NHS
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Referral Criteria/Commissioning Position:

Condition or Treatment:	Acne
Commissioning position:	*Refer to specialist services such as GPwSI in dermatology or to secondary care if patient:* • Has moderate acne which has failed to respond to treatment which should include at least 2 courses of oral antibiotics for at least 3 months each, with appropriate topical treatment. The success or failure of treatment is best assessed subjectively by the patient • is at risk of, or is developing, scarring despite primary care therapies • has a very severe variant such as fulminating acne with systemic symptoms (acne fulminans) or gram negative folliculate acne • has severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin • is experiencing severe social or psychological impact, including a morbid fear of deformity (dysmorphophobia) **Investigations prior to referral** • FBC, U&E, LFT, fasting cholesterol and triglycerides. • Organise contraception in all sexually active females (or those likely to become so shortly) before referral if oral isotretinoin may be considered. Isotretinoin can be combined with any oral contraceptive. • Discussion of most effective forms of contraception e.g. implant, IUS, should be had with patient to ensure they understand the effects on foetal development if an unplanned pregnancy occurs and can make fully informed decision on safest choice of contraceptive if considering isotretinoin. https://www.contraceptionchoices.org/infographic
Referral Guidance:	The GP referral letter should contain: • Details of how the patient meets the criteria • Current and previous treatments including t results, • Drug history (prescribed and non-prescribed) • Relevant past medical/surgical history • Current regular medication • BMI • Smoking status • Alcohol consumption • Contraception status
Effective From:	1 July 2021
Summary of evidence/ rationale:	Acne: http://www.patient.co.uk/health/acne

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Date:	November 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

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Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention: Breast reduction
Background:	Breast reduction surgery is a procedure used to treat women with breast hyperplasia (enlargement), where breasts are large enough to cause problems like shoulder girdle dysfunction, intertrigo and adverse effects to quality of life.
Commissioning Position:	This recommendation does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process following breast cancer treatment. The NHS will only provide breast reduction for women if **all** 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. • In cases of thoracic/ shoulder girdle discomfort, a physiotherapy assessment has been provided • 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 at least twelve months. • Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery. • Women should be informed that smoking increases complications following breast reduction surgery and should be advised to stop smoking. • Women should be informed that breast surgery for hypermastia can cause permanent loss of lactation. Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation if there is an impact on health as per the criteria above. Surgery will not be funded for cosmetic reasons. Surgery can be approved for a difference of 150 -200gms size as measured by a specialist. The BMI needs to be <27 and stable for at least twelve months. Resection weights, for bilateral or unilateral (both breasts or one breast)

	breast reduction should be recorded for audit purposes.
Effective From:	1 July 2021
Summary of evidence/ rationale:	One systematic review and three non-randomized studies regarding breast reduction surgery for hypermastia were identified and showed that surgery is beneficial in patients with specific symptoms. Physical and psychological improvements, such as reduced pain, increased quality of life and less anxiety and depression were found for women with hypermastia following breast reduction surgery. Breast reduction surgery for hypermastia can cause permanent loss of lactation function of breasts, as well as decreased areolar sensation, bleeding, bruising, and scarring and often alternative approaches (e.g. weight loss or a professionally fitted bra) work just as well as surgery to reduce symptoms. For women who are severely affected by complications of hypermastia and for whom alternative approaches have not helped, surgery can be offered. The aim of surgery is not cosmetic, it is to reduce symptoms (e.g. back ache).
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. An investigation into the relationship between breast size, bra size and mechanical back pain. British School of Osteopathy (2010). Pages 13 & 14

2. Royal College of Surgeons – https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/breast-reduction-guide/

3. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. British Journal of Plastic Surgery, 56(3), 230–236.

4. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. Chiropractic & Osteopathy, 16(1), 1-7.

5. Singh KA, Losken A. Additional benefits of reduction mammaplasty: a systematic review of the literature. Plast Reconstr Surg. 2012 Mar;129(3):562-70. PubMed: PM22090252

6. Strong B, Hall-Findlay EJ. How Does Volume of Resection Relate to Symptom Relief for Reduction Mammaplasty Patients? Ann Plast Surg. 2014 Apr 10. PubMed: PM24727444

7. Valtonen JP, Setala LP, Mustonen PK, Blom M. Can the efficacy of reduction mammoplasty be predicted? The applicability and predictive value of breast-related symptoms questionnaire in measuring breast-related symptoms pre-and postoperatively. J Plast Reconstr Aesthet Surg. 2014 May;67(5):676-81. PubMed: PM24508223

8. Foreman KB, Dibble LE, Droge J, Carson R, Rockwell WB. The impact of breast reduction surgery on low-back compressive forces and function in individuals with macromastia. Plast Reconstr Surg. 2009 Nov;124(5):1393-9. PubMed: PM20009823

9. Shah R, Al-Ajam Y, Stott D, Kang N. Obesity in mammaplasty: a study of complications following breast reduction. J Plast Reconstr Aesthet Surg. 2011 Apr;64(4):508-14. doi: 10.1016/j.bjps.2010.07.001. Epub 2010 Aug 3. PubMed PMID: 20682461.

10. Oo M, Wang Z, Sakakibara T, Kasai Y. Relationship Between Brassiere Cup Size and Shoulder-Neck Pain in Women. The Open Orthopaedics Journal. 2012;6:140-142. doi:10.2174/1874325001206010140.

11. https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/

12. Plast Reconstr Surg. 2011 Nov;128(5):395e-402e. doi:10.1097/PRS.0b013e3182284c05.The impact of obesity on breast surgery complications.Chen CL(1), Shore AD, Johns R, Clark JM, Manahan M, Makary MA

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Commissioning Statement:

Condition or Treatment:	Revisions of Breast reconstruction surgery and repeated courses of nipple tattooing
Background:	Breast reconstruction is surgery to make a new breast after removal of the breast or part of the breast due to cancer. The aim is to make a breast of similar size and shape to the original breast. Breast reconstruction can be done at the same time as the cancer surgery (immediate reconstruction), or after cancer surgery (delayed reconstruction) and may involve the use of implants to achieve the desired effect. Nipple tattooing is also a recognised procedure in relation to breast reconstruction surgery following treatment for breast cancer in order to improve the appearance of the breast.
Commissioning position:	A full course of treatment will be funded for patients undergoing either immediate or delayed breast reconstruction surgery, to include all aspects of the reconstruction. This includes the provision of implant(s) for the reconstruction, and one course of treatment for Nipple Tattooing. Revisions of reconstruction surgery for purely cosmetic reasons and further courses of Nipple Tattooing will not be funded. Please Note: Breast Reconstruction Surgery Post Mastectomy does NOT require Prior Approval
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	May 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Commissioning Statement:

Condition or Treatment:	Cholecystectomy
Background:	Gallstones are small stones usually made of cholesterol that form in the gallbladder. The majority of people with gallbladder stones remain asymptomatic and require no treatment. Patients with an incidental finding of stones in an otherwise normal gallbladder require no further investigation or referral. Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. Possible exceptions include patients who are at increased risk for gallbladder carcinoma or gallstone complications, in which prophylactic cholecystectomy or incidental cholecystectomy at the time of another abdominal operation can be considered. Although patients with diabetes mellitus may have an increased risk of complications, the magnitude of the risk does not warrant prophylactic cholecystectomy. Primary and secondary care discussions with patients should include identifying options (surgery versus no surgery), including the risks and benefits of each.
Commissioning position:	**Primary Care** Referral for a surgical opinion should only be made if there are any of the following circumstances: • Symptomatic Gallstones • Dilated common bile duct on ultrasound. If no gallstones, consider other causes and undertake appropriate investigations. • Asymptomatic gallstones with abnormal liver function tests results • Asymptomatic gall bladder polyps on ultrasound • Symptomatic gall bladder 'sludge' on ultrasound In addition the following information should also be available: • A recent ultrasound report has been conducted prior to referral • A liver function test report has been conducted within 1 month of referral Documentation that the threshold criteria are fulfilled is mandatory in the referral letter or form and the referral letter should, as a minimum, contain: • A clear indication of the grounds for referral against the threshold criteria • Any relevant medical history and current medication • Any known factors affecting the patient's fitness for day surgery

	If the gall bladder is sent for histological examination, the results should be reviewed by the requesting consultant and communicated to the GP. NB: Patients should be encouraged by their GP and surgeon to lose weight prior to surgery and given appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. GPs can refer patients for a surgical opinion whilst patients lose weight and surgeons (and anaesthetists) can consider the safety of surgery. There is a clinical balance between risk of surgical complications with obesity and with potential complications of gallstones whilst delaying surgery.
Referral Guidance:	Exceptional cases should be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	November 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

Additional Information/References:

1. Royal College of Surgeons Commissioning Guide: Gallstone disease October 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones
2. Ahmed, R., Freeman, J.V., Ross, B., Kohler, B., Nicholl J.P., Johnson, A.G. Long-term response to gallstone treatment – problems and surprises. The European Journal of Surgery 2000 V. 166 (6) pp: 447-54. http://www.ncbi.nlm.nih.gov/pubmed/10890540
3. British Society of Gastroenterology (January 2017) Guidelines on the management of common bile duct stones: https://www.bsg.org.uk/resource/Updated-guideline-on-the-management-of-common-bile-duct-stones-(CBDS).html
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5. Halldestam-I, Enell-E-L, Kullman-E Borch-K. 'Development of symptoms and complications in individuals with asymptomatic gallstones'. The British Journal of Surgery. 2004.Vol:91(6),Pg. 734-8. http://onlinelibrary.wiley.com/doi/10.1002/bjs.4547/abstract
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7. NICE IPG 346 - Single incision laparoscopic cholecystectomy. NICE Interventional Procedure Guideline (May 2010): http://guidance.nice.org.uk/IPG346

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Additional Information/References:

1. Female Genital Mutilation Act 2003
   http://www.legislation.gov.uk/ukpga/2003/31

2. Royal College of Surgeons Commissioning guide: Foreskin conditions October 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions

3. British Medical Association (2006), London. The law and ethics of male circumcision: guidance for doctors. J Med Ethics 2004; 30: 259–263.
   http://jme.bmj.com/content/30/3/259.full.pdf+html

4. NHS Choices – Information on Circumcision and medical reasons why it may be necessary.
   http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx

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Commissioning Statement:

Condition or Treatment:	Cosmetic / Plastic Surgery
Commissioning position:	Plastic surgery is routinely commissioned for patients undergoing treatment for: • *trauma reconstruction surgery; acute repair and acute reconstruction* • *cancer surgery and associated reconstruction* • *burns,acute care.* Patients in these circumstances may be referred directly to secondary care Cosmetic surgical procedures for the correction of changes associated with age, pregnancy, weight or because of unhappiness with body image are of low priority. These will not be routinely commissioned. A significant degree of exceptionality must be demonstrated before funding can be considered outside of these policies. Specifically, psychological factors are not routinely taken into consideration in determining NHS funding. Whilst some degree of distress is usual among people who consider aspects of their physical appearance as undesirable, the degree of this will not routinely be taken into account in any funding decision. Further, it is expected clinicians consider the possibility of psychological problems including Body Dysmorphic Syndrome NICE Guidance CG31 assess for these and ensure appropriate management before considering any referral for plastic surgery.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	It is the responsibility of NHS North Yorkshire CCG to commission the most clinically and cost effective treatments for its local population within the resources available to it. Treatments which are primarily cosmetic in nature are, therefore, considered a low priority.
Date:	March 2020
Review Date:	July 2023

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Clinical Commissioning Group

Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

Information for Commissioners of Plastic Surgery Services – Referrals and Guidelines in Plastic Surgery (NHS Modernisation Agency) London 2005

Intervention	Surgical Treatment for Dupuytren's Contracture
For the treatment of:	Dupuytren's contracture
Background	Dupuytren's contracture is a progressive disorder that affects the palmar fascia, causing the fibrous tissue to shorten and thicken, which may prevent full extension of the fingers and limit function. All treatments aim to straighten the finger/s to restore and retain hand function, but none cure the condition - which can recur after any intervention so that further interventions are required[1]. Several treatments are available: percutaneous needle fasciotomy and collagenase injections are outpatient procedures whereas fasciectomy and dermatofasciectomy are open surgical procedures. No procedure is entirely satisfactory with some having slower recovery periods, higher complication rates or higher need for further surgery (for recurrence) than others[1]. It is unclear which intervention is best for restoring and maintaining hand function and which are the most cost-effective in the long term. Research studies are trying to address these questions and patients should discuss the latest understanding with surgeons. A Patient information leaflet can be found here North Yorkshire CCG's commissioning statement is a modified version of the national Evidence Based Commissioning (EBI) policy thresholds
Commissioning position	Treatment is **not indicated** where there is no contracture or it is mild (less than 20º) or not progressing and does not impair function[1] NHS North Yorkshire CCG will commission surgical treatment for Dupuytren's Contracture only in the following circumstances. An intervention (collagenase injections; needle fasciotomy; fasciectomy and dermofasciectomy) should **only** be considered (and IFR approval is not required), when the patient meets **at least one** of the following functional difficulties. • finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. See here on how to measure the angles using a goniometer **OR** • thumb contractures which interfere with function **AND** • There is a current material impairment of hand function **AND** • Surgery is likely to restore function **Treatment in all other circumstances is not routinely**

	commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request panel. NICE concluded that collagenase treatment (Xiapex) should only be used for[2]: a. Participants in the ongoing clinical trial (HTA-15/102/04) **or** b. Adult patients with a palpable cord **if all of the following apply**: • there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints; and • percutaneous needle fasciotomy is not considered appropriate, but limited open fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting.
Summary of evidence / rationale	Dupuytren's disease is a benign, slowly progressive condition of unknown origin, characterised by connective tissue thickening in the palm of the hand, forming nodules and cords, which leads to difficulty in extending the fingers[3]. Early symptoms are usually often mild and painless and do not require treatment but can include reduced range of motion, reduced hand function and pain. Most patients are affected in both hands. Most patients do neither need treatment nor a referral to secondary care but do need explanation and reassurance. They do not require monitoring. It is important to emphasise that contractures can progress and only need treatment if symptomatic (usually 20 – 30 degrees) Contractures that do impact on function are better treated earlier as they can pull the joints into a permanently flexed position, making it difficult to straighten fully with any treatment if allowed to progress too far. The condition often occurs in later life, and is most common in men aged over 40. Around one in six men over the age of 65 are affected by early, asymptomatic disease in the UK. It can be associated with diabetes, liver disease and alcohol excess. Although there is great variation in the rate of progress, it is usually possible to distinguish the more aggressive form of the disease early

	on by its rapid progression. Recurrence following treatment is more likely in younger patients if the original contracture was severe or if there is a strong family history of the condition. Intervention is almost exclusively surgical, but surgery is not curative, complications and recurrence rates can be high (an overall complication rate of 26% has been reported for fasciectomy and fasciotomy[3] of which 4% have infection, numbness and stiffness). The evidence base provides no clarity about the best approach, which has to be judged for the individual patient. **To justify the risks of surgery a flexion deformity must be present.** Recent developments have been towards outpatient procedures, percutaneous needle fasciotomy (PNF) and collagenase injection (CCH) (more experimental, but supported by NICE TA459[2]). NICE guidance for PNF only exists as an IPG from 2004[4]. CCH is a potential (but more expensive) option if PNF is not considered appropriate by the clinician. Although NICE TA459 suggests it in defined circumstances (including access to the ongoing clinical trial), its cost-effectiveness has not yet been demonstrated. A recent Swedish RCT, with institutional not industry funding and high internal validity, randomised around 150 patients (with involvement of only one finger and no earlier treatments) between PNF and collagenase treatment[5]. They found no significant differences between the two methods with regard to any outcome measurement at any time during the 2 year follow up. Most (around 75%) retained a straight finger although there was a significant recurrence rate of palpable cords. They point out that in the US, the introduction of CCH has increased the percentage of Dupuytren's contractures that are treated with minimally invasive techniques from 14% (2007) to 39% (2013), while the number of PNFs remains steady (and the number of open surgical procedures has declined). There is a substantial difference in cost, with CCH treatment almost 3 times more expensive. Another study has reported a significantly inferior outcome for CCH at 2 years[6]. Patient selection therefore has to be made carefully according to agreed criteria, with a preference for PNF while the benefits of CCH (in particular its cost-effectiveness) remain unproven.
OPCS codes	T521, T522, T525, T526, T528, T529, T541, T549, T561 T562 ICD code: M720

Date effective from	1 July 2021
Review date	July 2023

References:

1. Evidence-Based Interventions: Guidance for CCGs N. Dupuytren's contracture release in adults**.** NHSE/NHSI Nov 2018, updated Jan 2019 https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf
2. NICE TA459 Collagenase clostridium histolyticum for treating Dupuytren's contracture. July 2017. https://www.nice.org.uk/Guidance/TA459
3. NICE Clinical Knowledge Summaries (CKS) 2015 https://cks.nice.org.uk/dupuytrens-disease#!scenario
4. National Institute for Health and Clinical Excellence (NICE). Needle fasciotomy for Dupuytren's contracture. IPG43. London: NICE; 2004 https://www.nice.org.uk/guidance/ipg43
5. Percutaneous Needle Fasciotomy Versus Collagenase Treatment for Dupuytren Contracture: A Randomized Controlled Trial with a Two-Year Follow-up Stromberg et al al J Bone and Joint Surgery July 2018 https://journals.lww.com/jbjsjournal/Fulltext/2018/07050/Percutaneous_Needle_Fasciotomy_Versus_Collagenase.1.aspx
6. Injectable collagenase versus percutaneous needle fasciotomy for Dupuytrens contracture in PIP joints: an RCT Skov et al J Hand Surg Am 2017

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Service Improvement Manager	Adopt VoY CCG policy	Policy Harmonisation Working Group	July 2021

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Commissioning Statement:

Condition or Treatment:	Exogen Therapy
Commissioning position:	Exogen may be funded under the following circumstances: Fractures of long bone fractures with non-union (failure to heal 9 months after fracture), where surgery is otherwise the option, if: • fracture gap is ≤ 1 cm, AND • non-union is not related/secondary to malignancy, AND • non-union confirmed by 2 radiographs minimum 90 days apart • and physician statement of no clinical evidence of fracture healing For the purposes of this evaluation, long bone fractures are defined as fractures of the humerus, ulna, radius, femur, tibia and fibula. If the fracture is unstable or inter-fragment gap >1 cm then surgery is the expected option. Exogen will NOT be funded for: Delayed healing (no radiological evidence of healing between 3 and 9 months) Additional information needed on referral: • Date of fracture • Dates of radiography confirming non-union and no further progression towards radiographic healing For the purposes of exceptionality, the cohort is defined as: Non-union fracture of long bone, where surgery is otherwise an option, and where fracture is stable, aligned and inter fragment gap is <1cm. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the CCG policy Investigations prior to referral • None
Referral Guidance:	This is a Secondary Care policy – Prior Approval for treatment to be completed by the Orthopaedic Surgeon
Effective From:	1 July 2021
Date:	November 2020

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Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

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Commissioning Statement:

Condition or Treatment:	Functional Electrical Stimulation
Background:	Functional electrical stimulation (FES) is a treatment that uses the application of small electrical charges to improve mobility. It is particularly used as a treatment for drop foot. Drop foot is caused by disruption in the nerve pathway to and from the brain, rather than in nerves within the leg muscles.
Commissioning Position:	**Non-Implantable Devices:** **Policy: Functional Electrical Stimulation for drop foot is routinely commissioned with the non-implantable device, in line with NICE IPG278, providing normal arrangements are in place for clinical governance, consent and audit, and provided ALL of the following criteria are met:** • Drop foot is impeding gait and in whom the use of all orthotics (AFO) has proven to be unsuccessful following specialist assessment; AND • The patient has demonstrable functional improvement from an individual trial of FES; AND • The intervention is recommended by a multidisciplinary team specialised in rehabilitation.
Effective From:	1st July 2021
Date:	March 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP NHS North Yorkshire CCG

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Commissioning Statement:

Intervention:	Gamete harvesting and storage (Cryopreservation)
For the treatment of:	Harvesting and storage of viable gametes in patients undergoing NHS funded medical treatment(s) that cause infertility
Background:	This is a formal policy on gamete harvesting and preservation for patients undergoing medical treatments that may leave them infertile. Cryopreservation is the process of freezing and storing sperm, oocytes and embryos so that they can potentially be used at a later date, typically in an attempt to conceive a pregnancy. The CCG has a comprehensive fertility policy available on their website which covers the commissioning of cryopreservation for routine infertility treatment. One circumstance which is not covered by the fertility policy is the provision of cryopreservation for an individual who is expected to undergo NHS funded medical treatment(s) that cause infertility.
Commissioning position:	NHS North Yorkshire CCG agrees to fund the harvesting and subsequent storage (cryopreservation) of viable gametes, for an initial period of 10 years, for patients undergoing NHS funded medical treatment that may leave them infertile. If after the initial 10 year period storage is still required, an IFR application should be made as an exceptional request, provided the patient wishes to keep their sample for potential future use. Each case will be considered on its own merit and in line with the HFEA legislation. Approval for harvesting and cryopreservation does not guarantee future funding of assisted conception or fertility treatment – in this instance the CCG policy for assisted conception should be applied. Prior to fertility preservation, the secondary care clinician at the organisation providing the fertility service must confirm: • That the planned treatment is likely to affect future fertility (and document this for the commissioner's audit purposes) • That the impact of the treatment on fertility has been discussed with the patient • That the patient is able to make an informed choice to undertake gamete harvesting and cryopreservation of semen, oocytes or embryos for an initial period of 10 years • That the patient is aware that funding for gamete harvesting and cryopreservation does not guarantee future funding of assisted conception treatment

Cryopreservation in males

In general, it is recommended that at least two semen samples are collected over a period of one week. The CCG will commission a maximum of three samples of semen; this is considered sufficient to provide future fertility.

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

Note: testicular sperm retrieval is commissioned by NHS England and not by the CCG.

Cryopreservation in Females

The CCG will normally fund one cycle of egg retrieval, with or without fertilisation. If fewer than 10 eggs are retrieved following this first cycle of egg retrieval, then one further cycle can be offered.

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

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.

Previous sterilisation

Gamete retrieval and cryopreservation will not be funded where the patient has previously been sterilised.

NHS Funded Assisted Conception

Access to NHS funded harvesting and cryopreservation will not be affected by previous attempts at assisted conception. However, funding for further assisted conception attempts will be subject to the criteria stated in the CCG's IVF policy at the time of any funding application.

Expectations of Providers

Cryopreservation of gametes or embryos must meet the current legislative standards, i.e. under Human Embryo and Fertility Act 1990

The provider of the service must ensure the patient receives appropriate counselling and provides full consent. The patient and their partner must be made aware of the legal position on embryo ownership should one partner remove consent to their ongoing storage or use.

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	The provider of the service must ensure patients are aware of legal issues on posthumous use of gametes and embryos should they wish a partner to be able to use these should their treatment not be successful. Patients will need to provide annual consent for continued storage. The provider must ensure appropriate consent to storage is in place and that the patient understands the need for on-going consent and has outlined the purposes for which they can be used. **Expectation of the Patient** The patient will be responsible for ensuring the storage provider has up to date contact details. Failure to provide on-going consent may result in the destruction of stored materials.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	Following notification of a recent legal challenge[i] having been brought against NHS England by the Equality and Human Rights Commission (EHRC), the CCG wishes to ensure that all patients undergoing medical treatments that may affect fertility, including transgender treatments, have the same access to gamete preservation services as patients undergoing cancer treatment. The challenge relates to the commissioning and provision of gamete retrieval and storage services for transgender patients. The EHRC argues that: • *NHS England wrongly interprets the words "Gender Identity Disorder Services" at paragraph 57, Schedule 4 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations") as not including gamete retrieval and storage, and has thereby misdirected itself as to its obligation to provide that service to transgender patients;* • *NHS England has unlawfully failed to exercise its power under s.2 of the National Health Service Act 2006 ("the 2006 Act"), in the light of its obligations under domestic and European equalities provisions, to provide gamete retrieval and storage to transgender patients;*

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	• *NHS England has unlawfully failed to exercise its power to issue guidance to clinical commissioning groups ("CCGs") to discourage them from unlawfully failing to arrange for the provision of gamete retrieval and storage to transgender patients.* NHS England's position is that the commissioning of gamete retrieval and storage services is appropriately the commissioning responsibility of CCGs. Responsibility for developing clinical commissioning policy in this area extends as much to trans patients as it does to patients, for example, undergoing chemotherapy. When formulating clinical commissioning policy in this, and indeed all areas of commissioning responsibility, CCGs are under a number of legal duties including the Public Sector Equality Duty. NHS England's position is that no additional statutory guidance on this issue is required. NHS England advised CCGs: 'in light of this challenge, [CCGs] may wish to review any commissioning policies … in place in this area and how they apply to different groups of patients.
Date:	May 2020
Review Date:	July 2023
Contact:	Dr Christopher Ives, Governing Body GP

Additional Information/References:

[i] NHS England CCG Bulletin - Issue 247 - 25 October 2018, Review of clinical commissioning policies for gamete retrieval and preservation

- NICE (CG156 Fertility Problems: assessment and management)
- Human Fertilisation and Embryology Act (1990) guidelines https://www.hfea.gov.uk/
- Human Tissue Authority guidelines https://www.hta.gov.uk/
- Leeds CCG Gynaecology and Urology Commissioning Policy

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Gastroelectrical Stimulation (GES) / Gastric Neuromodulation
Commissioning position:	Gastric neuromodulation (GNM) has been advocated for the treatment of drug refractory gastroparesis or persistent nausea and vomiting in the absence of a mechanical bowel obstruction. There is, however, little in the way of objective data to support its use, particularly with regards to its effects on gastric emptying.
Referral Guidance:	Gastric Neuromodulation for gastroparesis is NOT routinely commissioned. All requests for this treatment must be sent to the IFR Panel for consideration. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

References:

NICE Interventional procedures guidance (IPG489): Gastroelectrical stimulation for gastroparesis

https://www.nice.org.uk/guidance/ipg489

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	2019 NHSE Evidence Based Intervention for Grommets for Glue Ear in Children
Background:	This is a surgical procedure to insert tiny tubes (grommets) into the eardrum as a treatment for fluid build up (glue ear) when it is affecting hearing in children. Glue ear is a very common childhood problem (4 out of 5 children will have had an episode by age 10), and in most cases it clears up without treatment within a few weeks. Common symptoms can include earache and a reduction in hearing. Often, when the hearing loss is affecting both ears it can cause language, educational and behavioural problems. Please note this guidance only relates to children with Glue Ear (Otitis Media with Effusion) and SHOULD NOT be applied to other clinical conditions where grommet insertion should continue to be normally funded, these include: • Recurrent acute otitis media • Atrophic tympanic membranes • Access to middle ear for transtympanic instillation of medication Investigation of unilateral glue ear in adults
Commissioning Position:	The NHS should only commission this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met: • All children must have had specialist audiology and ENT assessment. • Persistent bilateral otitis media with effusion over a period of 3 months. • Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz • Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. • Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. • The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.

	• It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum. For further information, please see: https://www.nice.org.uk/Guidance/CG60 The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age). Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	In most cases glue ear will improve by itself without surgery. During a period of monitoring of the condition a balloon device (e.g. Otovent) can be used by the child if tolerated, this is designed to improve the function of the ventilation tube that connects the ear to the nose. In children with persistent glue ear, a hearing aid is another suitable alternative to surgery. Evidence suggests that grommets only offer a short-term hearing improvement in children with no other serious medical problems or disabilities. The NHS should only commission this surgery when the NICE criteria are met, as performing the surgery outside of these criteria is unlikely to derive any clinical benefit.
Date:	September 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

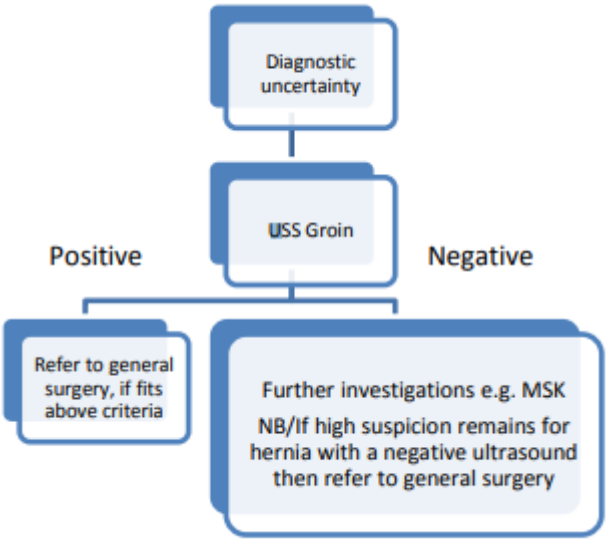
Additional Information/References:

1. NICE guidance: https://www.nice.org.uk/Guidance/CG60
2. Browning, G; Rovers, M; Williamson, I; Lous, J; Burton, MJ. Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD001801. DOI: 10.1002/14651858.CD001801.pub3

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Hernia Repair
Background:	A hernia is the protrusion of tissue or part of an organ through the cavity in which it is contained. There are different forms of abdominal hernia including inguinal, femoral, umbilical, para-umbilical, epigastric and incisional hernias. Groin hernia repair is one of the most common surgical procedures in England and Wales, with 71,000 carried out in 2014-151 with 98% of inguinal hernias occurring in men (1) The national Evidence Based Interventions (List 2) (4) recommends that "*watchful waiting is a safe option for people with minimally symptomatic inguinal hernias. Delaying and not doing surgical repair unless symptoms increase is acceptable because acute hernia incarcerations occur rarely. Many people with an inguinal hernia are asymptomatic or minimally symptomatic and may never need surgery*."
Commissioning position:	Referral for a surgical opinion should only be made if there are any of the following circumstances: 1. Umbilical, Para-umbilical & Epigastric (Please note; Congenital Umbilical hernia not included in this policy, generally most resolve spontaneously) Symptomatic – Patient complaining of pain and / or atrophic skin changes Asymptomatic but increasing in size 2. Incisional Hernia Symptomatic Asymptomatic but increasing in size 3. Female groin hernia – refer all due to the increased likelihood of a femoral hernia in this group. NB/ Patients with a high BMI are at higher risk of developing a femoral hernia. 4. Male femoral hernia – refer all due to the increased risk of incarceration or strangulation of femoral hernias. NB/ Patients with a high BMI are at higher risk of developing a femoral hernia. 5. Male Inguinal hernias that meet one of the following criteria: • Visible hernia on clinical examination (asymmetry on visual clinical examination whilst patient standing / coughing) AND

	symptomatic (pain, affecting activities of daily living or work) • Large inguinal / inguinal scrotal hernia – refer for opinion even if asymptomatic • The hernia increases in size month on month • Men with inguinal hernia that is asymptomatic or minimally symptomatic (minimal pain, minimal effect on activities of daily living or work) should be cared for with a watchful waiting approach, providing reassurance and informed consent. • If no hernia is seen on clinical examination but there is persistent groin pain and diagnostic uncertainty, then options may include referral to Musculoskeletal services and/or ultrasound of groin if locally available before referral to surgical specialty for diagnostic uncertainty. 
Effective From:	1st July 2021
Summary of evidence/ rationale:	Inguinal hernia repair is one of the most common surgical procedures, and how effectively this is done in a healthcare system has a substantial social and economic impact. In 2016, The 'Hernia Surge' Group developed recommendations regarding groin hernia management including diagnosis, referral and surgical Diagnostic uncertainty USS Groin Refer to general surgery, if fits above criteria Further investigations e.g. MSK NB/If high suspicion remains for hernia with a negative ultrasound then refer to general surgery Positive Negative management (2). The suggestion from this document is that surgery is recommended in men with symptomatic inguinal hernia and watchful waiting is recommended in men with

	asymptomatic or minimally symptomatic inguinal hernia as the risk of incarceration or strangulation in this group is low. The authors suggest that all women with a groin hernia should be referred for assessment and repair on an urgent basis. These guidelines agree with those developed by NHS England in 2013 (3)
Date:	March 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. References 1. NICE, 2004, Laparoscopic surgery for inguinal hernia repair, website accessed Feb 2017: https://www.nice.org.uk/guidance/ta83
2. The HerniaSurge Group, 2016, World Guidelines for Groin Hernia Management, HerniaSurgeGuidelinesPART1TREATMENT.pdf (europeanherniasociety.eu)
3. NHS England, 2013, Interim Clinical Commissioning Policy: Abdominal Wall Hernia Management and Repair in Adults
4. National NHSEI Evidence Based Interventions programme: https://www.aomrc.org.uk/evidence-based-interventions/

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	**Hip Replacement for Hip Arthritis**
Summary of Intervention:	Many people with hip osteoarthritis do not require joint surgery and can adequately manage their symptoms with compliance to a comprehensive non-surgical programme including appropriate use of analgesia, lifestyle modification, weight reduction and exercise therapy. Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery should ensure that the person has been offered the recommended non-surgical treatment options (NICE CG177) and meet the criteria listed in this policy. Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should share in the decision for referral for surgical assessment. This should include: • Confirmation of willingness to undergo surgery • The benefits and risks of surgery • The potential consequences of not having surgery • Recovery timescales and rehabilitation requirements after surgery
Policy Exclusions:	This policy does not apply to: • Children under 16 • Hip replacements required due to acute trauma • Cancer
Commissioning Position:	Referrals for surgical opinion should be made if patients present with one of the following: • Patient complains of intense or severe pain (please refer to the classification of symptomology table below) OR • Patient has radiological features of severe degenerative change or bone loss OR • Patients who have demonstrated good compliance to a comprehensive non-operative programme including NSAID's and analgesics, weight reduction, lifestyle modification and participation in therapy programmes

AND

continue to present with symptoms (please refer to the classification of symptomology table below)

For Hip Replacement: Classification of Symptoms

Variable	Definition
Mild	Sporadic pain. Able to carry out daily activities (those requiring great physical activity may be limited). Analgesia medication controls pain with no/few side effects.
Moderate	Occasional pain. Pain walking on level surfaces (half an hour, or standing) Some limitation of daily activities. Analgesia medication controls pain with no/few side effects.
Intense	Pain of almost continuous nature. Pain walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of analgesia medication to take effect. Requires the sporadic use of walking aid
Severe	Continuous pain. Pain at rest. Daily activities significantly limited constantly. Continuous use of analgesia medication with adverse effects or poor response. Requires more constant use of walking aid Rapid joint deformity / leg shortening

Oxford Hip Score

The Oxford hip score provides a single summed score which reflects the severity of problems that the respondent has with their hip and can be used when considering referral.

It may help a clinician assess the severity of this hip disease but should **not** be used as an arbitrary threshold. A score below 20 may indicate severe hip arthritis and it is highly likely that these patients may well require some form of surgical intervention and therefore may benefit from a surgical opinion.

The Oxford Hip Score can be found at:

http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html

Further guidance available at:

http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full

Conservative Management

- Patients with hip pain, and without red flag or acute trauma indications, should be managed in line with the North Yorkshire CCG MSK pathway and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective or are judged likely to be ineffective.
- Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted / failed.
- Conservative measures include weight reduction, analgesia, education on OA and the management of symptoms, referral to physiotherapy if required, lifestyle modification such as increased physical activity, exercise, and introducing a walking aid.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.

Shared Decision Making

- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment.
- This should include an understanding of rehabilitation requirements and likely duration of recovery and confirmation of willingness to undergo surgery.
- The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals.
- The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention.

Lifestyle Factors

- All patients being referred for hip pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at

	appropriate stages in their conservative management and in all instances before referral is made for surgical assessment. • Patients with a BMI of >40 (the super-obese) are at increased risk of surgical complications and careful consideration should be given for surgery • If there are specific indications where delay would increase bone loss and prolong suffering, the individual decision should be made by the clinician, with the patient, balancing the clinical risk against the perceived benefits.
Effective From:	1 July 2021
Summary of evidence/ rationale:	Osteoarthritis may not be progressive and a proportion of patients will not need surgery with their symptoms adequately controlled by non-surgical measures as outlined by NICE. Symptoms progress in 15% of patients with hip pain within 3 years and 28% within 6 years. When patient's symptoms are not controlled by up to 3 months of non-operative treatment they become candidates for assessment for joint surgery. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support such as the NHS Decision Aid for managing osteoarthritis. https://musculoskeletal.cochrane.org/sites/musculoskeletal.cochrane.org/files/public/uploads/What%20are%20my%20options%20for%20managing%20hip%20or%20knee%20osteoarthritis%20%20June%2015.pdf Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischemic heart disease (IHD), hypertension (HT) and sleep apnoea. Some years ago, an Arthritis Research Campaign Report stated that joint surgery is less successful in obese patients because: • Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (e.g. longer operations, excess blood loss requiring transfusions, deep vein thrombosis (DVT) and wound complications including infection). • The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (e.g. they are less likely to regain normal functioning or reduction in pain and stiffness). • The implant is likely to fail more quickly, requiring further surgery (e.g. within 7 years, obese patients are more than ten times as likely to have an implant failure). • People who have joint replacement surgery because of obesity related osteoarthritis are more likely to gain weight post

	operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels). It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". A recent extensive literature review advises assessment of "timely weight loss as a part of conservative care" It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.
Date:	October 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

1. Care and Management of Osteoarthritis NICE Clinical Guidelines CG177 Feb 2014 http://www.nice.org.uk/guidance/CG177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-

2. Optimising Outcomes from Elective Surgery Commissioning Statement – North Yorkshire CCG

3. Obesity prevention NICE CG 43 Dec 2006; last amended March 2015 https://www.nice.org.uk/guidance/cg43

4. RightCare shared decision-making tools https://musculoskeletal.cochrane.org/sites/musculoskeletal.cochrane.org/files/public/uploads/What%20are%20my%20options%20for%20managing%20hip%20or%20knee%20osteoarthritis%20%20June%2015.pdf

5. NHS Choices: http://www.nhs.uk/chq/Pages/849.aspx?CategoryID=51&SubCategoryID=165

6. Arthritis Research Campaign: "Osteoarthritis and Obesity" (2009) http://www.arthritisresearchuk.org/external-resources/2012/09/17/15/29/osteoarthritis-and-obesity-a-report-by-the-arthritis-research-campaign.aspx

7. Obesity and total joint arthroplasty: a literature based review. Journal of Arthroplasty May 2013

http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

8. Public and patient guide to the NJRs 14th annual report 2017. Hip replacement edition (2018)
http://www.njrcentre.org.uk/njrcentre/Portals/0/Documents/England/PPG/09736%20NJR%20PPG%20-%20HIPS%202018%20WEB%20SPREADS.pdf?ver=2018-02-08-112731-437

9. British Orthopaedic Association (2017) Commissioning Guide: Pain Arising from the Hip in Adults:

https://www.boa.ac.uk/uploads/assets/2a2182ef-979a-447b-95f671b7e73e15a9/pain%20arising%20from%20the%20hip%20guide.pdf

North Yorkshire
Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Hyperhidrosis (Referral)
Background:	Hyperhidrosis is a condition characterised by excessive sweating, and can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, armpits and the face of otherwise healthy people. Depending on the severity of the hyperhidrosis, it can be managed in primary or secondary care.
Commissioning position:	Primary care: lifestyle management, such as regular night-time antiperspirant use (up to 20% aluminium chloride hexahydrate available OTC), avoiding tight clothing and manmade fabrics, wearing white or black clothing to minimize the signs of sweating, dress shields to absorb excess sweat, and avoiding stimuli such as caffeine, spicy foods or crowded areas. Underlying anxiety should be treated. More patient information and support is available from Hyperhidrosis UK. http://hyperhidrosisuk.org/ Referral for Hyperhidrosis will only be funded in accordance with the criteria below: • The search for an underlying cause has been exhausted AND • Hyperhidrosis Disease Severity Scale (HDSS) 3 or 4 AND • Trial of lifestyle management for a minimum of 2 months AND • The patient has medical complications of hyperhidrosis (i.e. skin macerations and secondary infections)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021

North Yorkshire
Clinical Commissioning Group

Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

http://cks.nice.org.uk/hyperhidrosis#!scenario

http://www.bad.org.uk/

http://hyperhidrosisuk.org/

North Yorkshire
Clinical Commissioning Group

Access to Infertility Treatment –

Commissioning Policy Document

Yorkshire and Humber

Adopted by
North Yorkshire CCG

1 July 2021 – July 2023

Document Title:	Access to Infertility Treatment – Commissioning Policy Document Yorkshire and Humber
Version No:	V14
Latest version issued:	1 February 2022
Supersedes:	All previous access to infertility treatment policies
Name of Author (s):	Michelle Thompson
Consultation:	Yorkshire and Humber Expert Fertility Panel 2 March 2017 31 January 2018 25 June 2018 25 January 2019 15 November 2019 11 January 2022 (some members)
Approved by:	Yorkshire and Humber Expert Fertility Panel NEL CCG Council of Members
Approval date:	5 September 2019
Review date:	1 April 2023
Equality Impact Assessment Date:	January 2020
Target Audience:	Public
Dissemination:	CCG Global bulletin, CCG website and intranet

CHANGE RECORD

Version	Author	Nature of Change	Uploaded
11.1	Suzanne Savage	Adopted by North Yorkshire CCG	01.07.21
14	Bobbi Phillips	Clarification to section 5.5 regarding abandoned cycles and further cycles as recommended by the Yorkshire and Humber Expert Fertility Panel	XXXX

Any locally held old paper copies must be destroyed. ***When this document is viewed as a paper copy, the reader is responsible for checking that it is the most current version. This can be checked on the CCG website: https://www.northyorkshireccg.nhs.uk/***

Commissioning Policy Statement:

Commissioning

This document represents the commissioning policy of North Yorkshire CCG for the clinical pathway which 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 North Yorkshire CCG.

Funding

The policy on funding of specialist fertility services for individual patients is a policy of North Yorkshire CCG and is not part of the shared policy set out in the rest of this document. The number of full IVF cycles currently funded by the North Yorkshire CCG for patients who meet the access criteria set out in the shared policy is one. This is unchanged from the previous funding policy in March 2016. This policy will be updated in accordance with the review period of the policy or earlier should sufficient changes in practice or evidence base require it.

Immigration Health Surcharge; Right to Assisted Conception Services

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

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

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

Working group membership and Conflicts of Interest

See appendices E and F

For Further Information about this policy.

Please contact your local Clinical Commissioning Group. https://www.northyorkshireccg.nhs.uk/

Contents

1. Aim of Paper

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

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

2. Background

2.1 On April 1st, 2013 Clinical Commissioning Groups (CCGs) across the Yorkshire and the Humber regions adopted the existing Yorkshire and the Humber Fertility policy[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.

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 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 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 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 1 cycle for eligible couples where the woman is aged 40 - 42.

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

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

3. Clinical Effectiveness

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

4. Cost Effectiveness

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

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

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

[3] 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 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 reproductive cycles.
- Current research shows no cause for concern about the health of children born as the result of 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.

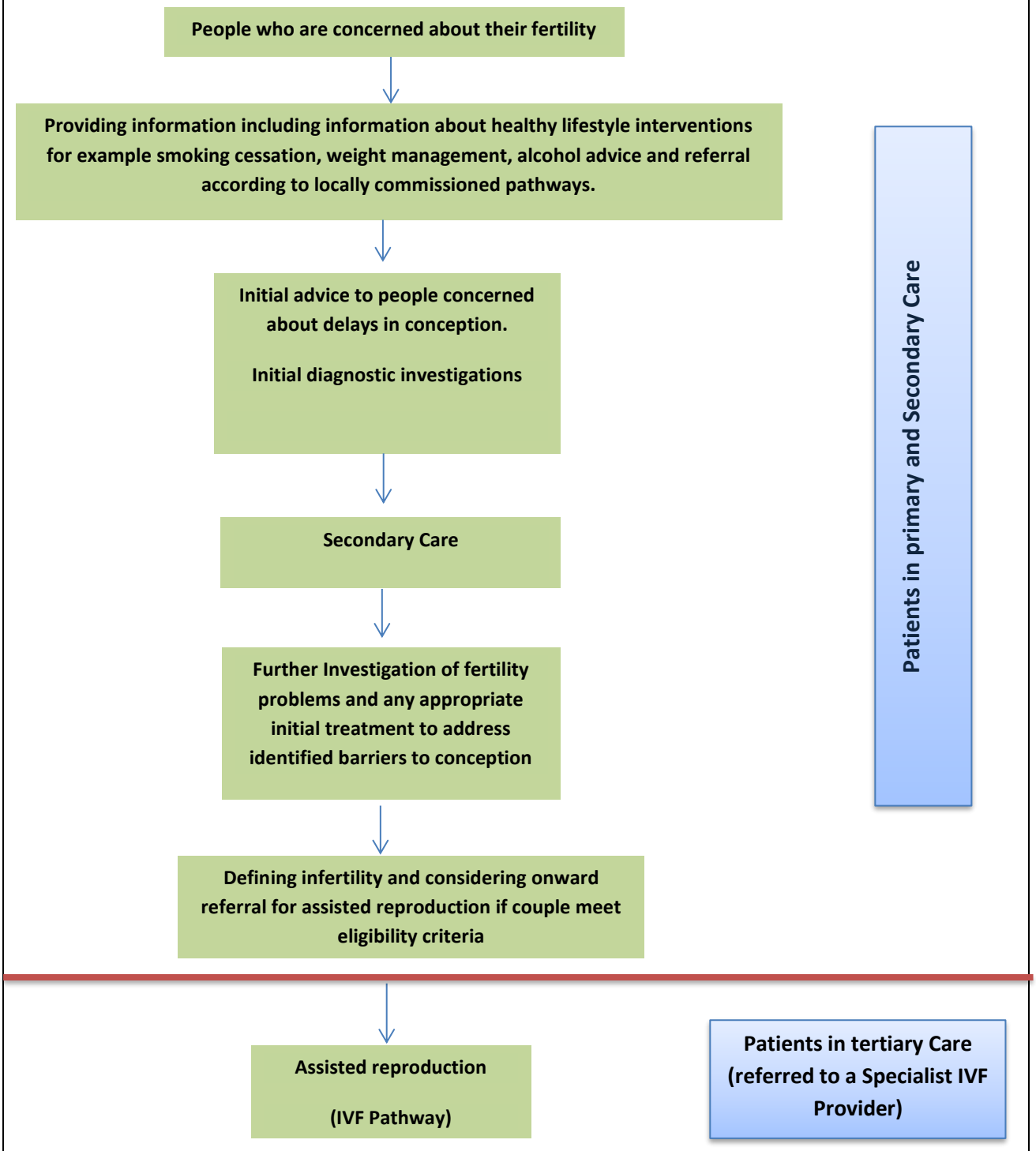
5.1.2 People should have the opportunity to make informed decisions regarding their care and treatment via access to evidence-based information. These choices should be recognised as an integral part of the decision-making process.

Information should be provided in the following formats:

- Face to face discussions with couples
- Written information and advice
- Culturally sensitive
- Sensitive to those with additional needs e.g. physical or 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 (fig, 1)



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 (fig 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 abandoned cycle should not affect the couple's entitlement to further IVF/ICSI (up to the maximum number of cycles provided by their CCG), providing that additional cycles are clinically appropriate. Further cycles will not be offered after a second abandoned cycle, but the clinician may submit an Individual Funding Request if there are exceptional circumstances.

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):

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

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.

5.6.3 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 is still met. If it is anticipated that there will be difficulty finding a suitable donor exceptionality would need to be considered. At this point consideration may need to be given to sourcing from alternative providers via IFR.

Donor Sperm

Where clinically indicated up to six cycles of donor insemination will be offered. This is dependent on the availability of donor sperm which is currently limited in the UK.
The cost of donor sperm is included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG.

Donor Eggs

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

5.7 Gametes and Embryo Storage

The cost of egg and sperm storage will be included in the funding of treatment for which it is required, to be commissioned in accordance with this policy and the funding policy of the CCG. Storage will be funded by the CCG for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter. This will be explained by the provider prior to the commencement of treatment. Following this period continued storage may be self-funded.

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

5.8 HIV/HEP B/ HEP C

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

5.9 Surrogacy

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

5.10 Single Embryo Transfer

Please refer to 5.3 for the definition of a full cycle.
Multiple births are associated with greater risk to mothers and children and the HFEA[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 Clinical Commissioning Groups.

[5] 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

Abbreviations used	
BMI	Body Mass Index
DI	Donor Insemination
GP	General Practitioner
HFEA	Human Fertilisation and Embryology Authority
ICSI	Intracytoplasmic sperm injection
IUI	Intra-uterine insemination
IVF	In vitro fertilisation
NICE	National Institute of Clinical Excellence
CCG	Clinical Commissioning Group

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 http://www.nhs.uk
ICSI	**Intra Cytoplasmic Sperm Injection (ICSI)**: Where a single sperm is directly injected into the egg.	Glossary, HFEA http://www.hfea.gov.uk
IUI	**Intra Uterine Insemination (IUI)**: Insemination of sperm into the uterus of a woman.	As above
IVF	**In Vitro Fertilisation (IVF)**: Patient's eggs and her partner's sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the female patient.	As above
DI	**Donor Insemination (DI)**: The introduction of donor sperm into the vagina, the cervix or womb itself.	As above

Appendix C, Equality Impact Assessment

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

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

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

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

4. Analysis of impact

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to;

eliminate unlawful discrimination; advance equality of opportunity; foster good relations

	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	Yes. IVF is only available to women aged between 18 and 42. As a woman ages the chances of successful pregnancy fall.	Both	Action cannot be taken to prevent this it is therefore incumbent simply to ensure clear age limitations are identified
Carers	No		
Disability	Yes. The policy has been enhanced to offer funding to couples who by reason of disability cannot conceive naturally	positive	The fact of this new change and opportunity to such couples can be publicised
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	Yes. The policy has been enhanced to offer funding to couples in a same sex relationship without having to demonstrate they have self-funded other trials	positive	The fact of this new change and opportunity to such couples can be publicised
Gender reassignment	Yes	positive	Gender reassignment is specifically referenced in the definition of infertility
Pregnancy and maternity	Yes. The policy enhances the ability to access fertility	positive	

	treatment and the potential to achieve pregnancy		
Marriage and civil partnership	No		
Other relevant group			

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Each CCG to monitor individual funding requests for this procedure and identify if there are issues with the policy which require a policy refresh.		
Lead Officer	Suzanne Savage, Service Improvement Manager	**Review date:**	4 February 2021

6.Sign off on behalf of the local CCG			
Lead Officer	NY CCG QCGC		
Director		**Date approved:**	4 February 2021

Appendix D, Version Control

VERSION	DATE	AUTHOR	STATUS	COMMENT
V14	March 2022	Bobbi Phillips		Clarification to section 5.5 regarding abandoned cycles and further cycles as recommended by the Yorkshire and Humber Expert Fertility Panel
V11.1	July 2021	S Savage		Adopted by North Yorkshire CCG
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.

NHS
North Yorkshire
Clinical Commissioning Group

Commissioning Statement Knee Arthroscopy

Condition or Treatment:	Knee arthroscopy for diagnostic or therapeutic reasons
Background:	Knee arthroscopy is a surgical procedure for inspection and treatment of problems arising in the knee joint such as inflammation or an injury. It can include repair or removal of any damaged tissue or cartilage. It has been used extensively in the past to diagnose knee problems, but this is no longer appropriate due to the invasive nature of the procedure and the increasing access to less invasive diagnostic methods such as MRI. With such a common procedure, it is important to ensure that the evidence base is robust so that patients are not exposed to the risks without good evidence of benefit. It is important for the NHS to optimise the safety and cost-effectiveness of procedures to ensure maximum benefit for the risks and costs involved. The figures suggest that this could represent an area of improvement in cost-effectiveness and possible cost saving. Surgery should be performed in-line with BASK guidelines as supported by EBI2 https://baskonline.com/professional/wp-content/uploads/sites/5/2018/07/BASK-Meniscal-Surgery-Guideline-2018.pdf
Commissioning Position:	NHS North Yorkshire CCG does NOT routinely commission referral to secondary care for knee arthroscopy and will ONLY commission knee arthroscopy in adults where the following criteria are met: **1) Washout and debridement in Osteoarthritis** Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, (in line with NICE guidance) **unless** the person has a clear documented history of **mechanical locking** (2, 3) **2) Diagnostic Arthroscopy** Patients who have knee pain with persistent mechanical symptoms (locking, catching and intermittent sudden pain on movement) that have not responded to three months of initial non-operative care may have a symptomatic meniscal tear. These patients should be referred for further investigation via agreed local MSK pathways

	where MRI scan may be requested by a MSK specialist. The majority of patients who present to primary care with knee pain **do not** require initial investigation with an MRI scan once red flag symptoms and signs have been excluded. Patients who have a clear history of a significant acute traumatic knee injury and mechanical symptoms or who have a locked knee or present with red flags require referral without delay to secondary care and should undergo MRI investigation (where clinically appropriate). As investigation of knee pain with locking should start with less invasive MRI scanning to identify meniscal tears and loose bodies diagnostic arthroscopy of the knee is therefore **not** routinely funded **unless** one of the following criteria apply: ➢ Significant knee pain having functional impact with diagnostic uncertainty following an MRI scan **OR** ➢ Suspected malignancy, infection, bony fracture or avascular necrosis (i.e. urgent need for investigation) **OR** ➢ Where there are contraindications to MRI scan **3) Therapeutic Arthroscopy** The CCG will ONLY commission therapeutic knee arthroscopy in adults where: ➢ The patient has clear mechanical features of true locking or urgent need for treatment e.g. knee trauma causing fracture or ligament avulsion, red flag conditions **OR** ➢ Clinical examination by a specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, chondral flap, ligament rupture or loose body) with symptomatic and functional impairment **and** conservative treatment (including exercise, weight loss where appropriate,

	physiotherapy and maximal analgesic medication) has been tried over a **3-month** period and failed **or** where it is clear that conservative treatment will not be effective. Summary to support criteria listed above from the ESSKA Meniscus Consensus Project can be found in Appendix A and in the link below: 2016-meniscus-consensus-proj.pdf (ymaws.com) Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes there is an exceptional clinical need that justifies deviation from the rule of this policy. Individual cases will be considered by the individual funding request panel
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1st July 2021
Summary of evidence/ rationale:	For patients with non-traumatic knee injury, evidence shows that, on average, conservative treatment is as effective as arthroscopic knee surgery for some procedures. As long ago as 2002, a controlled trial addressing knee arthroscopy, using placebo or "sham" surgery as a comparator, showed no benefit (4). Partial meniscectomy surgery showed no advantage over sham in one RCT of patients aged 35-65 years with degenerative meniscal tears without osteoarthritis (5) and no advantage over physical therapy in two RCTs of older patients (>45 years) with osteoarthritis (6, 7). In a systematic review of RCTs of young patients (mean age ~20 years) with a first occurrence of patellar dislocation, there was no conclusive advantage of surgical treatments compared with non-surgical treatments (8). In an RCT of patients with patellofemoral

	pain syndrome (18-40 years), mixed arthroscopic procedures and exercise resulted in equivalent improvements compared with exercise alone (9). Although rates of post-operative complications are generally low higher rates have been observed in children and young people (10,11). There may also be future knee damage associated with arthroscopic procedures (12, 13) and a recent meta-analysis showed that the small benefit from arthroscopic knee surgery seen in middle aged or older patients with knee pain and degenerative knee disease was absent one to two years after surgery and was associated with an increase in significant harms such as deep vein thrombosis, pulmonary embolism, infection and death (14). The paper concludes "The small inconsequential benefit seen from interventions that include arthroscopy for the degenerative knee is limited in time and absent at one to two years after surgery. Knee arthroscopy is associated with harms. Taken together, these findings do not support the practice of arthroscopic surgery for middle aged or older patients with knee pain with or without signs of osteoarthritis (14). The Royal College of Surgeons/British Orthopaedic Association commissioning guide points out that "osteoarthritis may not be progressive and most patients will not need surgery, with their symptoms adequately controlled by nonsurgical measures as outlined by NICE (1)." Regarding knee arthroscopy, it states that lavage and debridement should be considered in patients: - With clear history of mechanical symptoms e.g. locking that have not responded to at least 3 months of non-surgical treatment - Where a detailed understanding of the degree of compartment damage within the knee is required, above that demonstrated by imaging, when considering patients for certain surgical interventions (e.g. high tibial osteotomy) The RCS/BOA guidance also states (in line with NICE guidance) that "Knee arthroscopy, lavage and debridement should NOT be offered for patient with non-mechanical symptoms of pain and stiffness." More recently, the BMJ has published two editorials about arthroscopic surgery for degenerative knee or knee pain (15, 16). They both explore the evidence for benefit and harm and point out that, although this is one of the most common surgical procedures,

there is no convincing evidence for the procedure being beneficial beyond the placebo effect.

A series of rigorous trials summarised in two recent systematic reviews and meta-analyses provide clear evidence that arthroscopic knee surgery offers little benefit for most patients with knee pain (14, 17).

The most recent linked paper is a comparison between exercise therapy alone and arthroscopic partial meniscectomy alone (without any postoperative rehabilitation) in adults with a degenerative meniscal tear (18). The authors found no between group differences in patient reported knee function at the two-year follow-up, but greater muscle strength in the exercise group at three months.

Over time, the indications have extended from locked knees in young patients to all patients of all ages with knee pain and meniscus tears of any sort; tears which, on magnetic resonance imaging, have proved poorly associated with symptoms (19).

Essentially, the editorials say, good evidence has been widely ignored. The most recent editorial comments that arthroscopic surgery for knee pain continues unabated, as disinvestments in ineffective treatments are generally slow (16, 20). It calls for local commissioners to respond appropriately to the evidence, because "system level measures that result in more appropriate use of scarce medical resources are urgently required". In addition, it says that "in a world of increasing awareness of constrained resources and epidemic medical waste, what we should not do is ignore the results of rigorous trials and allow continuing widespread use of procedures for which there has never been compelling evidence".

Restricted use of MRI
MRI is a good diagnostic tool (21) but may be inaccurate when used by less experienced staff (22) and its use is, therefore, restricted to secondary care or specialists working in locally commissioned MSK pathways.

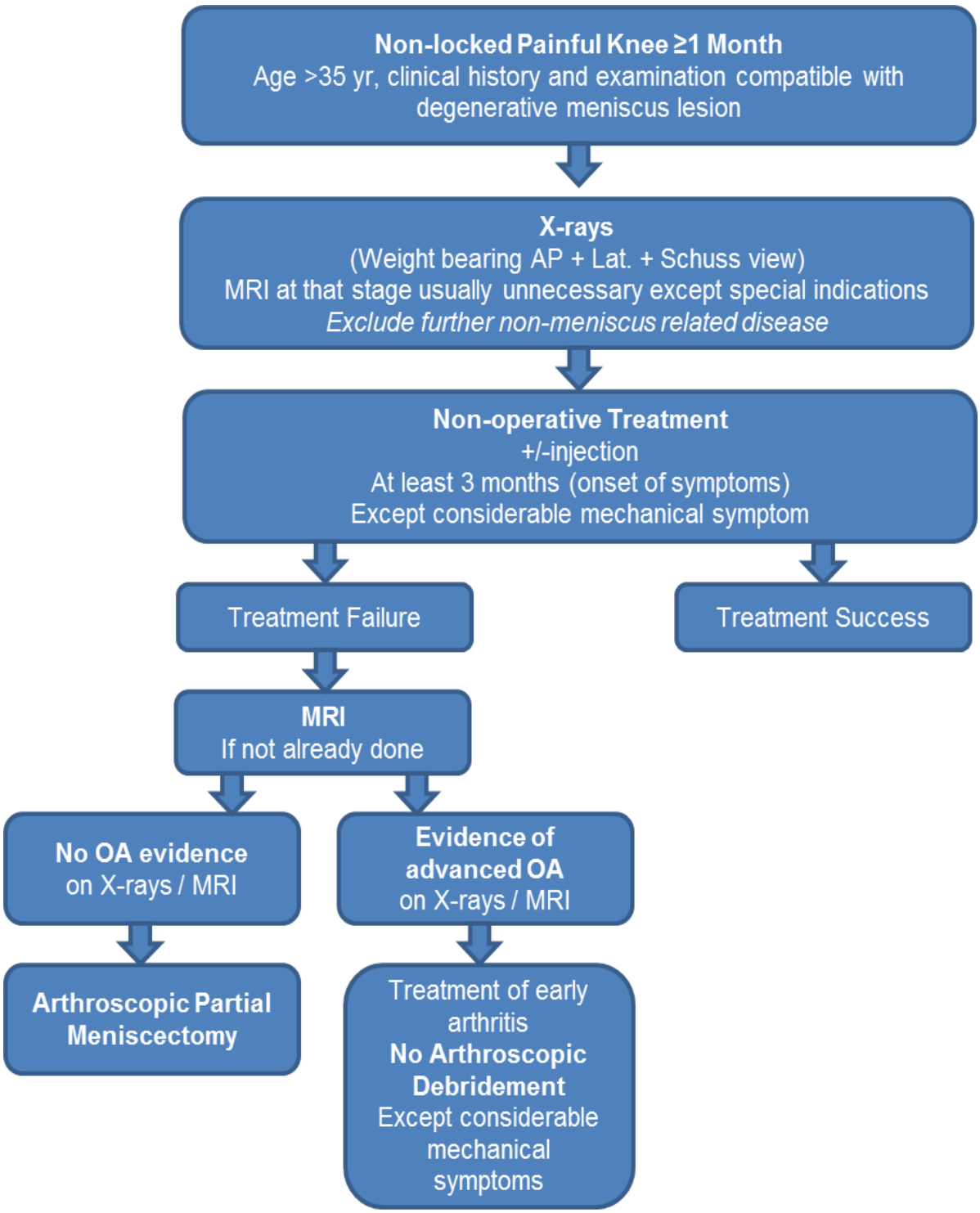
Adapted (and updated) from evidence review in Knee arthroscopy for chronic knee pain Cambridgeshire and Peterborough CCG31, with thanks to Dr Raj Lakshman, Consultant Lead in Healthcare

Shared decision-making
A letter following the recent BMJ editorial suggests that the overtreatment of knee pain with arthroscopy could be solved through the use of shared decision making (31). The NHS/BMJ aid

	for knee arthritis clearly states that arthroscopy for lavage and/or debridement doesn't make much difference to pain, increase mobility around or stop symptom progression (32). The British Orthopaedic Association recently claimed that GPs were over-diagnosing patients with non-arthritic complaints and referring them on for surgery (instead of prescribing exercise) with the expectation that the keyhole procedure would "cure" the problem, so that too many patients were undergoing needless arthroscopy. Easy access to MRI is also likely to be leading to over diagnosis of meniscal tears and subsequent overtreatment. "Shared decision making for the management of knee pain should begin in the GP surgery and continue through the patient's treatment. Given the research findings, it would be difficult to see why patients who are adequately supported in the decision-making process would be choosing surgery over physiotherapy." Patient information leaflets available Arthroscopy Knee cartilage injuries
Date:	April 2021
Review Date:	July 2023
Contact:	Dr Christopher Ives, Governing Body GP/Acute Commissioning lead

Additional Information/References:

Appendix A: ESSKA Meniscus Consensus Algorithm (34)



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29. NICE Interventional Procedure Guidance 474. Arthroscopic trochleoplasty for patellar instability. 2014.

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31. Arthroscopic surgery for knee pain; where is the shared decision making? Letter from Dr S Finnikin GP http://www.bmj.com/content/354/bmj.i3934/rr/927387

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https://www.england.nhs.uk/shared-decision-making/

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Commissioning Statement:

Condition or Treatment:	**Knee Replacement for knee Arthritis**
Summary of Intervention:	Many people with knee osteoarthritis do not require joint surgery and can adequately manage their symptoms with compliance to a comprehensive non-surgical programme including appropriate use of analgesia, lifestyle modification, weight reduction and exercise therapy. Clinicians with responsibility for referring a person with osteoarthritis for consideration of joint surgery, should ensure that the person has been offered the recommended non-surgical treatment options (NICE CG177) and meet the criteria listed in this policy. Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should share in the decision for referral for surgical assessment. This should include: • Confirmation of willingness to undergo surgery • The benefits and risks of surgery • The potential consequences of not having surgery • Recovery timescales and rehabilitation requirements after surgery
Policy Exclusions:	This policy does not apply to: • Children under 16 • Knee replacements required due to acute trauma • Cancer
Commissioning Position:	**Referrals for surgical opinion should be made if patients present with one of the following:** • Patient complains of intense or severe pain (please refer to the classification of symptomology table below) **OR** • Patient has radiological features of severe degenerative change or bone loss **OR** • Has demonstrated disease within all three compartments of the knee (tri-compartmental) or localised to one compartment plus patello-femoral disease (bi-compartmental). **OR** • Patient has radiological features of moderate disease **AND** is troubled by limited joint mobility

AND
limited stability of the knee joint
OR

- Patients who have demonstrated good compliance to a comprehensive non-operative programme including NSAID's and analgesics, weight reduction, lifestyle modification and participation in therapy programmes
  AND
  continue to present with moderate to intense symptomology (please refer to the classification of symptomology table below)
  AND
  are troubled by limited mobility and/or stability of the knee

Classification of pain levels and functional limitations are described in the table below:

For Knee Replacement: Classification of Symptoms

Variable	Definition
Mobility and Stability	
Preserved mobility and stable joint	Preserved mobility is equivalent to minimum range from 0° to 90°. Stable or not lax is equivalent to an slackness of more than 5mm in the extended joint.
Limited mobility and/or stable joint	Limited mobility is equivalent to a range of moveme to 90o unstable or lax is equivalent to the presence more than 5mm in the extended joint.
Symptomology	
Mild	Sporadic pain. Able to carry out daily activities (those requiring great physical activity may be limited). Analgesia medication controls pain with no/few side effects.
Moderate	Occasional pain. Pain walking on level surfaces (half an hour or standing). Some limitation of daily activities. Analgesia medication controls pain with no/few side effects.
Intense	Pain of almost continuous nature. Pain walking short distances on level surfaces or standing for less than half an hour. Daily activities significantly limited. Continuous use of analgesia medication to take effect. Requires the sporadic use of walking aid
Severe	Continuous pain. Pain at rest. Daily activities significantly limited constantly. Continuous use of analgesia medication with adverse effects or poor response. Requires more constant use of walking aid

	Rapid joint deformity / leg shortening

Oxford Knee Score
The Oxford knee score provides a single summed score which reflects the severity of problems that the respondent has with their knee and can be used when considering referral.

It may help a clinician assess the severity of knee disease but should **not** be used as an arbitrary threshold. A score below 20 may indicate severe knee arthritis and it is highly likely that these patients may well require some form of surgical intervention and therefore may benefit from a surgical opinion.

The Oxford Knee Score can be found at:

http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html

Further guidance available at:

http://www.bjj.boneandjoint.org.uk/content/89-B/8/1010.full

NICE Guidance:
https://www.nice.org.uk/guidance/cg177/chapter/1-Recommendations#referral-for-consideration-of-joint-surgery-2

https://www.nice.org.uk/guidance/cg189/chapter/1-Recommendations#identification-and-classification-of-overweight-and-obesity

Conservative Management

- Patients with knee pain, without red flag or acute trauma indications, should be managed in line with the North Yorkshire CCG pathways and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective or are judged likely to be ineffective.
- Referral should be when other pre-existing medical conditions have been optimised AND conservative measures have been exhausted / failed.
- Conservative measures include weight reduction, analgesia, education on OA and the management of symptoms, referral to physiotherapy if required, lifestyle modification such as increased physical activity, exercise, and introducing a walking aid.
- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.

	Shared Decision Making • Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral for surgical assessment. • This should include an understanding of rehabilitation requirements and likely duration of recovery and confirmation of willingness to undergo surgery. • The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. • The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention. **Lifestyle Factors** • All patients being referred for knee pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services. • All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment. • Patients with a BMI of >40 (the super-obese) are at increased risk of surgical complications and careful consideration should be given for surgery • If there are specific indications where delay would increase bone loss and prolong suffering, the individual decision should be made by the clinician, with the patient, balancing the clinical risk against the perceived benefits.
Effective From:	1 July 2021
Summary of evidence/ rationale:	20% of adults over 50 and 40% over 80 years report disability from knee pain secondary to osteoarthritis9. The majority of patients present to primary care with symptoms of pain and stiffness which reduces mobility and with associated reduction in quality of life. Osteoarthritis may not be progressive and most patients will not need surgery with their symptoms adequately controlled by non-surgical measures as outlined by NICE [1] .

	When patient's symptoms are not controlled by up to 3 months of non-operative treatment they become candidates for assessment for joint surgery. The decision to have joint surgery is based on the patient's pre-operative levels of symptoms, their capacity to benefit, their expectation of the outcome and attitude to the risks involved. Patients should make shared decisions with clinicians, using decision support such as the NHS Decision Aid for managing osteoarthritis https://musculoskeletal.cochrane.org/sites/musculoskeletal.cochrane.org/files/public/uploads/What%20are%20my%20options%20for%20managing%20hip%20or%20knee%20osteoarthritis%20%20June%2015.pdf Obesity is an increasing problem in the population and also a significant risk factor for osteoarthritis. It is often associated with comorbidities such as diabetes, ischemic heart disease (IHD), hypertension (HT) and sleep apnoea. Some years ago, an Arthritis Research Campaign Report [7] stated that joint surgery is less successful in obese patients because: • Obese patients have a significantly higher risk of a range of short-term complications during and immediately after surgery (e.g. longer operations, excess blood loss requiring transfusions, deep vein thrombosis (DVT) and wound complications including infection). • The heavier the patient, the less likely it is that surgery will bring about an improvement in symptoms (e.g. they are less likely to regain normal functioning or reduction in pain and stiffness). • The implant is likely to fail more quickly, requiring further surgery (e.g. within 7 years, obese patients are more than ten times as likely to have an implant failure). • People who have joint replacement surgery because of obesity related osteoarthritis are more likely to gain weight post operatively (despite the new opportunity to lose weight through exercise following reduction in pain levels). It also concluded that "Weight loss and exercise combined have been shown to achieve the same level of symptom relief as joint replacement surgery". A study of obese patients with knee osteoarthritis found that those who dropped their weight by 10% after a combination of diet and exercise reported less pain, better knee function, improved mobility and enhanced quality of life [8] . A recent extensive literature review advises assessment of "timely weight loss as a part of conservative care"[9]. It confirms in detail the increased risk of many perioperative and postoperative complications associated with obesity (as well as increased costs and length of stay), such as wound healing/infections; respiratory problems; thromboembolic disease; dislocation; need for revision surgery; component malposition; and prosthesis loosening.
Date:	October 2020

North Yorkshire
Clinical Commissioning Group

Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

Additional Information/References:

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4. .RightCare shared decision-making tools
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6. Royal College of Surgeons Commissioning Guides: Painful osteoarthritis of the knee November 2013

   https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/osteoarthritis-knee-guide/
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   http://www.arthroplastyjournal.org/article/S0883-5403(13)00174-5/abstract

NHS
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Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Labiaplasty / Vaginoplasty
Background:	This commissioning policy is needed as cosmetic procedures are not routinely commissioned. Labiaplasty is a surgical procedure where the folds of the labia minora are partially removed, usually for cosmetic reasons alone to change appearance. Non-reconstructive vaginoplasty or "vaginal rejuvenation" is another cosmetic procedure used to restore vaginal tone and appearance **Note**: Female circumcision is prohibited in law by the Female Genital Mutilation Act 20031 and is the subject of multi-agency guidelines from the Department of Health. Patients who have undergone female genital mutilation should be referred to a specialist female genital mutilation clinic via NHS England.
Commissioning position:	The CCG will ONLY routinely commission reconstructive labiaplasty/ vaginoplasty: • Following surgery for cancer; • vaginal repair following delivery; • for dyspareunia caused by scarring from vaginal delivery (including Fenton"s procedure); • for scarring caused by underlying dermatology condition such as Lichen Sclerosis NHS North Yorkshire CCG does not routinely commission labiaplasty/ vaginoplasty, for cosmetic reasons, as these procedures are considered to be of limited clinical value. This is in line with the Interim Clinical Commissioning Policy produced by NHS England. Requests for labiaplasty will be considered, via a request to the IFR Panel, for the following indication: • Where the labia are directly contributing to recurrent disease or infection Requests for vaginoplasty will be considered, via a request to the IFR Panel, for the following indication: • Congenital absence or significant developmental/endocrine abnormalities of the vaginal canal,

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	The clinician needs to submit an application to the CCG"s Individual Funding Request Panel (IFR)
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Summary of evidence/ rationale:	The number of requests for this procedure and the number of surgeons offering it has dramatically increased in recent years. Reasons for requesting labiaplasty are often to alleviate functional discomfort, improve appearance and increase self-esteem. Many women seeking labial reduction opt for the procedure because they feel stigmatised by social norms about how they should look and may have unrealistic expectations of the surgery. Recent work has demonstrated there is a wide range of what is regarded as "normal" and satisfaction at the cosmetic outcome of surgical attempts to create normative feminine genital appearance tends to be poor, with up to 80% requiring further reconstructive surgery. Surgery to the labia minora is being promoted as an effective treatment for complaints such as recurrent urinary tract infections (UTIs) or to enhance sexual functioning. There is no good evidence for clinical effectiveness so it can be considered as medically non-essential surgery and thus not routinely commissioned. In one large multicentre study, the author noted that although over 90% of patients were satisfied with the results of their surgery in the shortterm, sexual dysfunction before surgery and enhancement after surgery is highly subjective and difficult to quantify. Some case series also point to re-operation rates following labiaplasty of up to 7% for reasons such as wound dehiscence, infection and dissatisfaction with appearance. None of the studies found in a literature review looked at the potential for long-term obstetric complications after such surgery.
Date:	March 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

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Additional Information/References:

Female Genital Mutilation Act 2003 http://www.legislation.gov.uk/ukpga/2003/31

Female genital mutilation: multi-agency practice guidelines. July 2020

https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Interim Clinical Commissioning Policy: Labiaplasty, vaginoplasty and hymenorrhaphy Nov 2013 https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC023.pdf

Lloyd J, et al (2005) Female genital appearance: „normality" „unfolds". BJOG - An International Journal of Obstetrics and Gynaecology 2005; 112:643-646. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2004.00517.x/pdf

Bramwell R, et al (2007) Expectations and experience of labial reduction: a qualitative study. BJOG An International Journal of Obstetrics and Gynaecology 114:1493-1499. http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2007.01509.x/pdf

Liao LM, et al (2010) Labial surgery for well women: a review of the literature. BJOG An international Journal of Obstetrics and Gynaecology 2010;117: 20-25

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Commissioning Statement:

Condition or Treatment:	Referral for Nerve Conduction Studies from Primary Care
Commissioning position:	These investigations are not commissioned for access from Primary Care. If in doubt, advice and guidance from neurology may be sought.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Jablecki, C.K.; Andary, M.T.; So, Y.T.; Wilkins, D.E. and Williams, F.H. (1993)

Literature review of the usefulness of nerve conduction studies and electromyography for the evaluation of patients with carpal tunnel syndrome. AAEM Quality Assurance Committee. Muscle Nerve. 1993 Dec;16(12):1392-414.

Jarvik, Jeffrey G.; Yuen, Eric and Kliet, Michael (2004) Diagnosis of carpal tunnel syndrome: electrodiagnostic and MR imaging evaluation. Neuroimaging Clin N Am. 2004 Feb;14(1):93-102, viii.

Kilmer, D.D and Davis, B.A. (2002) Electrodiagnosis in carpal tunnel syndrome. Hand Clin. 2002 May;18(2):243-55.

Wilder-Smith, Einar P.; Seet, Raymond C.S. and Lim, Erle C.H. (2006)

Diagnosing carpal tunnel syndrome--clinical criteria and ancillary tests. Nat Clin Pract Neurol. 2006 Jul;2(7):366-74.

www.gp-training.net - on right hand side ‘Doctors’ click ‘protocols’ then ‘orthopaedics’ then ‘orthopaedic referral guidelines’

NHS Scotland National Patient Pathways 2005: Orthopaedics; Hand conditions.

New Zealand Ministry of Health National Referral Guidelines 2001: Orthopaedics

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Commissioning Statement:

Condition or Treatment:	Resurfacing Procedures; Dermabrasion, Chemical Peels and laser treatment
Background:	Dermabrasion involves removing the top layer of the skin with an aim to make it look smoother and healthier. Scarring and permanent discolouration of skin are the rare complications. This policy includes all laser skin treatments, for example for Rhinophyma or Rosacea.
Commissioning position:	Resurfacing procedures will not be routinely funded. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Commissioning Statement:

Condition or Treatment:	Rhinitis (Adult)

Background:	**Definition**
	Inflammation of the lining of the nose causing: blockage, rhinorrhoea (anterior or posterior), sneezing or itch.
	Classification
	• Infective
	• Irritant
	  Temperature, Chemicals
	• Allergic
	  Seasonal, Perennial, Occupational
	• Non-allergic
	  Drug induced (B-blockers, Topical decongestants, NSAIDs, ACEI)
	  Hormones (Pregnancy, OCP, Hypothyroidism)
	  Eosinophilic
	  Systemic disorders (Cystic fibrosis, Granulomatous disease)
	  Structural
	
	Primary care management
	Not greatly affected by diagnostic classification
	Regular prophylactic medication (even when asymptomatic) is more effective
	Starting treatment two weeks before known allergen improves efficacy
	For Detailed Management Refer to CKS guidelines:
	https://cks.nice.org.uk/topics/allergic-rhinitis/management/
	General Principles Include:
	1. Trigger avoidance
	2. Smoking cessation
	3. Nasal douching with high volume saline rinses see Appendix 1 for additional advice.
	4. Pharmacotherapy – See **(see Appendix 1 for additional advice)**
	  ○ Mild Rhinitis

	Intranasal or Oral Antihistamines ○ Moderate Rhinitis Intranasal Steroids ○ Severe Rhinitis Intranasal or Oral Antihistamines and Intranasal Steroids ○ Watery Rhinorrhoea (eg Senile Rhinitis) Intranasal Steroids or Ipratropium Bromide ○ Asthmatic patients Consider adding Oral Leukotriene Receptor Antagonist ○ In the case of treatment failure with nasal steroid sprays consider using nasal steroid drops instead. ○ In the case of very severe symptoms or symptoms not responding to maximal treatment refer to CKS and consider oral steroids and short term nasal decongestents. (Correct use of Nasal Drops and Sprays – see Appendix 2)
Referral Guidance:	**2WW** • Unexplained nasal obstruction **Routine** • Recurrent unexplained epistaxis • Nasal perforation, ulceration or collapse • Inadequate control of symptoms despite three months of compliant treatment. For management of Sinusitis please see CKS and the EBI2 statement https://cks.nice.org.uk/topics/sinusitis/management/chronic-sinusitis/ https://www.aomrc.org.uk/search/?archive_search=evidence+based+interventions
Effective From:	1 July 2021
Summary of evidence/ rationale:	"BSACI guideline for the diagnosis and management of allergic and non-allergic rhinitis (Revised Edition 2017; First edition 2007)" https://www.bsaci.org/wp-content/uploads/2020/01/Scadding_et_al-2017-Clinical_amp_Experimental_Allergy.pdf https://cks.nice.org.uk/topics/allergic-rhinitis/ www.evidence.nhs.uk/formulary/bnf/current

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	www.nhs.uk/Conditions/Rhinitis---non-allergic/Pages/Treatment.aspx
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

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Appendix 1.

Regimens

Saline douching

- 1 pint of boiled, cooled water
- 1 tablespoon of rock salt
- 1 teaspoon of bicarbonate of soda

Sniff the solution up into each nostril in turn from the palm of the hand although a 20ml syringe provides a higher volume. Best treatment is obtained with a sinus rinse bottle such as “NeilMed” or “Netipot”.

Antihistamines – See CKS

Steroids – See CKS

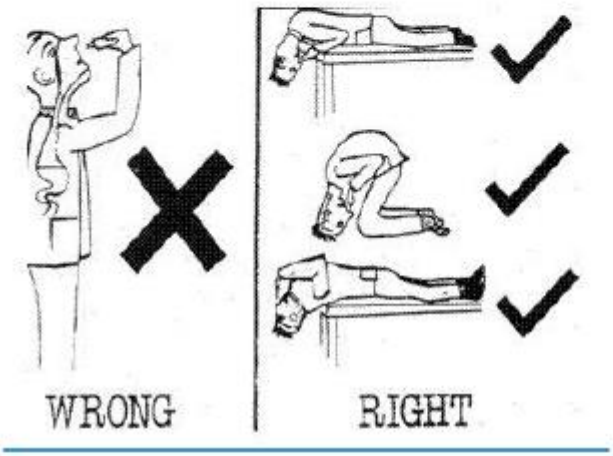
Intranasal Decongestants

Maximum 7/7 due to risk of rebound congestion (rhinitis medicamentosa), ephedrine nasal drops have the least risk.

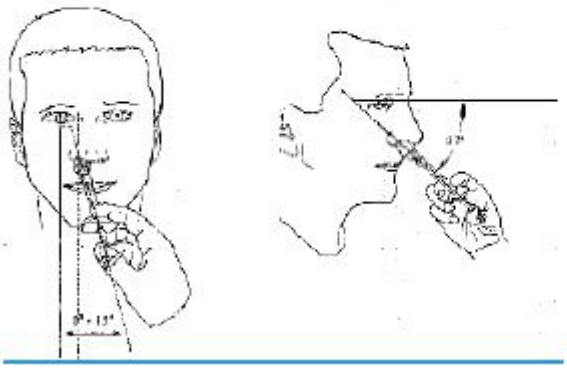
Appendix 2.

Correct way to use nasal drops and sprays

Nasal Drops should be inserted in the head down position and patient should remain in that position for 2 minutes



Nasal sprays should be directed away from the nasal septum and should be followed by a gentle sniff in with the other nostril held closed



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Clinical Commissioning Group

Commissioning Statement:

Condition or Treatment:	Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities
Background:	Septorhinoplasty, Rhinoplasty, and Septoplasty for nasal deformities are surgical procedures performed on the nose to change its size or shape or both. People usually ask for this procedure to improve self-image. The policy applies to all three procedures of Septorhinoplasty, Rhinoplasty, and Septoplasty.
Commissioning Position:	Rhinoplasty, Septoplasty, or Septorhinoplasty for nasal deformities will only be funded in accordance with the criteria specified below: • Where conservative treatment has been exhausted; AND • Problems caused by obstruction of the nasal airway OR • Objective nasal deformity caused by direct trauma and the treatment is required at the time of, or soon after the acute episode and before permanent healing has occurred. OR • Correction of complex congenital conditions to improve function e.g. cleft lip and palate. Surgery for primarily cosmetic reasons is not eligible for NHS funding.
Effective From:	1 July 2021
Date:	December 2020
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP North Yorkshire CCG

References:

1. A Policy To Make Best Use of Resources in Plastic Surgery and Related Specialities November 2006 Northern, Eastern, Southern and Western Health and Social Services Board

2. NHS Modernisation Agency: Action on Plastic, Information for Commissioners of Plastic Surgery Services: Referrals and Guidelines in Plastic Surgery 2004

3. Prasa, S., Kappor, P.K.D., Kumar, A., Reddy, V., Kumar, B.N. Waiting list priorisation in the NHS. Journal of Laryngology and Ontology 2004, 118(1) :39-45

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Commissioning Statement:

Condition or Treatment:	Scar Revision Surgery
Commissioning position:	NHS North Yorkshire CCG does not routinely commission scar revision surgery
Referral Guidance:	Exceptional cases can be referred to the CCG's Individual Funding Request Panel for prior approval. • HRW/SR GP Practices: https://ifryh.necsu.nhs.uk/ • HaRD GP practices: Referral Form
Effective From:	1 July 2021
Date:	April 2020
Review Date:	July 2023
Clinical Author:	Dr Emma O'Neill, Clinical Advisor North Yorkshire CCG

Additional Information/References:

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Commissioning Statement:

Condition or Treatment:	Surgery for minor foot problems
Commissioning position:	Referral for surgery for minor foot problems which include (but not limited to): claw toe, hammer toes, inner growing toenails, metatarsalgia, Morton's neuroma, plantar fasciitis, will only be considered when the following criteria are met: • The patient has been referred to a podiatrist and/or physiotherapist where appropriate and conservative management has failed (including avoiding high heels, exercises, applying ice, appropriate analgesia, non-surgical treatment) AND • the patient suffers from severe deformity that causes significant functional impairment OR • the patient suffers from severe pain that causes significant functional impairment OR • there is recurrent or chronic ulceration (or infection) due to the deformity **Metatarsus Varus:** Refer to secondary care if: • After the child reaches the age of 5 years the in-toeing is still evident as surgery may necessary All patients to be referred to local podiatry services prior to referral to secondary care **Hallux Valgus and Paediatric Curly Toes:** Please see separate NY policy **Exclusions:** If the patient has diabetic peripheral neuropathy or suspected osteomyelitis and a foot lesion may lead to amputation of a toe or foot, there is no restriction and prompt referral using appropriate local pathways is required. This policy does not affect the existing diabetic foot pathway This policy does not apply to surgery to correct deformity due to acute trauma.

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Effective From:	1 July 2021
Date:	April 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP, North Yorkshire CCG

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Commissioning Statement:

Condition or Treatment:	Urinary Incontinence Surgery (Female)
Commissioning position:	**Patients should be seen and assessed in a Local Continence Service prior to a secondary care referral** Threshold for referral for surgery: 1. The following assessment should be undertaken in primary care prior to referral (refer to local Continence Services): • UTI excluded or treated • Initial assessment and categorisation of incontinence • Voiding dysfunction excluded (refer to secondary care if this is confirmed/suspected) In addition patients should have been given advice on: • Advice on weight loss if BMI over 30 • Advice on fluid intake including effect of caffeine/alcohol 2. First-line conservative management to be undertaken in primary care as follows: • A trial of supervised pelvic floor muscle training for at least 3 months (stress/mixed incontinence) AND/OR • Bladder retraining lasting for a minimum of 6 weeks +/- antimuscarinic (urge/mixed incontinence) In addition, if appropriate: topical vaginal oestrogens in post-menopausal women with urogenital atrophy
Effective From:	1 July 2021
Summary of evidence/ rationale:	NICE guidance advocates the use of conservative measures before surgical treatments. NICE CG123: Urinary incontinence and pelvic organ prolapse in women, June 2019
Date:	February 2021
Review Date:	July 2023
Contact:	Dr C Ives, Governing Body GP

Additional Information/References:

NICE CG123: Urinary incontinence and pelvic organ prolapse in women, June 2019
https://www.nice.org.uk/guidance/ng123