NHS
Leeds
Clinical Commissioning Group

Gynaecology and Urology Commissioning Policy

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Ratified by:	NHS Leeds Clinical Commissioning Group Quality and Performance Committee – 13 March 2019
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Name of responsible committee/individual:	Dr Simon Stockill Medical Director, Leeds CCG
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Target audience:	Primary and secondary care clinicians, individual funding request panels, and the public
Document History:	Leeds CCGs Cosmetic Exceptions and Exclusions Policy Feb 2014 Leeds CCGs Targeted Interventions Policy Feb 2014 Leeds CCG Gynaecology and Urology Policy 2018-21

Executive Summary

This policy applies to all Individual Funding Requests (IFR) for people registered with General Practitioners in Leeds

This policy does not apply where NHS Leeds CCG is not the responsible commissioner.

The policy updates all previous policies and must (where appropriate) be read in association with the other relevant Leeds Clinical Commissioning Group commissioning policies, which are to be applied across Leeds , including but not limited to policies on cosmetic exceptions and non-commissioned activity.

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

This policy relates specifically to gynaecology and urology commissioning policies.

Contents

1 Introduction

The Clinical Commissioning Groups (CCGs) (NHS Leeds West CCG, NHS Leeds North CCG and NHS Leeds South and East CCG) were established on 1 April 2013 under the Health and 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 at 1 April 2018 these three CCGs have merged to become NHS Leeds Clinical Commissioning Group

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

In relation to decisions on Individual Funding Requests (IFR), NHS Leeds CCG has a clear and transparent process and policy for decision making. They have a clear CCG specific appeals process to allow patients and their clinicians to be reassured that due process has been followed in IFR decisions made by the Non Commissioned Activity Panel, Cosmetic Exclusions and Exceptions Panel, or Non NICE Non Tariff Drug Panel (the IFR panels).

Due consideration must be given to IFRs for services or treatments which do not form part of core commissioning arrangements, or need to be assessed as exceptions to Leeds CCGs Commissioning Policies. This process must be equitably applied to all IFRs.

All IFR and associated policies will be publically available on the internet for the CCG. Specialist services that are commissioned by NHS England or Public Health England are not included in this policy.

2 Purpose

The purpose of the IFR policy is to enable officers of NHS Leeds CCG to exercise their responsibilities properly and transparently in relation to IFRs, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs 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 CCG.

The policy outlines the process for decision making with regard to services/treatments which are not normally commissioned by the CCG in Leeds, and is designed to ensure consistency in this decision making process.

The policy is underpinned by the following key principles:

- The decisions of the IFR panels outlined in the policy are fair, reasonable and lawful, and are open to external scrutiny.
- Funding decisions are based on clinical evidence and not solely on the budgetary constraints.
- Compliance with standing financial instructions / and statutory instruments in the commissioning of healthcare in relation to contractual arrangements with providers.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the National Health Service (NHS). This may be due to advances in

medicine or the introduction of new treatments and therapies or a new cross-Leeds Clinical Commissioning Group statement. The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the NHS Leeds CCG to be considered for individuals in exceptional circumstances.

3 Scope

Policy development and review: consultation and engagement

The policy was developed to:

- ensure a clear and transparent approach is in place for exceptional/individual funding request decision making; and
- provide reassurance to patients and clinicians that decisions are made in a fair, open, equitable and consistent manner.

It was originally developed in line with NICE or equivalent guidance where this was available or based on a review of scientific literature. This included engagement with hospital clinicians, general practice, CCG patient advisory groups, and the general public cascaded through a range, mechanisms.

The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy

NHS Leeds CCG has established the processes outlined in this policy to consider and manage IFRs in relation to the following types of requests:

This policy relates specifically to gynaecology and urology commissioning policies.

NHS Leeds CCG *does not routinely commission* aesthetic (cosmetic) surgery and other related procedures that are medically unnecessary.

Providing certain criteria are met, the CCG will commission aesthetic (cosmetic) surgery and other procedures to improve the functioning of a body part or where medically necessary even if the surgery or procedure also improves or changes the appearance of a portion of the body.

Please note that, whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCG reserve the right not to commission other procedures considered cosmetic and not medically necessary. This policy is to be used in conjunction with the Individual Funding Requests (IFR) Policy for NHS Leeds CCG and other related policies.

NHS Leeds CCG routinely commission interventional procedures where National Institute for Health and Care Excellence (NICE) guidance arrangements indicate “normal” or “offered routinely” or “recommended as option(s)” and the evidence of safety and effectiveness is sufficiently robust.

NHS Leeds CCG *do not* routinely commission interventional procedures where NICE guidance arrangement indicates “special”, “other”, “research only” and “do not use”.

The commissioning statements for individual procedures are the same as those issued by NICE. (www.nice.org.uk).

An individual funding request (IFR) may be submitted for a patient who is felt to be an exception to the commissioning statements as per the Individual Funding Request Policy.

The CCG accept there are clinical situations that are unique (five or fewer patients) where an IFR is appropriate and exceptionality may be difficult to demonstrate.

Whilst the CCG is always interested in innovation that makes more effective use of resources, in year introduction of a procedure does not mean the CCG will routinely commission the use of the procedure.

An individual funding request is not an appropriate mechanism to introduce a new treatment for a group or cohort of patients. Where treatment is for a cohort larger than five patients, that is a proposal to develop the service, the introduction of a new procedure should go through the usual business planning process. CCG will not fund interventional procedures for cohorts over 5 patients introduced outside a business planning process.

Endpoints

Following completion of the agreed treatment, a proportionate follow up process will lead to a final review appointment with the clinician where both patient and clinician agree that a satisfactory end point has been reached. This should be at the discretion of the individual clinician and based on agreeing reasonable and acceptable clinical and/ or cosmetic outcomes.

Once the satisfactory end point has been agreed and achieved, the patient will be discharged from the service.

Requests for treatment for unacceptable outcomes post treatment will only be considered through the Individual Funding Request route. Such requests will only be considered where a) the patient was satisfied with the outcome at the time of discharge and b) becomes dissatisfied at a later date. In these circumstances the patient is not automatically entitled to further treatment. Any further treatment will therefore be the Clinical Commissioning Group's discretion, and will be considered on an exceptional basis in accordance with the IFR policy.

NHS Leeds CCG are committed to supporting patients to stop smoking in line with NICE guidance in order to improve short and long term patient outcomes and reduce health inequalities. Referring GPs and secondary care clinicians are reminded to ensure the patient is supported to stop smoking at every step along the elective pathway and especially for flap based procedures (in line with plastic surgery literature: abdominoplasty, panniculectomy, breast reduction, other breast procedures).

4 Definitions

The CCG is not prescriptive in their definitions. Each IFR will be considered on its merits, applying this Policy.

Routinely commissioned – this means that this intervention is routinely commissioned as outlined in the relevant policy, or when a particular threshold is met. Prior approval may or may not be required, refer to the policy for more information.

Exceptionality request – this means that for a service which is not routinely commissioned, or a threshold is not met, the clinician may request funding on the 'grounds of exceptionality' through the individual funding request process. Decisions on exceptionality will be made using the framework defined in the overarching policy 'Individual Funding Requests (IFR) Policy for the Clinical Commissioning Group in Leeds'.

5 Duties

The CCG will delegate its decision making in relation to IFRs to a delegateddecision maker/s f in accordance with its own scheme of delegation.

A d e l e g a t e d decision maker will attend the relevant IFR panel and will also have responsibility for approving the triage process. The triage process is the process of screening requests to see whether the request meets the policy criteria and which referrals need to be considered by an IFR panel; see sections on IFR panels for more information. This will be detailed in the CCG Scheme of Delegation

6 Main Body of Policy

Exceptionality funding can be applied for in line with the overarching policy through the IFR process if you believe your patient is an exception to the commissioning position. Please refer to the overarching policy for more information.

6.1 Dilatation and curettage in the management of heavy menstrual bleeding

Status: not routinely commissioned[1]

D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods. Medication and intrauterine systems (IUS) can be used to treat heavy periods.

For further information, please see:
- https://www.nice.org.uk/guidance/ng88
- https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy

6.2 Hysterectomy in the management of heavy menstrual bleeding

Status: routinely commissioned in the following circumstances[2]

Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices.

Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.

1.13.1.1.1 NICE guideline NG88 1.5 Management of HMB 1.5.1 When agreeing treatment options for HMB with women, take into account: the woman's preferences, any

[1] https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf (accessed 05.02.19)

[2] https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf (accessed 05.02.19)

comorbidities, the presence or absence of fibroids (including size, number and location), polyps, endometrial pathology or adenomyosis, other symptoms such as pressure and pain.

1.13.1.1.2 Treatments for women with no identified pathology, fibroids less than 3 cm in diameter, or suspected or diagnosed adenomyosis

1.5.2 Consider an LNG-IUS (levonorgestrel-releasing intrauterine system) as the first treatment for HMB in women with: no identified pathology or fibroids less than 3 cm in diameter, which are not causing distortion of the uterine cavity or suspected or diagnosed adenomyosis.

1.5.3 If a woman with HMB declines an LNG-IUS or it is not suitable, consider the following pharmacological treatments: non-hormonal: tranexamic acid, NSAIDs (non-steroidal anti-inflammatory drugs), hormonal: combined hormonal contraception, cyclical oral progestogens.

1.5.4 Be aware that progestogen-only contraception may suppress menstruation, which could be beneficial to women with HMB.

1.5.5 If treatment is unsuccessful, the woman declines pharmacological treatment, or symptoms are severe, consider referral to specialist care for: investigations to diagnose the cause of HMB, if needed, taking into account any investigations the woman has already had and alternative treatment choices, including: pharmacological options not already tried (see recommendations 1.5.2 and 1.5.3), surgical options: second-generation endometrial ablation, hysterectomy.

1.5.6 For women with submucosal fibroids, consider hysteroscopic removal.

1.1.3 Treatments for women with fibroids of 3 cm or more in diameter

1.5.7 Consider referring women to specialist care to undertake additional investigations and discuss treatment options for fibroids of 3 cm or more in diameter.

1.5.8 If pharmacological treatment is needed while investigations and definitive treatment are being organised, offer tranexamic acid and/or NSAIDs.

1.5.9 Advise women to continue using NSAIDs and/or tranexamic acid for as long as they are found to be beneficial.

1.5.10 For women with fibroids of 3 cm or more in diameter, take into account the size, location and number of fibroids, and the severity of the symptoms and consider the following treatments: pharmacological: non-hormonal: tranexamic acid, NSAIDs, hormonal: LNG-IUS, combined hormonal contraception, cyclical oral progestogens, uterine artery embolization, surgical: myomectomy, hysterectomy.

1.5.12 Be aware that the effectiveness of pharmacological treatments for HMB may be limited in women with fibroids that are substantially greater than 3 cm in diameter.

1.5.13 Prior to scheduling of uterine artery embolisation or myomectomy, the woman's uterus and fibroid(s) should be assessed by ultrasound. If further information about fibroid position, size, number and vascularity is needed, MRI should be considered. [2007]

1.5.14 Consider second-generation endometrial ablation as a treatment option for women with HMB and fibroids of 3 cm or more in diameter who meet the criteria specified in the manufacturers' instructions.

1.5.15 If treatment is unsuccessful: consider further investigations to reassess the cause of HMB, taking into account the results of previous investigations and offer alternative treatment with a choice of the options described in recommendation

1.5.10. 1.5.16 Pretreatment with a gonadotrophin-releasing hormone analogue before hysterectomy and myomectomy should be considered if uterine fibroids are causing an enlarged or distorted uterus.

For further information, please see:

- https://www.nice.org.uk/guidance/ng88**.**
- https://www.nhs.uk/conditions/heavy-periods/#Causes

6.3 Cryopreservation for both men and women where the usual fertility policy does not apply

Status: routinely commissioned in specific circumstances

6.3.1 Cryopreservation is the process of freezing and storing sperm, oocytes and embryos so that they can potentially be used at a future date, typically in an attempt to conceive a pregnancy. Leeds CCG has a comprehensive fertility policy available on their website which covers the commissioning of cryopreservation for routine infertility treatment.

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

6.3.3 This policy follows the clinical guidelines published by NICE (CG156 Fertility Problems: assessment and management)[3], the recommendations in 'The Effects of Cancer Treatment on Reproductive Functions'[4] (Royal Colleges of Physicians, Radiologists, and Obstetricians and Gynaecologists, 2007), the HFEA[5] and HTA[6] guidelines. In addition, any specific legal requirements must be followed.

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

6.3.5 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.

6.3.6 Duration of storage

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

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

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[3] https://www.nice.org.uk/guidance/cg156/chapter/Recommendations#people-with-cancer-who-wish-to-preserve-fertility (acceded 06.12.17)

[4] https://www.rcr.ac.uk/system/files/publication/field_publication_files/Cancer_fertility_effects_Jan08.pdf (accessed 06.12.17)

[5] https://www.hfea.gov.uk/ (accessed 21.12.17)

[6] https://www.hta.gov.uk/ (accessed 21.12.17)

storage periods for gametes and embryos permit patients to store for a maximum of 10 years, and regulations for extending storage periods up to a maximum of 55 years.).

6.3.7 Cryopreservation in Males

In general, it is recommended that at least two semen samples are collected over a period of one week and stored before treatment for cancer. Leeds 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 Leeds CCG [7].

6.3.8 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.

6.3.9 Patients requesting cryopreservation must satisfy all of the following criteria:

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

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

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

- The patient is aware that funding for gamete harvesting and cryopreservation of material does not guarantee future funding of assisted conception or fertility treatment. If the patient requests an estimate of the current costs of privately funded fertility treatment then details of how to find a clinic should be given[8] , along with information on the current local commissioning position for NHS fertility treatment, recognising this may be subject to change.

6.4 Reversal of Sterilisation in Men
Status: not routinely commissioned

A vasectomy is a surgical procedure in which the vans deferens are severed and then tied or sealed in such a manner that sperm travelling from the testicles is unable to reach the penis and results in infertility. It is a permanent form of contraception.

Guidance on sterilisation is clear that men should be counselled and fully informed prior to agreeing to a vasectomy.

Reversal of sterilisation in a male patient is NOT routinely commissioned

6.5 Reversal of female sterilisation
Status: not routinely commissioned

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[7] https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual-2.pdf (accessed 06.12.17, service 58A, Highly Specialised Adult Urology Services)

[8] https://www.hfea.gov.uk/choose-a-clinic/ (accessed 21.12.17)

Female sterilisation is a surgical procedure which is undertaken as a permanent form of contraception. This is done by tubal occlusion – the blocking, sealing or cutting of the fallopian tubes.

Guidance on sterilisation is clear that women should be counselled and fully informed prior to agreeing to surgical sterilisation.

Reversal of sterilisation in a female patient is NOT routinely commissioned

http://www.nhs.uk/conditions/contraception-guide/pages/female-sterilisation.aspx

Clinical Effectiveness Unit. Male and female sterilisation. London (UK). Faculty of Sexual and Reproductive Health 2014

6.6 Labial Reduction and Cosmetic Vaginal Procedures

Status: not routinely commissioned. Exceptionality requests only via IFR process.

NHS Leeds CCGs regard surgery for labial reduction as cosmetic.

Many requests for labial reduction are motivated by unrealistic expectations of the appearance of the vulva. Potential referrers and their patients are reminded that the normal vulva includes a wide spectrum of shape and size (referrers are requested to see reference below). Prominent labia minora and/or projection of the labia minora beyond the labia majora are normal variants and not an indication for surgery, even if visible through tight-fitting clothing.

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

Medical indications for surgical procedures for labial hypertrophy or asymmetric labial growth include:

- congenital conditions; or
- chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment); or
- excess androgenic hormones

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

7 Equality Impact Assessment (EIA)

This document has been assessed, using the EIA toolkit, to ensure consideration has been given to the actual or potential impacts on staff, certain communities or population groups, appropriate action has been taken to mitigate or eliminate the negative impacts and maximise the positive impacts and that the and that the implementation plans are appropriate and proportionate.

Include summary of key findings/actions identified as a result of carrying out the EIA. The full EIA is attached as Appendix A.

8 Implications and Associated Risks

This policy and supporting frameworks set evidence based boundaries to interventions available on the NHS. It may conflict with expectations of individual patients and clinicians.

9 Education and Training Requirements

Members of the panels will undergo training at least every three years, particularly in relation to the legal precedents around IFRs. Effective policy dissemination is required for local clinicians.

10 Monitoring Compliance and Effectiveness

Each IFR panel will maintain an accurate database of cases approved and rejected, to enable consideration of amendments to future commissioning intentions and to ensure consistency in the application of the CCGs in Leeds Commissioning Policies.

The financial impact of approvals outside of existing Service Level Agreements will be monitored to ensure the Leeds CCGs identify expenditure and ensure appropriate value for money. Member Practice clinicians need to be aware that all referrals will ultimately be a call on their own CCG budgets.

11 Associated Documentation

This policy must be read in conjunction with the underpinning Leeds CCGs decision making frameworks.

12 Additional References

Dilatation and curettage, hysterectomy

http://www.nhs.uk/conditions/dilatation-and-curettage-(dc)/pages/introduction-old.aspx accessed 27/4/16

NICE Guidelines (CG44) Heavy menstrual bleeding: assessment and management

http://www.nhs.uk/Conditions/Hysterectomy/Pages/Introduction.aspx accessed 27/4/16

Cryopreservation

NICE Guidelines (CG156) Fertility problems: assessment and management

Reversal of sterilisation in men

http://www.nhs.uk/Conditions/contraception-guide/Pages/vasectomy-male-sterilisation.aspx (accessed 14/7/16)

Clinical Effectiveness Unit. Male and female sterilisation. London (UK). Faculty of Sexual and Reproductive Health 2014

Reversal of sterilisation in women

http://www.nhs.uk/conditions/contraception-guide/pages/female-sterilisation.aspx accessed 14/7/16

Clinical Effectiveness Unit. Male and female sterilisation. London (UK). Faculty of Sexual and Reproductive Health 2014

Labial Reduction

Potential referrers and patients are encouraged to view Jamie McCartney's exhibition of anatomical moulds ("Changing female body image through art") at www.greatwallofvagina.co.uk for a demonstration of the wide variety of normal appearances.

Appendices

A Equality Impact Assessment

Title of policy	Gynaecology and Urology Commissioning Policy	
Names and roles of people completing the assessment	Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning	
Date assessment started/completed	21.3.18	21.3.18

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the Leeds 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. This policy relates to requests for gynaecology and urology services.
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	See list of references

3. Consultation, engagement	
Give details of all consultation and engagement activities used to inform the analysis of impact	Discussion with clinicians and patient representatives on the principles of decision making. Discussion with patient leaders relating to changes in the content of the policy and advice on proportionate engagement. The policy review was undertaken using any updated NICE or equivalent guidance, and input from clinicians was sought where possible. Engagement sessions with patient leaders were undertaken and all policies individually reviewed. Patient leaders were satisfied with the process by which the policy was developed, particularly in light of the robust process (including extensive patient engagement) by which NICE guidance are

	developed, and acknowledging their own local role in providing assurance. No concerns were raised with regard to the policy. Local clinical commissioning and clinical providers have had the opportunity to comment on the draft policies.

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	no		
Carers	No		
Disability	No		This policy ensures equity of access for patients with a disability eg cancer and cryopreservation. There is equity of access for cancer patients requiring cryopreservation. The policy does not restrict current access however does specify what treatment will be funded.
Sex	yes		The policy necessarily differentiates on the grounds of sex in terms of anatomy; but not in terms of access to treatment to nongender specific treatments.
Race	No		
Religion or belief	No		
Sexual orientation	No		

Gender reassignment	No		There is equity of access for gender reassignment patients requiring cryopreservation. The policy does not restrict current access however does specify what treatment will be funded.
Pregnancy and maternity	No		The policy seeks to protect fertility for patients undergoing a medically necessary treatment which may impact on their future fertility.
Marriage and civil partnership	No		
Other relevant group	No		

If any negative/positive impacts were identified are they valid, legal and/or justifiable? **Please detail.**	There are no identified adverse impacts on protected characteristics; the policy is designed to ensure equity of access for all patients including groups potentially at risk of discrimination eg patients undergoing gender transition.

5. Monitoring, Review and Publication			
How will you review/monitor the impact and effectiveness of your actions	Annual report of IFR activity reported through relevant committees to Governing Bodies of the 3 CCGs. A limited equity audit is undertaken as part of this. Complaints and appeals monitoring.		
Lead Officer	Simon Stockill	**Review date:**	Dec 2019

6.Sign off			
Lead Officer	Dr Simon Stockill, Medical Director		
NHS Leeds CCG Medical Director	,	**Date approved:**	9 May 2018

B Policy Consultation Process:

Title of document	Gynaecology and Urology Commissioning Policy
Author	F Day, M Everitt, Leeds City Council
New / Revised document	New
Lists of persons involved in developing the policy List of persons involved in the consultation process:	F Day Consultant in Public Health Medicine, Leeds City Council See appendix A

C Version Control Sheet

Version	Date	Author	Status	Comment
1.0	14/7/16	F Day, M Everitt	Draft	New hysterectomy for heavy menstrual bleeding policy in line with NICE. removal of specialist erectile dysfunction and specialist penile prostheses from policy as this is NHSE responsibility;
2.0	21.3.18	F Day, A Balen	Amended 6.3 cryopreservation policy	**Changes to previous policy:** Addition of new references, limits to number of samples of sperm and cycles of egg harvesting added (this is not a change to current practice but is a clarification of the maximum). Clarification of age, duration of storage, requirements for providers, methods of cryopreservation added.
3.0	5.2.19	F Day	updated	Updated 6.1 and 6.2 in line with NHS England Evidence Based Interventions : Response to the public consultation and next steps (November 28th 2018)