NHS Greater Huddersfield
NHS North Kirklees
NHS Calderdale
Clinical Commissioning Groups

NHS Greater Huddersfield, NHS North Kirklees & NHS Calderdale Clinical Commissioning Groups Commissioning Policy for Individual Funding Requests

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Responsible Committee:	**Greater Huddersfield CCG Governing Body** **North Kirklees CCG Governing Body** **Calderdale CCG Governing Body**
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Executive Summary

This policy applies to all Individual Funding Requests (IFRs) for people registered with General Practitioners in the following three Clinical Commissioning Groups (CCGs), where the CCG is the responsible commissioner for the treatment or service

- NHS Greater Huddersfield CCG
- NHS North Kirklees CCG
- NHS Calderdale CCG

This policy does not apply where any one of the above CCGs is not the responsible commissioner.

This policy supersedes all previous policies and must (where appropriate) be read in association with the other relevant CCGs commissioning policies.

All IFR and associated policies will be publically available on the internet for each CCG.

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1 Introduction

The Clinical Commissioning Groups (CCGs), NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Calderdale CCG were established on 1st April 2013 under the Health & Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006.

As part of these duties, there is a need to commission services which are evidenced based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. The Clinical Commissioning Groups are accountable to their constituent populations and Member Practices for funding decisions.

The above three Clinical Commissioning Groups throughout this policy will be referred to as the CCGs.

The policy identifies procedures / treatments which the CCGs consider to be primarily cosmetic in nature and which have relatively small health benefits compared to other competing priorities for NHS resources.

The policy will be applied in conjunction with the CCGs operating framework for decision making for Individual Funding Requests (IFRs) which is available on each CCGs website.

2 Scope of the Policy

The majority of service provision is commissioned through established service agreements with providers. However, there are instances when a treatment or procedure does not form part of the core commissioning arrangements.

Due consideration must be given to these procedures / treatments which do not form part of the core commissioning arrangements, or need to be assessed as exceptions to the CCGs commissioning policies.

Where a procedure or treatment is being requested that is not part of the core commissioning arrangements then an IFR must be submitted to the CCG in line with the IFR process detailed within the CCGs operating framework. The IFR process provides a mechanism to allow such requests to be considered for individuals in exceptional circumstances and all requests must strictly fulfil the criteria for exceptionality as defined within the CCGs current operating framework for considering IFRs.

Whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCGs reserve the right not to commission other procedures considered cosmetic and not medically necessary.

2.1 Exclusions to this Policy

- Specialist services that are commissioned by NHS England or Public Health England.
- Suspected cancer, diagnoses should be dealt with via a two week wait referral and not via an IFR request.
- Emergency or Urgent Care

2.2 Dissemination of the Policy

The policy will be disseminated via all the agreed communications and engagement channels internal and external to the CCGs.

The policy will be available to all stakeholders who are responsible for the broader dissemination of the policy within their individual organisations and services.

All members of staff responsible for commissioning services have a responsibility to familiarise themselves with the content of this policy.

A full copy of the policy will be available to the general public via each CCGs website.

2.3 Application of the Policy

The policy applies to all staff (clinical and non- clinical) who are involved in any way with the commissioning, authorising of treatments or proposed clinical interventions commissioned by the CCGs.

This policy must be followed by all staff who are employed by the CCGs including those on temporary, fixed-term or honorary contracts, secondments, pool staff and students. It must also be followed by any organisation contracted to commission, authorise or administer healthcare on behalf of the CCGs. Both referrers (including GP practices) and provider organisations are expected to adhere to the principles, criteria and policies set out in this document. Any service requested or provided outside of the funding criteria set out in this policy will be undertaken at the organisations' own risk.

3.0 Aims and Objectives

The aim of this policy is to detail the eligibility criteria for procedures / treatments that the CCGs do not routinely commission.

The objectives of this policy are to;

- Reduce the variation in access to procedures / treatments that are not routinely commissioned by the CCGs.

- To ensure that the procedures / treatments detailed within the policy are commissioned where there is robust evidence of clinical benefit and cost-effectiveness.
- To have systems in place that enable a consistent approach to decision-making within appropriate timescales.
- To ensure decisions made are based on the best available evidence at the time of consideration.
- To give clarity to our local population on what procedures / treatments are funded by the CCGs and under what circumstances.
- To give clarity to referring clinicians and providers of commissioned services on what procedures / treatments are funded by the CCGs and under what circumstances.

4.0 Equality and Quality Impact Assessments

The CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

This policy is not intended to discriminate against any group or individual on the grounds of age, gender, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, the CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. Equality (EIA) and Quality Impact Assessments (QIA) have been carried out for this policy. The EIA is attached as Appendix 2 of this policy and the QIA is available on request.

5.0 Procedures and Treatments with Eligibility Criteria

The following section provides further detail on the eligibility criteria that is applicable to the procedures / treatments that are not routinely commissioned.

In this policy aesthetic or cosmetic surgery is defined as surgery undertaken to improve one's appearance or reshape normal body parts to improve appearance. This differs from reconstructive surgery that is undertaken to reshape abnormal structures of the body, from accidents, injuries, infections, cancers or other diseases, as well as congenital deformities.

Revisional procedures will only be considered electively for clinical reasons due to evidenced clinical complications. Any revisional procedures will require prior approval unless they are required on an urgent / emergency basis.

Psychological distress will rarely be considered as a reason for cosmetic surgery. Only in rare clinically exceptional circumstances in which severe and enduring psychological dysfunction can be demonstrated, and for which all alternative psychotherapeutic interventions have been tried.

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

Patients who are current smokers should be referred or re-directed to a smoking cessation programme prior to surgical intervention.

In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.

Patients with a BMI >30 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.

6.0 Procedures that require Individual Funding Approval:

All of the following procedures / treatments are criteria led and will require completion of an Individual Funding Request form by an appropriate clinician.

1. ABDOMINOPLASTY / APRONECTOMY ("Tummy Tuck")

Abdominoplasty / Apronectomy will not be routinely commissioned by the CCGs for requests made for:

- Cosmetic / aesthetic reasons, including stretch marks
- Psychological benefit without associated clinical need

Abdominoplasty / Apronectomy may rarely be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m^2 (stable is defined as within the acceptable range detailed above **AND** stable at the same measurement for at least 2 years) **AND** be suffering from severe functional problems:

- Those with complex scarring following trauma or previous abdominal surgery
- Those who have undergone treatment for morbid obesity and have excessive skin folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years. (significant is defined as moved down two levels of the BMI SIGN guidance as shown below)
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery

Severe functional problems include:

- Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics
- Experiencing severe difficulties with daily living, i.e. ambulatory or urological restrictions
- Where previous post-trauma or surgical scarring (usually midline vertical or multiple) leads to very poor appearance and carries a risk of infection
- Problems associated with poorly fitting stoma bags

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- Confirmation that the panniculus hangs below the symphysis pubis when the patient is standing normally
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity

Body Mass Index is referred to as per SIGN guidance where:

Less than 18.5	Underweight
18.5 -24.9	Normal BMI
25.0 - 29.9	Overweight
30.0 - 39.9	Obese
40 or above	Extremely Obese

2. BREAST AUGMENTATION (Breast Enlargement)

Note: Breast augmentation which is part of reconstructive surgery after trauma or previous mastectomy or other excisional breast surgery does not go through the Individual Funding requests process as it is part of the treatment pathway for those conditions.

Breast augmentation will not be routinely commissioned by the CCGs for:

- Cosmetic reasons, for example for "small" but normal breasts or for breast tissue involution (including post-partum changes).
- Requests made for psychological benefit without associated clinical need.

Breast augmentation may rarely be considered on an exceptional basis, for example where the patient:

- Has congenital amastia (complete absence of bilateral breast tissue) or
- Has suffered trauma to the breast during or after development or
- Has endocrine abnormalities or
- Has developmental asymmetry (at least 3 cup sizes) or
- Has tubular breasts – type iii with severe breast constriction with minimal breast base and hypoplasia of all four quadrants (see http://cdn.intechopen.com/pdfs/33481/InTech-Tuberous_breast_clinical_evaluation_and_surgical_treatment.pdf%20accessed%20July%202013

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

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m^2

3. MASTOPEXY (Breast Lift)

Mastopexy will not be routinely commissioned by the CCGs for cosmetic reasons, for example weight loss, post lactation or age related ptosis.

Mastopexy may be included as part of the treatment to correct breast asymmetry and reduction. In this instance, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria.

4. REVISION OF BREAST AUGMENTATION

Revision of breast augmentation will not be routinely commissioned by the CCGs.

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

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

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

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

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

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m^2 **and**
- Ultrasound scan results to evidence implant rupture and / or capsular contracture
- Evidence to support the clinical need for revisional surgery
- Evidence to support that the patient meets the current criteria for augmentation

Baker Classification:
Class I - Augmented breast feels soft as a normal breast.
Class II - Augmented breast is less soft and implant can be palpated, but is not visible.
Class III - Augmented breast is firm, palpable and the implant (or distortion) is visible.
Class IV - Augmented breast is hard, painful, cold, tender and distorted

National supporting evidence

- NHS England Interim Commissioning Policy: Breast Implant removal and re-insertion November 2013; https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC004.pdf

5. BREAST REDUCTION - FEMALE
(Also known as surgery for breast hypertrophy or reduction mammoplasty)

Breast reduction surgery will not routinely be commissioned by the CCGs for cosmetic reasons.

The intention of this exception is to consider genuine issues with chronic neck or back pain related directly to breast size that cannot be dealt with effectively without surgical reduction of the breasts.

Breast reduction may rarely be considered on an exceptional basis, for example where the patient:

- Has a breast measurement of cup size H or larger **AND**
- Has a BMI of 30 kg/m^2 or less and stable for 2 years (stable is defined as within the acceptable range detailed above **AND** stable at the same measurement for 2 years)
- Age over 19 years to allow for completion of puberty **AND**
- That breast reduction surgery should result in a reduction in breast size of at least three cup sizes **AND**
- Evidence to support that the patient has significant musculo-skeletal pain causing functional impairment, with at least two of the following which have been present for at least one year;
- Pain in the neck
- Pain in the upper back
- Pain in the shoulders
- Painful kyphosis documented by X-rays
- Pain / discomfort / ulceration from bra straps cutting into shoulders
- Evidence of chronic intertrigo, eczema or dermatitis where the patient has failed to respond to 6 months of conservative treatment

AND

- Evidence to support that pain symptoms persist despite a 6 month trial of therapeutic measures including all of the following;
- Analgesic / non-steroidal anti-inflammatory drugs (NSAIDs)
- Physical therapy / exercises / posturing manoeuvres

In addition to the above, the following will also be required:

- A report from a physiotherapy assessment carried out within 6 months of the request being made. The report must clearly give an opinion as to the cause of the patient's pain.
- Written confirmation from a professional bra fitter of a professional bra fitting being carried out within 6 months of the request being submitted
- BMI to have been measured within 2 months of the request being submitted
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery

National supporting evidence

- NHS England Interim Commissioning Policy: Breast reduction and Breast lift November 2013; https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC005.pdf

6. BREAST ASYMMETRY

Surgery to correct breast asymmetry will not routinely be commissioned by the CCGs for cosmetic reasons.

Breast Prosthesis or Implants often have a limited lifespan and are likely to require replacement or revision during the patient's lifetime. Therefore, where possible, breast reduction of the larger breast should be the preferred option for patients seeking to correct breast asymmetry.

Surgery may rarely be considered on an exceptional basis when there is no ability to maintain a normal breast shape using non-surgical methods, for example where the patient:

- Has developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia) **OR**
- Patients with gross asymmetry (defined as a difference of 3 cup sizes) **AND**
  BMI in the range 18 – 27 kg/m^2
- Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting
- Age over 19 years to allow for completion of puberty

In addition to the above, the following will also be required:

- Written confirmation from a professional bra fitter evidencing a difference in breast size of at least 3 cup sizes difference.

Only the following cup sizes are recognised in the UK;

AA	A	B	C	D	DD	E	F	FF	G	GG	H	HH	J	JJ	K	L

National supporting evidence

- NHS England Interim Commissioning Policy: Breast Asymmetry November 2013; https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC003.pdf

7. BREAST REDUCTION FOR GYNAECOMASTIA – MALE

Surgery to correct benign gynaecomastia will not routinely be commissioned by the CCGs for cosmetic reasons. The CCG will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids.

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

- Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat) **AND**
- Has a BMI of 25 kg/m^2 or less and stable for 12 months (stable is defined as within the acceptable range detailed above and stable at the same measurement for 12 months), unless a specific uncorrectable aetiological factor is identified such as androgen therapy for prostate cancer **AND**
- Has been screened prior to referral to exclude endocrinological and drug related causes or if drugs have been a factor then a period of one year since last use should have elapsed **AND**
- Has completed puberty - surgery is not routinely commissioned below the age of 19 years
- Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger

In addition to the above, the following will also be required:

- BMI to have been measured within 2 months of the request being submitted
- Evidence that screening for endocrine and drug-related causes has taken place and their results
- Documented additional information where circumstances include:
    - Pain
    - Gross Asymmetry
    - The Gynaecomastia is iatrogenic

National supporting evidence

- NHS England Interim Commissioning Policy: Breast Reduction for Gynaecomastia (male) November 2013; https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC006.pdf

8. NIPPLE INVERSION

Surgical correction of benign nipple inversion will not be routinely commissioned by the CCGs for:

- Requests made for cosmetic/aesthetic reasons.
- Requests made for psychological benefit without associated clinical need.

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

Surgical correction of nipple inversion may only be funded where it has been documented that there was an inability to breastfeed during a previous pregnancy and the patient is considering a subsequent pregnancy. In this instance all of the following criteria must be met in full:

- The nipple(s) must be non-retractable based on clinical examination **AND**
- The patient is post pubertal **AND**
- The inversion has not been corrected by correct use of a non-invasive suction device

[1] https://www.nice.org.uk/guidance/NG12/chapter/Recommendations-organised-by-symptom-and-findings-of-primary-care-investigations#lumps-or-masses

9. HAIR REPLACEMENT

Hair Transplantation

Hair transplantation will not be routinely commissioned by the CCGs for cosmetic reasons, regardless of gender.

Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is required following cancer or trauma.

Correction of Male Pattern Baldness

Treatments to correct male pattern baldness will not be routinely commissioned by the CCGs for cosmetic reasons. This is excluded from treatment by the NHS.

10. HAIR REMOVAL

Hair removal will not be routinely commissioned by the CCGs for cosmetic reasons.

Patients concerned with the appearance of their body and facial hair should be advised about managing their condition through conservative methods including shaving, waxing, and depilatory creams although such treatments are also not routinely commissioned or funded by the CCGs.

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

- Has undergone reconstructive surgery resulting in abnormally located hair bearing skin to the face, neck or upper chest (areas not covered by normal clothing)
- Has a proven underlying endocrine disturbance resulting in hirsutism (e.g. Polycystic Ovary Syndrome)
- Are undergoing treatment for pilonidal sinuses to reduce recurrence

In addition to the above, the following will also be required:

- Evidence of the underlying endocrine disturbance eg. blood test results or ultrasound scan report

Where patients meet the above criteria, laser treatment for hair removal requested for hirsutism will only be approved for the removal of facial hair. In this instance three laser treatment sessions will be approved.

National supporting evidence

- NHS England Interim Commissioning Policy: Hair removal (including Electrolysis and Laser Therapy) November 2013: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC017.pdf

11. ACNE SCARRING

Procedures to treat facial acne scarring will not be routinely commissioned by the CCGs.

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

12. REMOVAL OF BENIGN SKIN LESIONS

Surgical treatment of benign skin lesions will not be routinely commissioned by the CCGs for cosmetic reasons.

This also includes the following minor skin lesions; pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrheic keratosis (basal cell papillomata), skin tags including anal tags, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata.

A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment.

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

- The lesion is unavoidably and significantly traumatised on a regular basis **AND**
- This results in infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year **OR**
- The lesion is obstructing an orifice or impairing visual field **OR**
- The lesion significantly impacts on function eg. restricts joint movement **OR**
- Greater than 1cm facial lesions that cause significant disfigurement **OR**
- Congenital deformity (this does not include normal variation)

In addition to the above, the following will also be required:

- Evidence of the size and location of the lesion
- Evidence to support whether the lesion has grown / is growing in size, measurements required
- Evidence to support the functional impact on the patient
- Where visual field is affected, a report will be required from an Ophthalmologist which evidences the visual field impairment

For moderate to large lesions that cause facial disfigurement which require surgical excision, the risks of scarring must be balanced against the appearance of the lesion.

13. BLEPHAROPLASTY (Surgery for drooping or mis-shaped eyelid/s)

Blepharoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery on the upper lid/s maybe considered on an exceptional basis, for example

- Impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow
- Significant ectropion or entropion that requires correction or for the removal of lesions of the eyelid skin or lid margin

In addition to the above, the following will also be required:

- Results from an appropriate visual fields test. Results from tests will be required with the eyelid/s both retracted and un-retracted to rule out an pathological causes.

14. BODY CONTOURING PROCEDURES (Skin Excision for Buttocks, Thighs & Arms)

Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m^2 (stable is defined as within the acceptable range detailed above **AND** stable at the same measurement for at least 2 years) **AND** be suffering from severe functional problems:

- has an underlying skin condition, for example cutis laxa (rare inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds)
- has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living (ie. walking, dressing and ambulatory restrictions) which have been formally assessed

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity
- If it is an adjunct to another surgical procedure, then patients would be required to meet the established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

15. FACELIFT / BROWLIFT

Facial procedures and Botulinum Toxin will not be routinely commissioned by the CCGs for cosmetic reasons.
Cases may be considered on an exceptional basis, for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin, e.g. cuffs axa pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery

In addition to the above, for a Browlift procedure the following will also be required:

- Results from an appropriate visual fields test with eyelid un-retracted

16. PINNAPLASTY (Correction of Prominent Ears)

Surgical correction of prominent ears will not be routinely commissioned by the CCGs for cosmetic reasons.
Cases may be considered on an exceptional basis, for example where the patient:

- Must be aged 5-19 at the time of referral and the child (not the parents alone) expresses concern
  AND
- has very significant ear deformity or asymmetry

Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy.

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004)), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.

National supporting evidence

- NHS England Interim Commissioning Policy: Pinnaplasty / Otoplasty November 2013; https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC027.pdf

17. LIPOSUCTION

Liposuction will not be routinely commissioned by the CCGs for cosmetic reasons or to correct the distribution of fat.

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

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

18. LABIAPLASTY

Labiaplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery may be considered on an exceptional basis, for example where the patient has;

- Congenital conditions **or**
- Recurrent disease or chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment **or**
- Excess androgenic hormones

Note: Treatment for female genital mutilation is not considered cosmetic and does not require funding approval.

- NHS England Interim Commissioning Policy: Labiaplasty/Vaginoplasty/Hymenorrhaphy https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC023.pdf

19. REPAIR OF EXTERNAL EAR LOBES (Lobules)

Repair of external ear lobes will not be routinely commissioned by the CCGs for cosmetic reasons.

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

Repair of external ear lobes as a result of a gauge piercing is excluded from treatment by the CCGs.

20. RHINOPHYMA

Surgical / laser treatment of rhinophyma will not be routinely commissioned by the CCGs for cosmetic reasons.

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered on an exceptional basis for surgery or laser treatment.

21. SCAR REVISION / KELOIDECTOMY

Revision surgery for scars including keloid scars will not be routinely commissioned by the CCGs for cosmetic reasons.

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

- Has significant deformity
- Has severe functional problems, or needs surgery to restore normal function
- Causes significant pain requiring chronic analgesic medication
- Bleeding
- Obstruction of orifice or vision
- Has a scar resulting in significant facial disfigurement

22. SKIN HYPO-PIGMENTATION & SKIN RESURFACING TECHNIQUES

Skin Hypo-Pigmentation

The recommended NHS suitable treatment for hypo-pigmentation is cosmetic camouflage. Access to a qualified camouflage beautician must be available on the NHS for this and other skin conditions requiring camouflage.

Skin Resurfacing Techniques

All resurfacing techniques including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

Any requests for skin resurfacing techniques for scarring would be required to meet the established criteria for scar revision as shown above in section 22.

23. SEPTO-RHINOPLASTY / RHINOPLASTY

Septo-rhinoplasty and Rhinoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Septo-rhinoplasty may be considered on an exceptional basis, for example in the presence of;

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

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

- When it is being performed to correct a nasal deformity secondary to congenital cleft lip and / or palate
- To correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect when all of the following criteria are met:
    - Nasal airway obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing), **AND**
    - Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids; **AND**
    - Airway obstruction will not respond to septoplasty and turbinectomy alone

In addition to the above, the following will also be required:

- Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); **AND**
- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; **AND**
- Documentation of results of conservative management of symptoms

Note: For requests that meet the above criteria in relation to sporting / activity trauma, the CCGs reserve the right to decline funding where the request is for a repeat surgical procedure in relation to trauma where it is as a direct cause of the same sport / activity.

24. CIRCUMCISION (for religious reasons)

Circumcision for social, religious or cultural reasons will not be routinely commissioned by the CCGs.
Cases may be considered on an exceptional basis, for example;

- When an underlying medical condition means that routine surgery in the usual setting may be unsafe

25. TATTOO REMOVAL

Tattoo removal will not be routinely commissioned by the CCGs.
Cases may be considered on an exceptional basis, for example where the patient:

- Has suffered a significant allergic reaction to the dye and medical treatments have failed
- Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo")
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial functioning.)

National supporting evidence

- NHS England Interim Commissioning Policy: Tattoo Removal November 2013; .http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC032.pdf

26. IVF – INFERTILITY TREATMENT and SURROGACY

Criteria has been agreed across the Yorkshire and Humber. See separate policy on each CCG website.

The CCGs arrangements are in line with the Yorkshire & Humber policy but the CCGs will only fund one full cycle of IVF where the eligibility criteria are met in full.

Surrogacy arrangements will not be funded, but the CCGs will fund treatment (IVF component and storage) in identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the eligibility criteria are met in full.

27. REVERSAL OF VASECTOMY AND FEMALE STERILISATION

Surgery for the reversal of a vasectomy or female sterilisation will not be routinely commissioned by the CCGs.
Cases may be considered on an exceptional basis, for example:

- the death of an existing child through accidents or illness
- There is clear evidence (over and above the patient's assertion) that the original operation had been performed under duress. E.g. Cases when the patient was very young when the procedure was carried out and evidence from the referring clinician shows that they did not receive any counselling

Funding is not agreed for these procedures for patients who are in a new relationship or who are not in contact with children from a previous relationship. The CCGs reserve the right to decline funding where either partner has living children (this includes adopted children but not fostered) from that or any previous relationship.

28. COMPLEMENTARY OR ALTERNATIVE THERAPIES

Complementary and alternative therapies are not routinely commissioned as stand-alone treatments by the CCGs.

See Appendix 1 for the list of therapies which are not routinely commissioned. The list is not exhaustive and other therapies not listed but that are considered 'alternative' therapies will be considered in the same way.

Those complementary and alternative therapies which are an integral part of an agreed care pathway within existing contracts (supported by a service specification) are excluded from this policy.

29. ALLERGY TREATMENTS AT A SPECIALIST ALLERGY CENTRE

The CCGs will support referrals being made to an NHS Specialist Allergy Centre when the condition has been thoroughly assessed and standard treatment given by a GP or Clinician has not improved the condition and that the condition is considered "resistant" to conventional treatment.

The CCGs will not support referrals made to non-NHS providers.

30. LYCRA GARMENTS

Lycra garments are not routinely commissioned by the CCGs. Cases may be considered on an exceptional basis for example;

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

Contraindications

- Lycra garments are contraindicated when adequate monitoring and supervision are not available, there is deemed to be a lack of purposeful intent or, dependent on site of the garment, if severe epilepsy or chronic respiratory problems are present. Lycra splinting is not recommended if there is severe uncontrolled reflux or chronic skin conditions.
- Problems with comfort, reflux sickness and putting on / taking off the suit have been reported. Temperature can also be an issue, particularly in summer. These factors may all impact on compliance and motivation of the patient.
- A study carried out with the support of Scope and Birmingham Community Health Trust from 1998 – 2000 also found that some people stop wearing the garments altogether because of:
    - The level of support needed to get the garments on and off
    - Toileting issues
    - Garment took too long to dry after washing
    - Unable to maintain the function gains achieved without continued use

Funding requests for replacement garments will be required to evidence on-going clinical benefit. Funding for a replacement garments will not normally be agreed within:-

1) 12 months from last approval for children aged upto 18 or
2) 18 months to 2 years from last approval for patients aged 18+

31. FUNCTIONAL ELECTRICAL STIMULATION (FES)

(For Foot Drop of Central Neurological Origin)

The CCGs will routinely commission Functional Electrical Stimulation (FES) for drop foot, with the non-implantable wired device (skin surface FES - OPCS A70.7 application of transcutaneous electrical nerve stimulator), in line with NICE IPG278. Provisions for clinical, governance, consent, audit and research are fully expected to be in place for this service.

- The patient must be over 18 years of age and being treated for foot drop (deficit of dorsiflexion and / or eversion of the ankle) which must be of central neurological origin, due to an upper motor neurone lesion i.e. one that occurs in the brain or spinal cord at or above the level of T12.
- Upper motor neurone lesions resulting in dropped foot occur in conditions such as stroke, brain injury, multiple sclerosis, incomplete spinal cord injury at T12 or above, cerebral palsy, familial /hereditary spastic paraparesis and Parkinson's disease.

Exclusions

The following forms of FES are not commissioned by the CCGs:

- Other forms of electrical stimulation for conditions other than foot drop
- FES for upper limb
- Implanted FES
- Wireless FES

Funding will only be considered for wireless or implantable devices where there are exceptional clinical circumstances.

National supporting evidence

- NICE IPG 278 - Functional Electrical Stimulation for drop foot of central neurological origin: http://www.nice.org.uk/Guidance/IPG278

32. OPEN / UPRIGHT MRI SCANNING

Open MRI

Referral to an NHS Open MRI scanner for an Open MRI scan as an alternative to a conventional MRI scan may be commissioned in the following circumstances as an exception where the following criteria are met:

- Patients who suffer from claustrophobia where an oral prescription sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). For the use for Spinal cord compression and neural axis tumours, the use of an Open MRI is recommended rather than the use of a general anaesthetic as there is a lesser risk to the patient.
- Patients who are obese and cannot fit comfortably in a conventional MRI scanner as determined by a Radiology department policy. (The issue re size is how the weight is distributed).

Upright MRI

Upright MRI scanning within the Private sector is not routinely commissioned by the CCGs.
Upright MRI scanning may be considered for cases on an exceptional basis where;

- Evidence supports that due to severe pain (having utilized appropriate pain medication) **AND**
- The patient cannot lie properly for the required scan time in a conventional MRI scanner due to the patient's condition
  OR
- The patient cannot lie properly for the required scan time in a conventional MRI scanner due to the patient's condition

33. BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS

Botulinum Toxin for axillary hyperhidrosis will not be routinely commissioned by the CCGs.

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

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

Exclusion

The CCGs will not commission Botulinum Toxin to treat hyperhidrosis in people with social anxiety disorder. – NICE CG159

NOTE - for approved requests the CCGs will fund a maximum of 2 treatments per year per patient, not to be repeated more frequently than every 16 weeks.

National supporting evidence

- NICE CG159 - Social anxiety disorder: recognition, assessment and treatment; https://www.nice.org.uk/guidance/cg159

34. BOTULINUM TOXIN FOR PROPHYLAXIS MIGRAINE

Botulinum Toxin for prophylaxis migraine will not be routinely commissioned by the CCGs.

Botulinum Toxin Type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine)

- that has not responded to at least three prior pharmacological prophylaxis therapies **AND**
- whose condition is appropriately managed for medication overuse.

Treatment with Botulinum Toxin Type A that is recommended according to the above should be stopped in people whose condition:

- is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) **or**
- has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months.

NOTE - for approved requests the CCGs will fund a maximum of 4 treatments per year per patient of Botulinum Toxin, not to be repeated more frequently than every 2 treatments without specialist review.

National supporting evidence

- NICE TA260 - Botulinum toxin type A for the prevention of headaches in adults with chronic migraine
  https://www.nice.org.uk/guidance/ta260

35. SPINAL CORD STIMULATION

Spinal Cord Stimulation (SCS) device and leads fall outside PbR tariff. Clinicians are responsible for deciding if the treatment is appropriate for individual patients. NICE Technology Appraisal Guidance 159 recommends SCS for adults with chronic neuropathic pain who:

- Continue to experience chronic pain (measuring at least 50mm on a 0-100mm visual analogue scale) for at least 6 months despite all other reasonable treatment alternatives having been tried with an unsatisfactory outcome **AND**

- Who have had a successful spinal cord stimulation trial (this determines suitability for permanent implantation by assessing tolerability and the degree of pain relief likely to be achieved by full implantation)

SCS is NOT commissioned for adults with chronic pain of ischaemic origin, except in the context of research as part of a clinical material (due to lack of evidence of clinical effectiveness).

SCS may only be commissioned after an assessment by a multidisciplinary team (MDT) experienced in chronic pain assessment and management of people with SCS devices, including experience in the provision of ongoing monitoring and support.

If different SCS systems are considered to be equally suitable for a person the least costly should be used. (Assessment of cost should take into account acquisition costs, the anticipated longevity of the system, the stimulation requirements of the person with chronic pain and the support package offered).

National supporting evidence

- NICE TA159 - Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin; https://www.nice.org.uk/guidance/ta159

36. SACRAL NEUROMODULATION

Sacral Neuromodulation in relation to urinary retention and constipation will be commissioned in line with NICE IPG 536. Individual funding must be sought prior to commencement of treatment.

Sacro Neuromodulation for faecal and urinary incontinence are currently commissioned by NHS England.

National supporting evidence

- NICE IPG 536: Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention (published 25/11/15) https://www.nice.org.uk/Guidance/IPG536

37. ADVICE & PATHWAY FOR THE SUPPLY OF NHS FUNDED WIGS

NHS wigs will be routinely funded outside of cancer pathways for the following indications:

1. Consultant Dermatologist request
   AND
2. Specialist diagnosis of
   a) Alopecia totalis
   OR
   b) Scarring alopecia including
   - Scleroderma
   - Lichen planus
   - Discoid lupus
   - Folliculitis decalvans
   - Frontal fibrosing alopecia

A Consultant Dermatologist will determine the patients' diagnosis and suitability for a wig and issue a prescription where appropriate.

Patients are entitled to either two stock modacrylic fibre wigs per year **or** one stock real hair wig every 2 years.

There are no nationally set limits on the number of wigs a patient can have from the NHS. However, this is a locally agreed own limit.

The patient will be expected to pay the current standard prescription charge for either of the above types of wig. This prescription charge is payable to either the hospital Trust or any NHS wig provider that accepts NHS prescriptions. The balance of the cost of the wig is paid by the NHS.

Some patients may be exempt from paying this prescription charge, see the following link for more information on exemption and current prescription charges.

https://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx

Many hospital Trusts will carry wigs as part of their appliance offering, however advice can be provided to patients on other NHS wig providers who will accept an NHS prescription.

Exclusions

Bespoke wigs including bespoke human hair wigs are not routinely prescribed. The patient's clinician would need to submit an Individual Funding Request to the Clinical Commissioning Group on behalf of the patient to request funding for a bespoke human hair wig or any other non-standard wig.

The funding request must evidence on what exceptional grounds that the patient should be prescribed a bespoke wig. Evidence of 'allergy' needs to be proven by patch testing prior to the clinician submitting an Individual Funding Request.

Should funding be successfully granted, patients would be expected to pay the current standard prescription charge (see more information on the NHS England link above for charges and exemptions).

The CCG will fund up to a maximum of one bespoke real hair wig every 2 years up to a maximum balance cost of £1,500.

Re-issue process in subsequent years

For bespoke wigs agreed through the Individual Funding Request process, once the initial request has been approved the patient can request subsequent years funding from the Clinical Commissioning Group when the wig is due for replacement.

The patient will be required to write to the IFR team informing them that the wig is due for replacement. The IFR team will process the request and confirm in writing to the patient that a replacement wig has been authorised.

7.0 References

Department of Health (2013). The NHS Constitution the NHS belongs to us all. Available at:- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

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Department of Health (2010). Equity and Excellence: Liberating the NHS. Available at:- https://www.gov.uk/government/publications/liberating-the-nhs-white-paper

Scottish Intercollegiate Guidelines Network (2013). Information about SIGN. Available at:- http://www.sign.ac.uk/assets/sign115.pdf

The NHS Confederation (2008a) Priority Setting: Legal Considerations. www.nhsconfed.org/publications

The NHS Confederation (2008b) Priority Setting: Managing Individual Funding Requests:- www.nhsconfed.org/publications

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APPENDIX 1 – List of Complementary / Alternative Therapies

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

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

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

Appendix 2 – Equality Impact Assessment Checklist Tool

Title of policy	Commissioning Policy for Individual Funding Requests	
Names and roles of people completing the assessment	Claire Wood – Assistant Manager Individual Funding Requests Sarah MacKenzie-Cooper – Equality & Diversity Manager	
Date assessment started/completed	01.07.2017	29.01.2018

1. Outline	
Give a brief summary of the policy	The purpose of the policy is to enable officers of the CCGs 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 IFRs. 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.
What outcomes do you want to achieve	That the CCGs commission services equitably and only when clinically necessary and in line with current evidence on cost effectiveness.

2.Analysis of impact			
This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations			
	Are there any likely 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?**
General			Equality monitoring of IFR

			request has been introduced and will be continuously reviewed against outcomes. Where any trends are noticed further work will be undertaken to establish any areas for action.
Age	Yes. Some of the IFR criteria have age limitations. This is based on clinical evidence or considered a justifiable proxy for physical maturity. In the case of Pinnaplasty this is only considered for children up to the age of 19 due to the significant psychosocial dysfunction for children and adolescents and impact on education.	This could be negative for those people who fall outside the age related criteria.	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process. The IFR policy is published on the CCGs websites so clinicians and patients can access the criteria and be fully informed of any restrictions.
Carers	Not applicable		
Disability	Yes. There is recognition that there may be psychological impacts of some of the conditions which present to IFR however clinical need must be evidenced.	Potentially negative	This is addressed in the policy (section 5). Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Sex	Some procedures are likely to be sex related; e.g. labiaplasty. Where this is the case the clinical thresholds will need to be met. Most procedures are gender neutral.		The IFR committee receives redacted patient information which should mitigate the impact for gender neutral processes. Equality monitoring of requests will be reviewed.
Race	No evidence to date – equality monitoring introduced and will be reviewed.		
Religion or belief	There may be an expectation that circumcision for religious reasons should be approved however it is only undertaken for clinical reasons.		Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.

Sexual orientation	Not applicable		
Gender reassignment	IFRs are considered in the patients affirmed gender and therefore subject to the clinical criteria within the policy. Other treatments may be available through the gender reassignment pathway, if not an IFR could be submitted.		Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Pregnancy and maternity	Some IFRs could be impacted by pregnancy and maternity, e.g. breast procedures. There may be a delay to allow for full recovery after childbirth. Inverted nipple treatment is only available to support breast feeding in specific clinical circumstances.		Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Marriage and civil partnership	Not applicable		
Other relevant group	No evidence		

4. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	We will review equality monitoring data. The number of IFR equality monitoring forms received is limited so we will do this review across the CCGs. Following the introduction of this policy we will report annually to the constituent CCGs.		
Lead Officer	Claire Wood	**Review date:**	**2019**

5.Sign off			
Lead Officer	Vicky Dutchburn		
Title	Head of Strategic Planning & Transformation	**Date approved:**	29.01.2018

Version Control Sheet

The table below evidences the history of the steps in development of the document.

Version Control:

Version	Date	Author	Status	Comment
0.1	June 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.1	Initial starting draft
0.2	July 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.2	Updated using Joint Commissioning Policy from North Kirklees & Wakefield CCGs
0.3	August 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.3	Updated using NHS England commissioning policies & NICE Guidance
0.4	October 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.4	Updated after discussions with Dermatology and Plastics Departments at LTHT
0.5	December 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.5	Updated after review of STP & other CCGs IFR policies
0.6	January 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.6	Updated after review of North East London CSU commissioning policy for complementary therapies
0.7	February 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.7	Updated after wig pathway included
0.8	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.8	Additional wording in relation to revisional procedures
0.9	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.9	Additional wording in relation to breast re-augmentation
0.10	June 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.10	Change to format of criteria in relation to breast reduction
1.0	June 2018	Claire Wood – Assistant Manager IFR GHCCG	FINAL V1.0	Approved by: - Greater Huddersfield CCG - 13/06/2018 - North Kirklees CCG - 13/06/2018 - Calderdale CCG - 14/06/2018