular, well documented episodes of eruptions of foul smelling discharge and or bleeding with a Dermatology Life Quality Index of >10* to be able to access treatment without seeking prior approval

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
AND • A Dermatology Life Quality Index (DLQI) score >=10 **AND** • *Condition has not responded to first line treatment of rosacea* **AND** • Following recommendation from a Consultant Dermatologist.				
Scar Revision (Including Acne Scarring) and Keloidectomy Treatment for Scarring (including acne scarring) and Keiloidectomy is not routinely funded, except in specific circumstances Scar Revision, treatment for scarring related to acne and Keloidectomy treatment is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Treatments for Scarring (Including Keloid scars) may be considered on an individual, exceptional basis. 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 from scar site; • Obstruction of orifice or vision; • Has a scar resulting in significant facial disfigurement. **Keloid and hypertrophic scars;** Can be considered for excision if scar is symptomatic – i.e. resulting in physical impairment due to contractures, tethering, severe pain/pruritus or recurrent breakdown.	No change for Acne Scaring – clarity is now provided around psychological exceptions for this condition as it follows NICE guidance No change to criteria and which patients can access, but provides clarity to clinicians and patients on commissioning position and criteria for Scar revision and Keloidectomy by using clearer and consistent wording	No change for Acne Scaring – clarity is now provided around psychological exceptions for this condition as it follows NICE guidance No change to criteria and which patients can access, but provides clarity to clinicians and patients on commissioning position and criteria for Scar revision and Keloidectomy by using clearer and consistent wording	No change for Acne Scaring – clarity is now provided around psychological exceptions for this condition as it follows NICE guidance No change to criteria and which patients can access, but provides clarity to clinicians and patients on commissioning position and criteria for Scar revision and Keloidectomy by using clearer and consistent wording	No change for Acne Scaring – clarity is now provided around psychological exceptions for this condition as it follows NICE guidance No change to criteria and which patients can access, but provides clarity to clinicians and patients on commissioning position and criteria for Scar revision and Keloidectomy by using clearer and consistent wording

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
Skin Resurfacing Techniques *All resurfacing techniques including laser, dermabrasion and chemical peels are considered experimental and are not routinely funded. However, they may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled, and exceptionality has been demonstrated*				
Skin hypopigmentation and skin resurfacing Policy not required – consensus is to remove this policy. The NHSE recommended treatment for skin hypopigmentation is cosmetic camouflage and there is currently a policy for these interventions and is indicated for review by the WY Area Prescribing Committee.				
Surgical correction of Benign Nipple Inversion Surgical correction of benign nipple inversion is not routinely commissioned by the ICB for; • Cosmetic/aesthetic reasons. • Psychological benefit without associated clinical need. **NB** Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded, this policy does not relate to those cases where there is malignancy. Surgical correction of benign nipple inversion is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Surgical correction of	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
nipple inversion may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Surgical correction of nipple inversion may only be funded where it has been well documented that there was an inability to breastfeed during a previous pregnancy due to the nipple inversion and the patient is considering a subsequent pregnancy (but is not yet pregnant). 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 (Aged 19 or over). **AND** • The inversion has not been corrected by correct use of a non-invasive suction device Photographic evidence of the condition is also required by the IFR panel to support the request – only photographs taken by medical photography will be accepted.				
Tattoo Removal Tattoo removal is not routinely commissioned. The treatment of decorative tattoos is considered cosmetic and will not be funded. Treatment for the removal of Tattoo/s is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Tattoo removal may be	A minor change to include Patients who have traumatic tattoos to be considered under exceptionality	A minor change to include Patients who have traumatic tattoos to be considered under exceptionality	A minor change to include Patients who have traumatic tattoos to be considered under exceptionality	A minor change to include Patients who have traumatic tattoos to be considered under exceptionality

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. 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). • Tattoos placed for radiotherapy • Traumatic tattoos, secondary to inadequate wound cleansing from abrasions, fires and explosions.				
Thread Veins – Telangiectasia Treatment for Telangiectasia (Thread Veins) is not routinely commissioned. Patients suffering with well documented, functional problems related to the condition (e.g. large disfiguring spider angiomas or those which bleed profusely or affect vision), with a DLQI >10 do not need prior approval for treatment. Treatment for Telangiectasia is not routinely commissioned. Any requests that are not medically necessary are considered cosmetic	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.	No material change. Greater clarity is provided by using consistent and harmonised wording across the policy to give clearer guidance to clinicians and patients.

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
and will not be funded. These treatments may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Funding may be considered in the following cases; Hereditary haemorrhagic telangiectasia (HHT) - NHS (www.nhs.uk) where visible at conversational distance and causing disfigurement sufficient to score 10 or more on Dermatology Life Quality Index (DLQI) and limited to 4 treatments at each affected skin site to include: • Telangiectasia associated with chronic inflammatory dermatoses (including rosacea, rhynophyma, lupus erythematosus, scleroderma, granuloma faciale, sarcoidosis and chronic radiation dermatitis). • Extensive or severe telangiectasia as seen in progressive ascending arborising telangiectasia and essential telangiectasia. • Telangiectasia associated with severe scarring as seen following large surgical wounds and burns. • Spider angiomas in children. Telangiectasia of all types generally will respond to four treatments to each affected site. The number of treatments offered to each skin site will therefore be restricted to four. The following are considered cosmetic and will not be funded; Minor telangiectasia or minor acquired vascular lesions in adults which are asymptomatic to include: • Minor forms of telangiectasia not visible at conversational distance or insufficient to score 10 or more on DLQI. • Spider Angiomas in adults • Cherry angiomas or Campell de Morgan spots				

Intervention	Bradford & Craven	Calderdale and Kirklees	Leeds	Wakefield
• Telangiectasia of legs due to or associated with varicose veins • Rosacea including mild to moderate telangiectasia & rhinophyma				
Vascular skin lesions Procedures for congenital vascular abnormalities are not routinely commissioned. Treatments for congenital vascular lesions are not routinely commissioned. Any requests that are not medically necessary are considered cosmetic and will not be funded. Treatment for congenital vascular abnormalities may be considered on an individual, exceptional basis, where the GP or consultant has completed the necessary Individual Funding Request form. Cases may be considered on an exceptional basis for lesions of considerable size on exposed areas only and in the following circumstances; **Laser treatable naevi (congenital and late onset) or genetically determined skin tumours at all skin sites;** • in children • in adults with a Dermatology Life Quality Index (DLQI) >10 to include: • Vascular and lymphatic malformations and tumours • All naevoid lesions that cause either functional problems (such as bleeding, pain, or secondary infection) Many naevi and genetically determined tumours develop in late childhood or early adult life and many will undergo changes throughout life which result in increasing functional problems.	Have removed threshold relating to psychological/psychosocial criteria for treatment as this was not in line with NICE guidance and no cosmetic treatments are currently commissioned for psychological/psychosocial reasons without clear supporting evidence. This provides greater clarity to clinicians and patients and that only evidence interventions are undertaken.	Same	Same	Same

Appendix 5 – Quality and Equality Impact Assessment – Bundle 1 Policies

West Yorkshire and Harrogate
Combined Impact Assessment

Title of Scheme/Project:	Harmonisation of WY Commissioning Policies_Bundle 1, December 2021

Project Manager:	Kirsty Shuttleworth/Gaynor Goodman
Clinical Lead:	Dr James Thomas
Programme Lead:	Catherine Thompson
Senior Responsible Officer (SRO):	Jo Webster
Quality Lead:	Gemma Hinchcliffe, Kirklees CCG
Equality Lead:	Equality team, Kirklees CCG

Proposed change:

Harmonisation of WY commissioning policies to a single clinical threshold to address variation in care across the 5 WY Places when the WY ICS becomes a statutory organisation on 1 April 2022: Allergy, Circumcision, Cryopreservation, Infertility treatment & surrogacy, Labial reduction & cosmetic vaginal procedures, Lycra garments, Pinnaplasty, Repair of external ear lobes, Reversal of vasectomy & female sterilisation.

Which areas are impacted:

NHS Airedale, Wharfedale and Craven CCG	☑	NHS Harrogate and Rural Districts CCG	☐	Acute services	☑
NHS Bradford City CCG	☑	NHS Leeds CCG	☑	Yorkshire Ambulance Service	☐
NHS Bradford Districts CCG	☑	NHS North Kirklees CCG	☑	Independent Sector	☑
NHS Calderdale CCG	☑	NHS Wakefield CCG	☑	Primary Care	☑
NHS Greater Huddersfield CCG	☑	Community services	☑	Mental Health services	☐
				Third sector	☑

Summary of engagement activity:

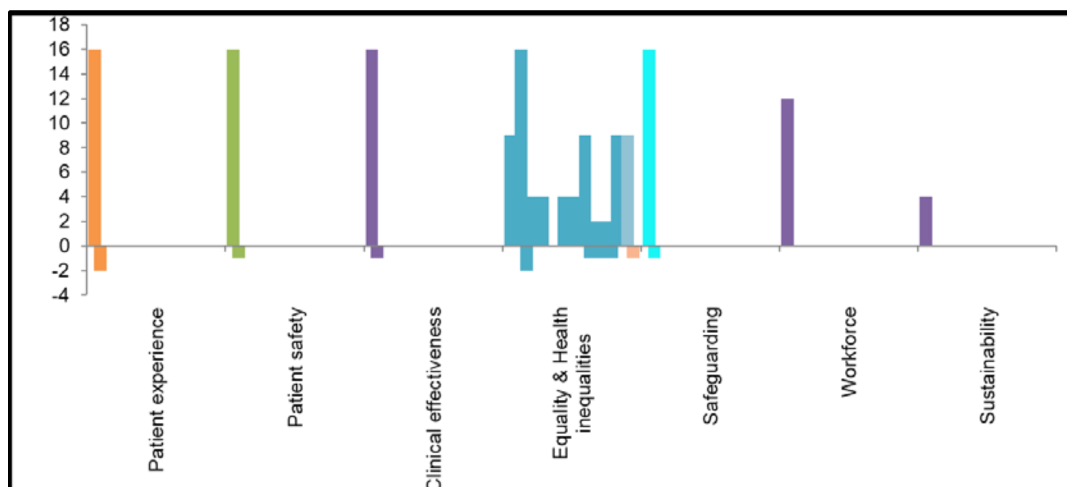
The mapping & gapping of these 9 commissioning policies highlights minimal change, with some improvement to patients in harmonisation of the clinical thresholds across WY, and provides clarity of information for patients and clinicians around those clinical thresholds for these interventions;indicating no additional engagement required from when these policies were implemeted across the WY Places:changes minimal.

Summary of impacts graph - This will automatically populate from the impact score on each tab

Note that scores above zero indicate positive impact and below zero indicate negative impact

Links to each area for further detail:

- Patient Experience
- Patient Safety
- Clinical Effectiveness
- Safeguarding
- Equality and Health Inequality
- Workforce
- Sustainability



Summary of findings:

Addressing variation in care and health inequalities. Improved patient experience and patient safety, and improving clinical effectiveness.

QEIA completed by (name, role and organisation):	Gaynor Goodman (Programme Manager) Improving
Date QEIA completed:	31-Dec-21

QEIA signed off by:	**Name**	**Date**
Senior Responsible Officer:	Jo Webster	
Committee		

Appendix 6– Quality and Equality Impact Assessment – Bundle 2 Policies

West Yorkshire
Combined Impact Assessment

Title of Scheme/Project:	Harmonisation of WY Commissioning policies - Bundle 2

Project Manager:	Kirsty Shuttleworth/Gaynor Goodman
Clinical Lead:	Dr James Thomas
Programme Lead:	Catherine Thompson
Senior Responsible Officer (SRO):	Jo Webster
Quality Lead:	Valerie Aguirregoicoa
Equality Lead:	Sarah Mackenzie-Cooper

Proposed change:
Harmonisation of WY commissioning policies to a single threshold for clinical interventions where a policy exists to support addressing variation in care across the 5 WY Places when the WY system becomes an ICB on 1 July 2022: Comprising Cosmetic Skin and Breast Policies: Surgery to correct Breast Asymmetry, Breast Augmentation and Reconstruction, Revision of Breast Augmentation, Mastopexy, Breast Reduction for Male Gynaecomastia, Surgical correction of Benign Nipple Inversion, Mammoplasty, Rhinophyma, Scar Revision/Keloidectomy inc Acne Scarring, Thread Veins/Telangiectasis, Tattoo Removal, Vascular Skin Lesions, Other Laser treatments not covered elsewhere.

Which areas are impacted:		
NHS Airedale, Wharfedale and Craven CCG ☑	NHS Harrogate and Rural Districts CCG ☐	Acute services ☑
NHS Bradford City CCG ☑	NHS Leeds CCG ☑	Yorkshire Ambulance Service ☑
NHS Bradford Districts CCG ☑	NHS North Kirklees CCG ☑	Independent Sector ☑
NHS Calderdale CCG ☑	NHS Wakefield CCG ☑	Primary Care ☑
NHS Greater Huddersfield CCG ☑	Community services ☑	Mental Health services ☐
		Third sector ☑

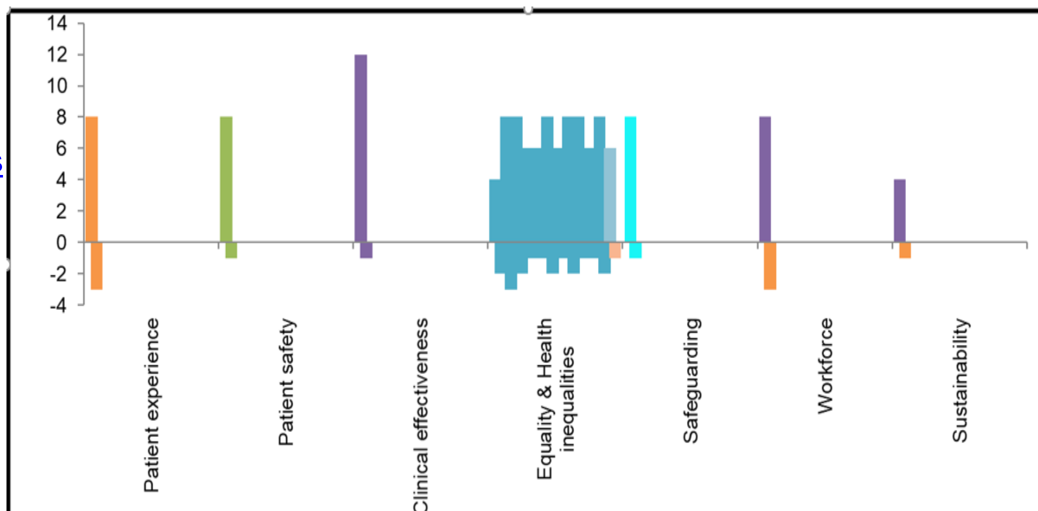
Summary of engagement activity:
Engaging with clinicians, both in primary care and secondary care in adopting clinical evidence and best practice to reach a single threshold for these clinical interventions, and with commissioners in considering the individual funding request process and current engagement and communication processes across our WY Places in communicating these changes to patients and the public, and with Yorkshire Ambulance Service as any increase in elective activity could result in an increase in patient transport services, and use of the independent sector, plus working with the Third Sector to identify and support communities

that may be negatively affected by these changes, and working with them to ensure communicating those changes reaches into those communities.

Summary of impacts graph - This will automatically populate from the impact score on each tab

Note that scores above zero indicate positive impact and below zero indicate negative impact

Links to each area for further detail:
Patient Experience
Patient Safety
Clinical Effectiveness
Safeguarding
Equality and Health Inequality
Workforce
Sustainability



Summary of findings:
Addressing variation in care and equity of access to ensure there's no widening of existing health inequalities. Improved clinical effectiveness resulting in improved patient health outcomes and experience of care.

QEIA completed by (name, role and organisation):	Gaynor Goodman and Kirsty Shuttleworth, Improving Planned Care Programme, WY HCP
Date QEIA completed:	09/02/2022, revised 11 April 2022

QEIA signed off by:	**Name**	**Date**		
Senior Responsible Officer:	Jo Webster			
Committee				