Aligning commissioning policies across north east London

Full quality impact assessment tool (fQIA)

Full Quality Impact Assessment (fQIA)

1. Purpose

1.1 The purpose of this is to provide staff with a framework to ensure that Quality and Equality Impact Assessments are defined and embedded within our organisation.

1.2 The tool tests the impact of a proposed change on quality of patient care, and is based on the Care Quality Commission (CQC) key lines of enquiries. The impact is tested through a narrative account and the CCG risk matrix. The impact is rated using a scale of positive, negative or none to allow for risks and benefits to be quantified.

2. Quality Impact Assessment (QIA) Process

2.1 The Commissioner should review through the QIA process prior to using this document to check whether this is the correct document to use. In most circumstances an initial quality assessment (iQIA) would have been completed and assessed by panel prior to this document being completed.

2.2 Under the duty of equality, a full equality impact assessment is required as per the CCGs Equality Analysis Impact Assessment Form (http://nww.newhamccg.nhs.uk/engagement/Pages/Equality-and-Diversity.aspx). Where there is a moderate, major or sever impact identified under the quality domains, the CCG Quality Performance and Finance Committee may wish to explore this further with the relevant CCG officer or committee.

3. Quality Impact Assessment Tool

3.1 The tool is based on the following core components:

- Duty of quality
- Are services safe?
- Are services effective?
- Are services responsive to people's needs?
- Are services caring?
- Are services well led?
- Duty of equality

3.2 The definitions for the following components are:

Component	Definition
Duty of quality	The Health and Social Care Act 2012 Section 14R *1) Each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness. (2)In discharging its duty under subsection (1), a clinical commissioning group must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services. (3)The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show—. (a)the*

	effectiveness of the services,. (b)the safety of the services, and. (c)the quality of the experience undergone by patients.
Are service Safe	People are protected from abuse* and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.
Are service effective	People's care, treatment and support achieve good outcomes, promote a good quality of life and is based on the best available evidence.
Are services responsive to people's needs?	Services are organised so that they meet people's needs.
Are services caring?	Staff involve and treat people with compassion, kindness, dignity and respect.
Are services well led?	The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
Duty of equality	The equality Act 2010 states clearly under section 4 the protected characteristics.

3.4 Impact and Risk Matrix

Impact is assessed to determine the effect of change on patients and the population the CCG serves. The definitions of impacts are the following:

Impact	**Definition**
Positive	The change will improve the quality of services to deliver safe care; the experience of patients will be good and improve patient outcomes and adhere to national clinical standards or best practice.
Negative	The change will reduce the quality of care being delivered, patient safety and experience and outcomes will be compromised, or does not comply with national clinical standards or best practice.
None	Quality of care remains the same as currently commissioned, there is no change in the delivery of care, safety, experience and outcomes for patients remain the same.

3.5 Risk Matrix

The Risk Matrix on the tool is based on the CCG Board Assurance Framework which allows the assessment of risk and impact to be aligned with the CCGs corporate assurance framework.

The CCG risk matrix is the following:

		Likelihood				
		Rare	**Unlikely**	**Possible**	**Likely**	**Certain**
Severity	**Insignificant**	1	2	3	4	5
	Minor	2	4	6	8	10
	Moderate	3	6	9	12	15
	Major	4	8	12	16	20
	Severe	5	10	15	20	25

***For further details refer to the Board Assurance Framework*

4. Process for review and approval

4.1 Once the fQIA has been completed, the assessment should be sent to the Quality team for review prior to this being submitted to the Quality Performance and Finance Committee (QPF committee).

4.2 The relevant commissioner will be responsible for presenting the full QIA to the QPF Committee.

4.3 The CCG QPF Committee may wish to seek further assurances from the relevant CCG officer or CCG committee.

4.4 For impact identified as Moderate, Major and Severe an action plan for mitigation will be requested which will require approval from the QPF Committee.

Quality Impact Assessment Tool

Date	04/04/2019
Project Lead	Alison Glynn
Brief background of service	The purpose of having a POLCE policy is to: **Reduce avoidable harm to patients.** With surgical interventions, there is always a risk of complications. Weighing the risks and benefits of appropriate treatments should be co-produced with patients. **Save precious professional time**, when the NHS is severely short of staff, professionals should offer appropriate and effective treatment to patients. **Create headroom for innovation**. If we want to accelerate the adoption of new, proven innovations, we need to reduce the number of inappropriate interventions. This frees up resource and allows innovation in new technologies to improve patients' ability to self-care and live with long term conditions. **Maximise value and avoid waste**. Inappropriate care is poor value for money. Resources should be focused on effective and appropriate NHS services.
Rationale for change	POLCE policies need to be constantly reviewed and updated to ensure they reflect the latest clinical guidance and best practice in order to remain fit for purpose. BHR CCGs current policy was updated in July 2018. WELC CCGs current policy was last updated in 2015. Since then, Healthy London Partnership and NHS England have conducted clinically led reviews of existing policies across London and England respectively in order to develop their own POLCE policies. The London policy (London Choosing Wisely) contained eight procedures. The National policy (Evidence Based Interventions) contained seventeen procedures. NHS England are mandating compliance with the Evidence Based Interventions policy through the NHS standard contract. In the NHSE Evidence Based Outcomes paper it is stated that from 1st April 2019 commissioners and providers must endeavour to comply with the Evidence Based Interventions policy. The aim of NEL spending money wisely is to develop one POLCE policy for North East London by combining the BHR, WELC, London and National policies to ensure the new policy reflects the aforementioned developments and latest clinical guidance. By having one policy across North East London this will ensure patients across North East London have access to

	the same treatments. At present with two different policies in place, different treatment options remain available/unavailable depending upon which borough the GP practice of the patient belongs to. This creates inequity of access to treatments and places additional administrative burdens on trusts to determine which policy to apply for each patient before they can treat.
What is the change?	**BHR** **IFR and Prior Approval Process** No change to the existing Prior Approval and Individual Funding Request (IFR) process. **IFR process:** Full details of the IFR process can be found here: http://www.redbridgeccg.nhs.uk/downloads/BHR-CCGs/News-and-pub/Policies/NEL-IFR-Policy-2014-17.pdf **Abridged version of IFR process:** 1. Clinician sends IFR form to IFR team via nhs.net. 2. IFR team reviews and process if patient consent has been given. IFR triage will either a. Return to the clinical applicant stating i. Respond stating case is not for IFR process i.e. NHSE commissioned ii. Respond stating the patient does not meet policy criteria and no clinical exceptionality has been provided. iii. Respond stating that the request is for a non commissioned service/provider and no clinical exceptionality has been provided If the outcome is i, ii or iii the IFR team send letter to the clinical applicant via email stating the outcome and next steps. This is done in around 20 working days (1 month) from date application received by IFR team. b. Put forward for further review which might lead to an IFR panel discussion and decision i. cases are sent for clinical work up, which may lead to the case being referred back to a (above) ii. cases are sent for clinical work up, which may identify further information is required from the clinical applicant.

iii. When cases have sufficient clinical information they will be presented to an IFR panel for consideration, the IFR panel typically meets once per month. The IFR team send letter to the clinician applicant stating the outcome and next steps. This process can take between 1 month and 4.5 months.

Abridged version of Prior Approval Process:

1. Clinician sends prior approval form to IFR team via nhs.net.
2. IFR team reviews the form and either
   a. Approve if clear patient meets local access criteria
   b. Decline if clear patient does not meet local access criteria
   c. Decline if form not completed correctly
      i. If the outcome is a,b or c the IFR team send an email to the clinician stating the outcome. This is completed within 24 hours (1 working day) from the date the IFR team receive the prior approval form

Please note that the activity and cost figures below provide an indication as to the number of procedures that fall into each procedure category not the volume of activity that will be stopped. Activity and costs are taken from SUS Apr-2018 to January 2019 inclusive, forecast up to year end and look across all providers

Eight new procedures for BHR CCGs:.

From National:

1. Dilation & Curettage (D&C) for heavy menstrual bleeding in women (IFR) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	7	£	4,682
NHS Havering CCG	2	£	1,351
NHS Redbridge CCG	4	£	2,106

2. Chalazia removal (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	36	£ 18,750
NHS Havering CCG	50	£ 32,534
NHS Redbridge CCG	85	£ 43,872

3. Surgical treatment of carpal tunnel syndrome (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	116	£ 156,564
NHS Havering CCG	217	£ 288,031
NHS Redbridge CCG	180	£ 241,580

4. Shoulder Decompression (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	65	£ 296,821
NHS Havering CCG	97	£ 396,750
NHS Redbridge CCG	76	£ 396,617

From London:

5. Interventional treatments for back pain without sciatica (Prior Approval) – London

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	716	£ 427,339
NHS Havering CCG	1241	£ 724,868
NHS Redbridge CCG	1019	£ 663,130

From WELC:

6. Repair of split ear lobes (IFR) – WELC

   No codes specific enough to identify split ear lobes in SUS.

7. Herbal medicines (IFR) – WELC

   No codes available to identify herbal medicines in SUS.

8. Treatment for scarring and skin hyper- or hypo- pigmentation (IFR) – WELC

   No activity identified in SUS.

Five procedures are proposed to be removed from POLCE for BHR CCGs

Procedures that are removed from the POLCE policy will become available to patients without the need for prior approval to be sought or for an IFR application to be made.

1. **Continuous glucose monitoring for type 1 diabetes (IFR)** – CGM is being split out from national tariff from 1st April 2019. CCG's are expected to make a commissioning decision about how this cohort of patients will access CGM. BHR CCGs have commissioned a new pathway from 1st April 2019 and WELC CCGs are expected to make a commissioning decision in the future. Patients will now be able to access CGM easier.

   CGM activity cannot be identified in SUS.

2. **Elective caesarean (Prior Approval)** – propose to remove - should be a decision between clinician and patient. Ensuring patient choice and would instead be covered through existing maternity commissioning. Previously a

tick box form would have need to be completed for this. Patients will be able to access elective caesareans easier as the requirement for a tick box form to be completed prior to treatment will be removed.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	62	£	254,030
NHS Havering CCG	2	£	9,770
NHS Redbridge CCG	19	£	97,859

3. **Ear wax removal via aural microsuction (Prior Approval)** – procedure is needed for consultants to conduct other procedures. Needs to be addressed instead through coding challenge and/or service commissioning. By removing this from the policy the need for prior approval to be sought is removed.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	578	£	58,608
NHS Havering CCG	1056	£	106,148
NHS Redbridge CCG	1292	£	133,174

4. **Podiatry (Prior Approval)** – Majority of activity occurs under a block contract with NELFT. Will be managed through commissioning of podiatry services removing the need for prior approval to be sought before treatment can go ahead.

   Activity not provided as commissioned under block contract arrangement.

5. **Occipital nerve stimulation for cluster headache (IFR)** – This falls under specialised commissioning and is funded by NHSE. Remove on the basis that this is commissioned by NHSE. (p404: https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual.pdf)). CCG cannot restrict procedures commissioned by NHSE.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	2	£	1,202
NHS Havering CCG	0	£	-
NHS Redbridge CCG	0	£	-

Policies where there has been a change to criteria for patients to access treatment:

1. **Trigger Finger (Prior Approval) – National:** Propose to adopt national policy. This would move trigger finger from being IFR to being funded if certain criteria are met. Has also been made clear that this policy does not apply to children. This exclusion was previously not stated. This would make access to trigger finger procedures easier for patients.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	4	£	4,732
NHS Havering CCG	22	£	28,127
NHS Redbridge CCG	13	£	19,184

2. **Sympathectomy for severe hyperhidrosis (palmar, plantar, axillary) (Prior Approval) – WELC**: This would now require a prior approval tick box form to be completed before the procedure can be carried out to ensure clinical criteria are met. Previously this was not routinely funded and would have required exceptionality to be proven via an IFR application. This would make access to treatment easier for patients.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	1	£	1,096
NHS Havering CCG	5	£	2,498
NHS Redbridge CCG	1	£	176

3. **Pinnaplasty/Otoplasty (Prior Approval) – SEL TAP (South East London Treatment & Access Policy**): The criteria of having 'significant' ear deformity is now defined as having 'prominence measuring >30mm'. This provides

clarity to the clinicians on the definition of significance as this was previously undefined. The criteria for the patient to be aged between 5 and 18 has been relaxed to under 18. This procedure was previously treated as an IFR due to the need for high quality clinical photographs with the criteria listed in the policy taken into consideration. This is no longer required as the procedure will be classed as prior approval and provided as long as the criteria is met rather than an IFR application needing to be made. This will improve the turnaround time for pinnaplasty applications making access to treatment for patients faster.

No activity identified in SUS.

4. **Rhinoplasty/Septoplasty/Rhinoseptoplasty (Prior Approval) – Birmingham & Solihull:** Clarified that rhinoplasty policy includes septoplasty and rhinoseptoplasty as was previously unclear as only rhinoplasty was generically stated, causing confusion for clinicians as to whether this would also encompass septoplasty. The criteria that conservative treatments need to be tried for at least 3 months has been altered to stating a need for all conservative treatments to have been exhausted without a time limit being placed on this. This allows for flexibility if all conservative treatments are tried inside of 3 months, but also for conservative treatments to be tried for longer based on clinical judgement as to the appropriateness. The previous criteria for significant symptoms to be confirmed by an ENT consultant as resulting from nasal obstruction has been removed as under prior approval the clinician requesting funding has to confirm that there is documented evidence of medical problems caused by an obstruction of the nasal airway mitigating the need for this additional criteria. Rhinoplasty is a procedure listed as requiring prior approval in the current BHR policy. In the new policy this procedure will remain as requiring prior approval.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	18	£ 41,273
NHS Havering CCG	17	£ 39,630
NHS Redbridge CCG	36	£ 88,308

5. **Dupuytren's contracture release (Prior Approval) – National:** This remains prior approval. Main change is that treatment will now be funded if patient has a loss of finger extension of 20 degrees or more at the proximal interphalangeal joint, this was previously 30 degrees under the existing policy. The threshold is therefore lower and so more patients will be able to access this treatment.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	16	£	44,208
NHS Havering CCG	56	£	164,748
NHS Redbridge CCG	26	£	74,766

6. **Cataract Surgery (Prior Approval) – London**: Cataract Surgery (Prior Approval) - London – Cataract surgery is contained within the existing BHR policy and remains as requiring prior approval. The main change to the clinical criteria is that the patients visual acuity must now be 6/9 or worse in either the first or second eye for treatment to be approved via prior approval. Under the existing BHR policy the patients visual acuity must be 6/12 or worse in either the first or second eye. This change would allow access to this procedure for more patients. It has also been made explicitly clear that children are excluded from requiring prior approval to access cataract surgery, under the existing BHR policy children were not excluded.

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS Barking and Dagenham CCG	332	£	262,788
NHS Havering CCG	521	£	389,198
NHS Redbridge CCG	822	£	621,109

7. **Bariatric surgery (Prior Approval)** – **BHR**: Bariatric surgery remains as a procedure requiring prior approval in the proposed policy. It is proposed to update the existing bariatric surgery policy to ensure the clinical criteria mentioned aligns with the latest NICE guidance (NICE CG 189) on bariatric surgery. The existing bariatric surgery policy states that surgery will be funded when the patient has type 2 diabetes AND a BMI of greater than 35 kg/m2. The proposed policy alters this criteria to adhere to latest NICE bariatric surgery guidance as follows. Criteria altered to state 'the patient has a BMI of 40 kg/m2 or more' which would remove the additional requirement for the patient to have type 2 diabetes in the existing policy. This would make access easier for some patients. Criteria altered to state 'the patient has a BMI of between 35 kg/m2 and 40 kg/m2 and other significant diseases (type 2 diabetes or high blood pressure) that could be improved if they lost weight. This allows patients with a wider range of significant diseases that can be improved by weight loss to be considered for bariatric surgery. There is also additional criteria which has been added that requires all non-surgical measures to have been tried, that intensive management is provided in a tier 3 service, that the person is generally fit for anaesthesia and surgery; and the person commits to long term follow up. These encourage bariatric surgery to be used as a last resort.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	32	£ 211,830
NHS Havering CCG	38	£ 251,945
NHS Redbridge CCG	20	£ 126,466

8. **Female breast reduction (Prior Approval) – National:** Female breast reduction surgery remains as a procedure requiring prior approval. The clinical criteria for bilateral breast reduction surgery that previously stated the cup size must be H or larger has been removed. This criteria removal would allow patients with a smaller cup size to access breast reduction surgery as previously they would not have met the requirement for the cup size to be H or larger and would have had to request funding via an IFR application.

   The previous criteria requirement for bilateral breast reduction surgery that stated the breast reduction planned should be 500gms or more per breast or at least 3 cup sizes has been updated to state the breast reduction planned should 500gms or more per breast or at least 4 cup sizes. This may therefore require women to have a more of a breast reduction than before.

   The previous criteria for bilateral breast reduction surgery that stated the patient has a BMI equal to or below 27 kg/m2 for at least two years (documented) has been updated to state the patient has a BMI below 27 kg/m2 for at least 12 months. This reduces the time the patient has to keep their BMI below 27 kg/m2 before they can access breast reduction surgery, though BMI must now be below 27 kg/m2 rather than equal to.

   The previous criteria for bilateral breast reduction surgery that stated the evidence must be submitted to demonstrate pain symptoms persist as documented by the physician despite a six month trial of therapeutic measures has been removed. This would make access to breast reduction surgery easier as this criteria is no longer mentioned in the policy.

   Additional clinical criteria that was not previously contained in the bilateral breast reduction policy has been added. The patient must now receive a full package of supportive care from their GP in the form of advice on weight loss and pain management. If the patient has thoracic or shoulder girdle discomfort a physiotherapy assessment has to be provided. The patient must receive written information of the risks and benefits involved with bilateral breast reduction surgery. Patients must be advised that smoking increases complications and should be advised to stop smoking. Patients should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

The previous criteria for unilateral breast reduction surgery that stated there must be gross asymmetry (defined as a difference in size a minimum three cup sizes) has been altered to a difference of 150 - 200gms size as measured by a specialist. This ensures the measurement is carried out by a specialist.

The previous criteria that required the patient to demonstrate that there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra). This has been removed. This would make access to this procedure for patients easier.

The previous criteria that required the woman's breasts to be fully developed i.e. there has been no change in the size of either breast over the previous 18 months has been removed. This will make access to this procedure easier for patients.

A requirement for the body mass index (BMI) to be <27 and stable for at least 12 months has been added. This promotes a healthy weight prior to surgery being undertaken and encourages maintenance of a healthy weight.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	7	£ 19,872
NHS Havering CCG	8	£ 19,540
NHS Redbridge CCG	4	£ 10,091

9. **Grommets for glue ear in children (Prior Approval) – National:** Grommets for glue ear in children remains as a procedure requiring prior approval. The previous criteria that the child should be aged between three and twelve has been removed. This opens up access to this treatment for children outside of that age range. The additional previous criteria that stated the child must have documented persistent hearing loss on two occasions at intervals of three months or more has been changed to one episode of at least three consecutive months. This allows grommets for glue ear to be considered earlier as only one episode of three months required to be demonstrated rather than two.

   The previous criteria that stated grommets for glue ear in children can be funded via prior approval if the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma has been removed from the new policy. This ensures that the cholesteatoma is treated before a new grommet is fitted.

Previous criteria that stated grommets for glue ear in children can be funded via prior approval if the child has five or more episodes of acute otitis media has been removed. This would allow access to treatment when there are fewer episodes of acute otitis media provided other clinical criteria are met.

An additional criteria has been added to one of the options for approving funding for grommets for glue ear in children via prior approval which states that all children must have had a specialist audiology and ENT assessment. This ensures that any audiology and ENT assessments are carried out be a specialist prior to the fitting of a grommet for glue ear.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS Barking and Dagenham CCG	65	£ 56,754
NHS Havering CCG	104	£ 89,323
NHS Redbridge CCG	84	£ 74,708

WELC

IFR and Prior Approval Process

No change to the IFR process for all four WELC CCGs, however for the prior approval procedures in WELC CCGs all procedures listed in the prior approval category will now require application via prior approval for funding whereas before some procedures in the prior approval category could be done without the need to seek prior approval. For those procedures that could previously be done without the need to seek prior approval, if the prior approval process remains the same as it currently is, these will now take between 2 to 4 weeks to process. If the prior approval process moves to the proposed process these will now take around 7 working days. For those procedures previously listed as prior approval only, if the proposed prior approval process is adopted then the time to process the applications will reduce from 2 to 4 weeks down to around 7 working days. If the proposed prior approval process is not adopted then processing applications will remain at between 2 to 4 weeks.

With additional investment into the IFR team, the standard of 1 working day (24 hours) could be met as per BHR service level agreement.

For information the procedures that could previously be carried out without the need to seek prior approval are:

- Revision of breast augmentation
- Benign skin lesions
- Blepharoplasty
- Hysterectomy for heavy menstrual bleeding
- Bartholin's cyst
- Circumcision
- Surgery for varicocele
- Sympathectomy for severe hyperhidrosis
- Pinnaplasty/otoplasty
- Tonsillectomy
- Grommets
- Surgical treatment of chronic sinusitis
- Varicose veins
- Dupuytren's contracture
- Trigger finger
- Carpal tunnel syndrome surgery
- Excision of ganglion
- Bunion surgery (hallux valgus)
- Botulinum toxin injections
- EXOGEN bone healing
- Knee washout for osteoarthritis AND mechanical locking
- Open MRI (for obesity)

IFR process:

Full details of the IFR process can be found here:

http://www.redbridgeccg.nhs.uk/downloads/BHR-CCGs/News-and-pub/Policies/NEL-IFR-Policy-2014-17.pdf

Abridged version of IFR process:

1. Clinician sends IFR form to IFR team via nhs.net.

2. IFR team reviews and process if patient consent has been given. IFR triage will either

a. Return to the clinical applicant stating

i. Respond stating case is not for IFR process i.e. NHSE commissioned

ii. Respond stating the patient does not meet policy criteria and no clinical exceptionality has been provided.

iii. Respond stating that the request is for a non commissioned service/provider and no clinical exceptionality has been provided

If the outcome is i, ii or iii the IFR team send letter to the clinical applicant via email stating the outcome and next steps. This is done in around 20 working days (1 month) from date application received by IFR team.

b. Put forward for further review which might lead to an IFR panel discussion and decision

i. cases are sent for clinical work up, which may lead to the case being referred back to a (above)

ii. cases are sent for clinical work up, which may identify further information is required from the clinical applicant.

iii. When cases have sufficient clinical information they will be presented to an IFR panel for consideration, the IFR panel typically meets once per month. The IFR team send letter to the clinician applicant stating the outcome and next steps. This process can take between 1 month and 4.5 months.

Abridged version of current Prior Approval Process:

1. If procedure is listed as prior approval but with criteria met, then clinician may go ahead and carry out the procedure without the need to seek prior approval.
2. If procedure is listed as prior approval only then clinician sends prior approval form to IFR team via nhs.net.
3. IFR team reviews the form and either
   a. Approve if clear patient meets local access criteria
   b. Decline if clear patient does not meet local access criteria
   c. Decline if form not completed correctly
      i. If the outcome is a,b or c the IFR team send an email to the clinician stating the outcome. This is completed within 2 to 4 weeks from the date the IFR team receive the prior approval form.

Abridged version of proposed Prior Approval Process:

1. Clinician sends prior approval tick box form to IFR team via nhs.net.

2. IFR team reviews the tick box form and either
   a. Approve if clear patient meets local access criteria
   b. Decline if clear patient does not meet local access criteria
   c. Decline if form not completed correctly
      i. If the outcome is a,b or c the IFR team send an email to the clinician stating the outcome. This is completed within 7 working days from the date the IFR team receive the prior approval form

Fourteen new procedures for WELC CCGs

From National:

1. Injections for non-specific low back pain (IFR) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS City and Hackney CCG	67	£	43,897
NHS Newham CCG	36	£	23,712
NHS Tower Hamlets CCG	13	£	9,383
NHS Waltham Forest CCG	44	£	29,160

2. Surgical interventions for snoring in the absence of obstructive sleep apnoea (IFR) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs	
NHS City and Hackney CCG	1	£	1,632
NHS Newham CCG	6	£	6,714
NHS Tower Hamlets CCG	1	£	1,718
NHS Waltham Forest CCG	0	£	-

3. Chalazia removal (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	114	£ 60,068
NHS Newham CCG	67	£ 36,815
NHS Tower Hamlets CCG	86	£ 44,537
NHS Waltham Forest CCG	61	£ 32,653

4. Haemorrhoidectomy (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	71	£ 81,104
NHS Newham CCG	86	£ 100,117
NHS Tower Hamlets CCG	74	£ 87,830
NHS Waltham Forest CCG	20	£ 23,783

5. Shoulder Decompression (Prior Approval) – National

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	2	£ 11,554
NHS Newham CCG	29	£ 147,176
NHS Tower Hamlets CCG	13	£ 54,077
NHS Waltham Forest CCG	41	£ 198,431

From London:

1. Interventional treatments for back pain without sciatica (Prior Approval) – London

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	202	£ 219,959
NHS Newham CCG	866	£ 695,596
NHS Tower Hamlets CCG	538	£ 473,806
NHS Waltham Forest CCG	791	£ 767,399

2. Cataract Surgery (Prior Approval) – London

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	596	£ 528,709
NHS Newham CCG	523	£ 402,601
NHS Tower Hamlets CCG	368	£ 291,775
NHS Waltham Forest CCG	631	£ 440,377

3. Hip arthroplasty (Prior Approval) – London

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	83	£ 573,937
NHS Newham CCG	67	£ 469,970
NHS Tower Hamlets CCG	42	£ 291,338
NHS Waltham Forest CCG	144	£ 1,026,029

4. Knee arthroplasty (Prior Approval) – London

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	91	£ 673,792
NHS Newham CCG	185	£ 1,361,168
NHS Tower Hamlets CCG	70	£ 525,576
NHS Waltham Forest CCG	224	£ 1,620,096

From BHR:

1. Laser surgery for short sightedness (IFR) – BHR

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	1	£ 968
NHS Newham CCG	0	£ -
NHS Tower Hamlets CCG	0	£ -
NHS Waltham Forest CCG	0	£ -

2. Spinal surgery (Prior Approval) – BHR

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	19	£ 23,819
NHS Newham CCG	70	£ 77,426
NHS Tower Hamlets CCG	30	£ 27,823
NHS Waltham Forest CCG	86	£ 92,558

3. Functional electrical stimulation (FES) for foot drop (Prior Approval) – BHR

   No activity identified in SUS.

4. Abdominal wall hernia management and repair (Prior Approval) – BHR

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	220	£ 385,264
NHS Newham CCG	269	£ 467,264
NHS Tower Hamlets CCG	167	£ 288,446
NHS Waltham Forest CCG	230	£ 400,812

5. Bariatric Surgery (Prior Approval) – BHR

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	36	£ 239,381
NHS Newham CCG	28	£ 193,038
NHS Tower Hamlets CCG	13	£ 87,343
NHS Waltham Forest CCG	29	£ 194,838

One procedure is proposed to be removed for WELC CCGs

Procedures that are removed from the POLCE policy will become available to patients without the need for prior approval to be sought or for an IFR application to be made.

1. Continuous glucose monitoring for type 1 diabetes (IFR) – CGM is being split out from national tariff from 1st April 2019. CCG's are expected to make a commissioning decision about how this cohort of patients will access CGM. BHR CCGs have commissioned a new pathway from 1st April 2019 and WELC CCGs are expected to make a commissioning decision in the future.

   CGM activity cannot be identified in SUS.

Policies where there has been a change to criteria:

1. **Pinnaplasty/Otoplasty (Prior Approval) – SEL TAP (South East London Treatment & Access Policy**): The criteria of having 'significant' ear deformity is now defined as having 'prominence measuring >30mm'. This

provides clarity to the clinicians on the definition of significance as this was previously undefined. The criteria for the patient to be aged between 5 and 18 has been relaxed to under 18.

No activity identified in SUS.

2. **Rhinoplasty (Prior Approval) – Birmingham & Solihull**: Clarified that the existing rhinoplasty policy includes septoplasty and rhinoseptoplasty as was previously unclear as only rhinoplasty was generically stated, causing confusion for clinicians as to whether this would also encompass septoplasty. The criteria that conservative treatments need to be tried for at least 3 months has been altered to stating a need for all conservative treatments to have been exhausted without a time limit being placed on this. This allows for flexibility if all conservative treatments are tried inside of 3 months, but also for conservative treatments to be tried for longer based on clinical judgement as to the appropriateness. The previous criteria for significant symptoms to be confirmed by an ENT consultant as resulting from nasal obstruction has been removed as under prior approval the clinician requesting funding has to confirm that there is documented evidence of medical problems caused by an obstruction of the nasal airway mitigating the need for this additional criteria.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	28	£ 65,706
NHS Newham CCG	43	£ 103,916
NHS Tower Hamlets CCG	41	£ 92,556
NHS Waltham Forest CCG	34	£ 82,702

3. **Dupuytren's contracture release (Prior Approval) – National:** This remains prior approval. Main change is that treatment will now be funded if patient has a loss of finger extension of 20 degrees or more at the proximal interphalangeal joint, this was previously 30 degrees under the existing policy. The threshold is therefore lower and so more patients will be able to access this treatment.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	16	£ 53,623
NHS Newham CCG	12	£ 29,806
NHS Tower Hamlets CCG	18	£ 44,410
NHS Waltham Forest CCG	23	£ 58,334

4. **Female breast reduction (Prior Approval) – National:** Female breast reduction surgery remains as a procedure requiring prior approval. The clinical criteria for bilateral breast reduction surgery that previously stated the cup size must be H or larger has been removed. This criteria removal would allow patients with a smaller cup size to access breast reduction surgery as previously they would not have met the requirement for the cup size to be H or larger and would have had to request funding via an IFR application.

   The previous criteria requirement for bilateral breast reduction surgery that stated the breast reduction planned should be 500gms or more per breast or at least 3 cup sizes has been updated to state the breast reduction planned should 500gms or more per breast or at least 4 cup sizes. This may therefore require women to have a more of a breast reduction than before.
   The previous criteria for bilateral breast reduction surgery that stated the patient has a BMI equal to or below 27 kg/m2 for at least two years (documented) has been updated to state the patient has a BMI below 27 kg/m2 for at least 12 months. This reduces the time the patient has to keep their BMI below 27 kg/m2 before they can access breast reduction surgery, though BMI must now be below 27 kg/m2 rather than equal to.

   The previous criteria for bilateral breast reduction surgery that stated the evidence must be submitted to demonstrate pain symptoms persist as documented by the physician despite a six month trial of therapeutic measures has been removed. This would make access to breast reduction surgery easier as this criteria is no longer mentioned in the policy.

   Additional clinical criteria that was not previously contained in the bilateral breast reduction policy has been added. The patient must now receive a full package of supportive care from their GP in the form of advice on weight loss and pain management. If the patient has thoracic or shoulder girdle discomfort a physiotherapy assessment has to be provided. The patient must receive written information of the risks and benefits involved with bilateral breast reduction surgery. Patients must be advised that smoking increases complications and

should be advised to stop smoking. Patients should be informed that breast surgery for hypermastia can cause permanent loss of lactation.

The previous criteria for unilateral breast reduction surgery that stated there must be gross asymmetry (defined as a difference in size a minimum three cup sizes) has been altered to a difference of 150 - 200gms size as measured by a specialist. This ensures the measurement is carried out by a specialist.

The previous criteria that required the patient to demonstrate that there is no ability to maintain a normal breast shape using non-surgical methods (e.g. padded bra). This has been removed. This would make access to this procedure for patients easier.

The previous criteria that required the woman's breasts to be fully developed i.e. there has been no change in the size of either breast over the previous 18 months has been removed. This will make access to this procedure easier for patients.

A requirement for the body mass index (BMI) to be <27 and stable for at least 12 months has been added. This promotes a healthy weight prior to surgery being undertaken and encourages maintenance of a healthy weight.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	14	£ 17,574
NHS Newham CCG	14	£ 36,095
NHS Tower Hamlets CCG	5	£ 10,690
NHS Waltham Forest CCG	13	£ 27,967

5. **Grommets for glue ear in children (Prior Approval) – National:** Grommets for glue ear in children remains as a procedure requiring prior approval. The previous criteria that the child should be aged between three and twelve has been removed. This opens up access to this treatment for children outside of that age range. The additional previous criteria that stated the child must have documented persistent hearing loss on two occasions at intervals of three months or more has been changed to one episode of at least three consecutive months. This allows grommets for glue ear to be considered earlier as only one episode of three months required to be demonstrated rather than two.

The previous criteria that stated grommets for glue ear in children can be funded via prior approval if the otoscopic features are atypical and accompanied by a foul-smelling discharge suggestive of cholesteatoma has been removed from the new policy. This ensures that the cholesteatoma is treated before a new grommet is fitted.

Previous criteria that stated grommets for glue ear in children can be funded via prior approval if the child has five or more episodes of acute otitis media has been removed. This would allow access to treatment when there are fewer episodes of acute otitis media provided other clinical criteria are met.

An additional criteria has been added to one of the options for approving funding for grommets for glue ear in children via prior approval which states that all children must have had a specialist audiology and ENT assessment. This ensures that any audiology and ENT assessments are carried out be a specialist prior to the fitting of a grommet for glue ear.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	65	£ 61,842
NHS Newham CCG	71	£ 64,166
NHS Tower Hamlets CCG	110	£ 99,624
NHS Waltham Forest CCG	71	£ 61,306

6. **Trigger Finger (Prior Approval) – National:** Surgical treatment for trigger finger remains as a procedure requiring prior approval. It has been made clear that this policy does not apply to children. This exclusion was previously not stated. The previous criteria that stated splinting must be tried for 3 months or more has been relaxed in the national policy, this requirement has been reduced to between 3 and 12 weeks. This would allow patients to seek surgery for trigger finger earlier. It has been made clear in the new policy that trigger finger surgery will be allowed for diabetics, this would make access to trigger finger surgery easier for patients with diabetes. An additional option has been added, that states treatment will be approved if the patient has had two other trigger digits unsuccessfully treated with nonoperative methods. This will prevent patients who have already tried nonoperative methods previously from having their request for trigger finger surgery rejected.

	2018/19 Forecast Activity	2018/19 Forecast Costs
NHS City and Hackney CCG	19	£ 26,590
NHS Newham CCG	22	£ 31,069
NHS Tower Hamlets CCG	16	£ 24,547
NHS Waltham Forest CCG	20	£ 28,786

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Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
Duty of Quality	1. Could the proposal impact on the CCGs compliance around the NHS Constitution?	None	All procedures listed in the policy remain available through IFR and the IFR policy is compliant with the NHS constitution, in particular: **1. The NHS provides a comprehensive service, available to all –** IFRs remove all reference to protected characteristics, except when they are fundamental to the treatment being requested. **2. Access to NHS services is based on clinical need, not an individual's ability to pay –** the policy review has upheld the national evidenced based interventions (EBI) ethos of selecting criteria based on where treatment will have the greatest impact on the patient's clinical need.	Insignificant	Rare	1

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			3. The NHS aspires to the highest standards of excellence and professionalism – safety and clinical effectiveness are core principles in IFR decision making. Bringing the four policies together (WELC POLCV, BHR POLCE, National EBI and London Choosing Wisely) will ensure patient equality, providers will be able to apply the same funding criteria and that commissioners will be able to focus on high quality care that is safe, effective and focused on patient experience in their commissioning decisions. **4. The patient will be at the heart of everything the NHS does –** Funding decisions are made based on each patient's clinical need. **5. The NHS works across organisational boundaries –** the new policy will allow integrated care systems and organisations to work together to deliver services for all patients. **6. The NHS is committed to providing best value for taxpayers' money –** the policy update has also focused on using financial resources in the most effective, fair and sustainable way. **7. The NHS is accountable to the public, communities and patients that it serves –** All funding decisions will be made in a fair,			

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			consistent and transparent way. Where cases require IFR decisions this will be set out in full for clinicians to share with their patients. *https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england* The NHS Constitution sets out a right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible. Ensuring that only appropriate pathways and interventions are commissioned supports the prioritisation of resources to meet waiting times set out in the Constitution.			
Are Services Safe?	2. Could the proposal impact on patient safety?	Positive	The patient will receive the most clinically effective treatment. A reduction in non clinical evidence based interventions will result in improved patient safety.	Minor	Rare	2
	3. Could the proposal impact on safeguarding adults?	None	No impact	Insignificant	Rare	1
	4. Could the proposal impact on safeguarding children?	None	No impact	Insignificant	Rare	1

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
	5. What impact does the proposal have on compliance with existing governance, IT and safety processes and systems?	None	No impact	Insignificant	Rare	1
Are Services Effective?	6. What impact does the proposal have on relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	Positive	The new policy has been based on the latest evidence-based guidance available, and will bring outdated policies up to date. Based on National, London wide and local (BHR/WEL pre-existing evidence based standards)	Insignificant	Rare	1
	7. What impact will the proposal have on patient outcomes?	None	As the new policy has been based on the latest evidence-based guidance, patients will continue to receive the most clinically effective treatment within an evidence based pathway, ensuring that lower risk interventions are undertaken instead of/or prior to more invasive, higher risk interventions.	Minor	Rare	2

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
	8. Does the proposal have an impact on staff skills, knowledge or experience to deliver care?	Positive	During clinical review of policies GP's expressed that it was useful as a knowledge base having criteria listed for reference and useful for conversations with patients to refer to. The frequency of some procedures will be reduced e.g. Spinal injections, Providers will need to ensure that adequate opportunities for training are still provided in clinically appropriate circumstances.	Insignificant	Rare	1
	9. What impact does the proposal have on information needed to deliver effective care and treatment available to relevant staff in a timely and accessible way?	None	No change from current requirements	Insignificant	Rare	1
Are Services responsive to people's needs?	10. Based on information about the needs of the local population, what is the impact of how services are planned and delivered?	None	Trusts will continue to plan and deliver services as before i.e. seek approval for funding for treatments for patients that demonstrate exceptionality via IFR or seek approval of funding for treatment for patients that meet certain criteria via Prior Approval. This process will require trusts to deliver treatment in accordance with the new policy. See 'what is the change' section above for details. Adherence with the policy will be monitored via audit as and when required.	Moderate	Unlikely	6

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
	11. What is the impact for commissioners, relevant stakeholder and providers involved?	Positive	**Commissioner** The impact on commissioners is positive. The new policy will ensure the local population are accessing clinically effective care and that patients have access to all effective treatments via IFR or prior approval as appropriate. Resources should be focused on effective and appropriate treatments, the policy will ensure CCGs are funding appropriate care, ergo providing good value for money. There is a reputational risk for the CCGs that patients may view this as restricting access to healthcare. To mitigate this risk an extensive engagement exercise setting out the clinical evidence for these proposals will be carried out. **Stakeholders** The impact for patients is positive. The policy aims to reduce avoidable harm to patients. With surgical interventions, there is always a risk of complications arising. This policy will encourage conversations between clinicians and patients, helping them to weigh the risks and benefits of appropriate treatments together. The perception however by patients and stakeholders may be that this is about restricting access to healthcare. This will be mitigated through the Comms and Engagement Plan. Documents will be produced	Moderate	Likely	12

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			that set out in an easy to read format the proposals and the clinical evidence behind them. The clinicians involved in the development of this policy were very clear that this should not be about restricting access to procedures that have clinical value but it is about making sure that clinically appropriate pathways are followed and any savings realised through the changes to the policy will be available to reinvest in other areas of healthcare. This will create headroom for innovation, whether this be through service redesign, the commissioning of new services or the acceleration and adoption of new technology to help transform patient care. **Providers** The impact for providers is positive. The policy will help save precious professional time by ensuring a focus on clinically effective treatments. When the NHS is severely short of staff, as is the case currently, professionals should offer appropriate and effective treatment to patients. A single policy across North East London will also help minimise confusion for trusts about which policy to apply for which patients as all patients would be covered by one policy.			

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
	12. What impact does the proposal have on the needs of the population, flexibility, choice and continuity of care?	Negative	Continuity of care, flexibility and the ability of healthcare services to meet the needs of the population are not affected. Choice and continuity of care is unaffected as patients can still be referred to their provider of choice. Providers will however be required to adhere to the clinically evidence based policies wherever possible applying the national and London polices for the interventions, the risk of postcode lottery is minimised. All treatments are available via IFR which is compliant with the NHS constitution, provided exceptionality can be proven. For the new interventions being added to the policy and for those interventions where criteria has changed (see 'what is the change' section above) patients will need to meet funding criteria or prove exceptionality. It must be noted that proving exceptionality can be difficult. There is a risk that there will be the perception of limiting choice and access, however to mitigate this during the engagement exercise it will be emphasised that access to clinically effective treatment is not impacted.	Moderate	Likely	12

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
	13. Does the proposal impact on the appropriateness of facilities and premises to deliver care?	None	No impact.	Insignificant	Rare	1
	14. Does the proposal impact on people with complex needs? E.g. Learning disabilities	None	At the start of the policy it states that 'NEL CCGs have committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, NEL CCGs will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. The policy is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.' Cancer patients or those suspected of having cancer are excluded from this policy.	Minor	Unlikely	4
	15. Does the proposal impact on people's access to care and treatment at a time to suit them?	Negative	For interventions listed in the policy prior approval or IFR approval must be sought before treatment can be provided. **Mitigation**	Moderate	Likely	12

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			The turnaround times for prior approval process and IFR remain the same: • between 1 and 4.5 months for IFR requests for both BHR and WELC • one working day for BHR prior approval requests (as per SLA) • between 2 and 4 weeks for prior approval requests in WELC (if tick box forms not adopted) or 7 days for prior approval requests in WELC if tick box forms adopted and no additional investment made in IFR team capacity. The digital advancement of IFR processes will help mitigate any impact on waiting times and GDPR risks, by ensuring information only contained and shared via secure software and allows checks that only necessary information to support cases is uploaded. **BHR** By moving the IFR and Prior Approval application process online CCGs will have better compliance with GDPR. E.g. at present requests for funding and decisions are emailed, risk these can get sent to wrong account. If move online via existing BlueTeq software this risk is removed. The online			

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			system is also more efficient than the current process mentioned above. **WELC** By moving the IFR application process online CCGs will have better compliance with GDPR. E.g. at present requests for funding and decisions are emailed, risk these can get sent to wrong account. If move online via existing BlueTeq software this risk is removed. The online system is also more efficient than the current process mentioned above. By moving the current application process for treatments listed within the existing POLCE policy to a prior approval process in addition to the above benefits, clinicians will also reduce the amount of clinical information that they have to share with NEL CSU and the CCGs to gain a decision on funding. E.g. lots of supporting evidence is attached to emails at present, by having a tick box form this removes the need for this to be provided.			
Are Services Caring?	16. Does the proposal have an impact on self-reported patient experience?	Negative	It is possible that patients may view new policies as preventing access to interventions or treatments that they could have accessed before. **Mitigation** Engagement with the public about changes to policies. Be clear that the aim is not to prevent	Moderate	Likely	12

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
			patients accessing interventions or treatments. The aim is to ensure that health care being provided is clinically effective and in line with latest guidance. Any savings realised are merely freed up to be reinvested in other areas of the healthcare system to drive improvements. Ensures valuable clinician time is not lost conducting ineffective surgery. Promotes discussion between clinicians and patients.			
	17. What impact does the proposal have to empower and support people to manage their own health, care and wellbeing to maximise independence?	Positive	Many of the proposed policies include elements of self care for example weight management and physiotherapy prior to invasive surgery which will also improve outcomes of surgery. The policy will encourage discussions between patients and clinicians and allow appropriate management. This will be supported by the existing literature available to GPs and clinicians on the appropriate pathways for patients.	Insignificant	Rare	1
	18. What impact does the proposal have on patient choice?	None	Choice of provider is unaffected as patients can still be referred to their provider of choice. Providers will however be required to adhere to the clinically evidence based policies wherever possible applying the national and London polices for the interventions, the risk of postcode lottery is minimised.	Minor	Unlikely	4

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
Are Services Well-led?	19. What impact does the proposal have on effective governance framework to support the delivery of the strategy and good quality care?	None	No impact on existing governance arrangements	Insignificant	Rare	1
	20. What impact does the proposal have on staff roles and do they understand what they are accountable for?	Negative	Requires clinicians to seek prior approval or IFR approval before carrying out procedure. Ensures that treatment is clinically effective, will provide effective outcomes for patients and value for money for the NHS. Clinicians will be supported through the appropriate policy and supporting evidence. An easy reference guide will be made available to GPs. Any complaints can be directed through the CCG complaints procedure.	Minor	Possible	6
	21. What impact does the proposal have on service performance measures, which are reported and monitored?	Positive	From 1st April 2019, NHS England will be monitoring CCGs to see a reduction in the interventions within the National Evidence Based Interventions programme. By adopting this new policy, those interventions are included and this will support CCGs with performance in this area. As referenced earlier, this will also support the delivery of the 18 week referral to treatment standard	Minor	Rare	2
	22. What impact does the proposal have on leaders capacity, capability, and experience to lead effectively?	None	None	Insignificant	Rare	1

Domain	Impact Question	Impact	Rationale to impact	Risk Matrix		
				Severity	Likelihood	Score
Duty of Equality	23. Could the proposal impact on any of the following protected characteristics: ○ Age ○ Disability ○ Gender reassignment ○ Marriage and civil partnership ○ Pregnancy and maternity ○ Race ○ Religion and belief ○ Sex ○ Sexual orientation ○ Others (may not be regarded as protected group e.g. homeless people and new migrants).	Choose an item	See accompanying EQIA	Minor	Certain	10