Commissioning Policy

NHS Redditch and Bromsgrove Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Wyre Forest Clinical Commissioning Group

Surgical Management of Pelvic Organ Prolapse

November 2018

This policy applies to patients for whom the following Clinical Commissioning Groups are responsible:

- NHS South Worcestershire Clinical Commissioning Group (CCG)
- NHS Redditch & Bromsgrove Clinical Commissioning Group (CCG)
- NHS Wyre Forest Clinical Commissioning Group (CCG)

Collectively referred to as the Worcestershire CCGs

COMMISSIONING SUMMARY

Surgery for asymptomatic or mild pelvic organ prolapse is not commissioned by the Worcestershire CCGs.

Referral Criteria

Referral is appropriate for people with symptoms causing reduced quality of life or significant functional impairment that prevent the person from properly fulfilling work, domestic or carer activities or educational responsibilities, for whom conservative methods have failed. Including:

- pelvic floor muscle training for a minimum of 3 months
- topical vaginal oestrogen therapy, where clinically indicated
- specialist physiotherapy referral
- vaginal ring or other pessary, where clinically indicated and available

For people with BMI > 40 (> 45 if stress incontinence), there needs to be evidence of engagement with weight management strategies and exercise.

Direct referral, with or without a trial of conservative measures, may be appropriate for:

- Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven urinary tract infections and/or urinary or faecal incontinence

Surgical Criteria

The Commissioner **will fund** pelvic organ prolapse surgery when:

1. Following failure of conservative methods (as above, including failure of/declined vaginal ring or other pessary, where clinically indicated)

   WITH

   Symptoms causing reduced quality of life or significant functional impairment that prevent the person from properly fulfilling work, domestic or carer activities or educational responsibilities

OR

2. Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven urinary tract infections and/or urinary or faecal incontinence

Follow-Up Arrangements

All patients, who receive an intervention in secondary care, will be reviewed at 6 months following discharge; this ensures recording of outcomes on the national database to ensure compliance with national recommendations for use of these interventions and accreditation of providers.

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Name of originator/author:	Chris Emerson, Specialist Adviser PMO
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Key individuals involved in developing the document:

Name	Designation	Version Reviewed
Mr Paul Moran	Consultant Gynaecologist	V1.0
Dr Louise Bramble	CCG Board Member	V1.0
Fiona Bates	CCG Medicines Commissioning and Public Health Support	V1.0

Circulated to the following individuals/groups for comments:

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Clinical Commissioning Policy Collaborative, which includes: GPs, Commissioners, Medicines Commissioning, Public Health, Patient and Public Representatives	12.06.2018 14.07.2018 14.08.2018 18.12.2018	V1.0
Clinical Innovation Group	13.12.2018	

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Version No	Type of Change	Date	Description of change
1.0	New Policy	December 2018	

Table of Contents

1. Definitions

1.1 **Pelvic Organ Prolapse (POP)** is defined as symptomatic descent of one or more of: anterior vaginal wall, posterior vaginal wall, cervix or uterus or apex of the vagina (vault or cuff).

1.2 **Mixed urinary incontinence** is involuntary urine leakage associated with both urgency and exertion, effort, sneezing or coughing.

1.3 **Overactive bladder** (OAB) is defined as a sensation of urgency to pass urine that occurs with or without urgency urinary incontinence and often with frequency and nocturia. OAB that occurs with incontinence is known as 'OAB wet'. OAB that occurs without incontinence is known as 'OAB dry'. These combinations of symptoms are suggestive of the urodynamic finding of detrusor over-activity, but can be the result of other forms of urethrovesical dysfunction.

1.4 **Stress urinary incontinence** is involuntary urine leakage on effort or exertion or on sneezing or coughing

1.5 **Urgency urinary incontinence** is involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to delay).

1.6 **Parous** - having given birth one or more times.

1.7 **Mesh** - describes a number of different types of manufactured biological or synthetic implantable devices. Mesh is used in a range of surgical procedures to support tissues. In obstetrics and gynaecology, mesh is one option for the treatment of stress urinary incontinence (SUI) and pelvic organ prolapse (POP).

1.8 **Exceptional clinical circumstances** are clinical circumstances pertaining to a particular patient, which can properly be described as exceptional, when compared to the clinical circumstances of other patients with the same clinical condition and at the same stage of development of that condition (i.e. similar patients). A patient with exceptional clinical circumstances will have clinical features or characteristics which differentiate that patient from other patients in that cohort and result in that patient being likely to obtain significantly greater clinical benefit (than those other patients) from the intervention for which funding is sought.

1.9 A **Similar Patient** is a patient who is likely to be in the same or similar clinical circumstances as the requesting patient and who could reasonably be expected to benefit from the requested treatment to the same or a similar degree. The existence of more than one similar patients indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.

1.10 An **individual funding request (IFR)** is a request received from a provider or a patient with explicit support from a clinician, which seeks exceptional funding for a single identified patient for a specific treatment.

1.11 An **in-year service development** is any aspect of healthcare, other than one which is the subject of a successful individual funding request, which the Commissioner agrees to fund outside of the annual commissioning round. Such unplanned investment decisions should only be made in exceptional circumstances because, unless they can be funded through disinvestment, they will have to be funded as a result of either delaying or aborting other planned developments.

2. Scope of policy

2.1 This policy is part of a suite of locally endorsed Commissioning Policies. Copies of these Commissioning Policies are available on the following website address: http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/

2.2 This policy applies to all patients for whom the Worcestershire CCGs have responsibility including:

- People provided with primary medical services by GP practices which are members of any one of the CCGs and
- People usually resident in any of the areas covered by the CCG's and not provided with primary medical services by any CCG.

2.3 This policy applies to people with pelvic organ prolapse who may need specialist clinical review.

2.4 Where a patient's clinical presentation does not clearly meet the requirements for secondary care management within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.

2.5 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for surgery or is not considered clinically suitable for surgery. Such patients should be discharged without surgery.

2.6 Any referral for consideration of treatment/intervention should be made on the appropriate electronic referral form where this is available.

2.7 For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has exceptional clinical circumstances, an Individual Funding Request may be submitted for consideration. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.

For a definition of the term "exceptional clinical circumstances", please refer to the Definitions section of this document.

3. Background

3.1. The NHS Constitution, which details the principles and values that guide the NHS, has been applied in the agreement of this policy.

3.2. NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group consider all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability except where a difference in the treatment options made available to patients is directly related a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment

3.3. **Pelvic organ prolapse** (POP) occurs when the group of muscles and tissues that normally support the pelvic organs, called the pelvic floor, becomes weakened and can't hold the

organs in place firmly. The pelvic floor can be weakened by a number of things which increases the chance of developing POP. This includes: pregnancy and childbirth, getting older and going through the menopause, being overweight or obese, having long-term constipation or a long-term condition that causes you to cough and strain, having a hysterectomy, a job that requires a lot of heavy lifting. Some health conditions can also make a prolapse more likely. Symptoms of POP include a feeling of heaviness in the pelvis, discomfort inside or protrusion from the vagina, a bulge or lump in or from the vagina, discomfort or numbness during sex and urinary incontinence.

3.4. There are a range of **interventions** that can help treat these symptoms which should be exhausted before more invasive options are considered; this includes:

- lifestyle changes – avoid heavy lifting, prevent/treat constipation, exercise
- weight loss, if obese
- topical oestrogen therapy – cream, pessary or ring
- supportive pessary
- pelvic floor exercises – muscle training for at least 3 months

Surgery such as anterior or posterior vaginal wall repair may be carried out as well as more specific surgical treatments for SUI (see section 5).

3.5. **Urinary incontinence** (UI) may occur as a result of a number of abnormalities of function of the lower urinary tract or as a result of other illnesses, which tend to cause leakage in different situations. There are different types of UI, and stress incontinence is one type of UI.

3.6. A Worcestershire pathway for primary care management of pelvic organ prolapse is available within the "Common Gynaecological Conditions Leading to Referral" document available via the following link:
http://www.worcestershire.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=157394

3.7. People should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Although the CCGs respect that autonomy and individual choice are important for the NHS and its users, they should not have the consequence of promoting the use of interventions that are not clinically and/or cost effective.

4. Relevant National Guidance and Facts

4.1 The National Institute for Health and Care Excellence (NICE) has produced guidance for "Urinary incontinence in women: management" (CG171) published in 2013 (updated 2015). A draft update (October 2018) to this guidance incorporates guidance on pelvic organ prolapse. These documents have been used to inform this policy.

4.2 Pelvic organ prolapse is common, occurring in 40-60% of parous women[3]. The exact incidence of genital prolapse may be difficult to determine, as many women do not seek medical advice.

- A woman's lifetime risk of surgery for pelvic organ prolapse is 12-19%[1].
- 1 in 12 women in the community in the UK report symptoms of pelvic organ prolapse[4].
- Prolapse is the most common reason postmenopausal women have a hysterectomy and it accounts for 15-18% of hysterectomies overall[1].
- Prolapse of the anterior vaginal wall is the most common type.

5. Types of Surgical Interventions

5.1 **Surgical Procedures for Pelvic Organ Prolapse**

The choice of surgery will be guided by the clinical presentation and preference of the individual, informed by a discussion regarding the risks and benefits of each procedure, risk of recurrent prolapse and nature of approach, vaginal, open or laparoscopic (key hole). The following types of surgery may be considered, and some may be undertaken together:

5.1.1 **Anterior and posterior repair** (colporrhaphy) are minimally invasive procedures used to correct pelvic organs that have dropped out of their normal positions. Anterior and/or posterior repair is used to tighten the support tissues that hold these organs in place, restoring their normal position and function.

- Anterior vaginal repair – vaginal approach to treat an anterior (front) vaginal wall prolapse also called a cystocoele. This involves repair of supporting tissues using dissolvable stitches and without the use of mesh (native tissue repair).
- A posterior vaginal repair – vaginal approach to treat a posterior (back) vaginal wall prolapse also called a rectocoele. It involves repair of supporting tissues using dissolvable stitches and without the use of mesh (native tissue repair); often combined with a repair of the area between the vagina and the back passage, the perineum (perineorrhaphy).

5.1.2 Surgery for **vault prolapse** (top of the vagina/front passage) may include:

- Sacrocolpopexy - an incisional operation to treat a prolapse in people who have had a hysterectomy (removal of womb) using a strip of synthetic mesh to lift the top of the vagina and hold it in place.
- Sacrospinous fixation - the top of the vagina is stitched to a ligament (sacrospinous ligament) at the back of the pelvis, so there are no cuts in the stomach. In most cases the stitch is placed through the ligament on the right side. Occasionally, if extra support is required, a stitch is placed through the left ligament as well.
- Iliococcygeus fixation – involves attachment of the prolapsed vaginal vault to the iliococcygeus fascia, which maintains the vaginal vault axis and preserves vaginal length. The iliococcygeus can be approached from an anterior or posterior vaginal incision; therefore concomitant anterior or posterior repair is easily facilitated.

5.1.3 **Uterine prolapse** surgery may include:

- Vaginal hysterectomy (only where no preference about preserving uterus), with or without sacrospinous fixation - an operation to remove the uterus (womb), including the cervix, through the vagina.
- Vaginal sacrospinous hysteropexy - treats a uterine prolapse without removing the uterus in people who do not wish to have a hysterectomy. The intervention, performed through the vagina, involves supporting the uterus using stitches to fix it to a strong ligament inside the pelvis; this is often performed at the same time as other prolapse operations such as anterior and posterior repair.
- Sacro-hysteropexy or Sacrocolpocervicopexy - an incisional operation involving suspension of the uterus or the cervix (after removing the body of uterus), by stitching one end of a strip of synthetic mesh to the back or around the lower part of the uterus/cervix with the other end being stitched or stapled (titanium staples) to a prominent part of the back bone (the sacral promontory) internally; this lifts the uterus/cervix and holds it in place.
- Manchester repair – a vaginal operation to support the body of the womb (uterus) by shortening the cervix (neck of womb) and conserving the body of the womb. This can be combined with a repair of the vaginal walls if these are prolapsing significantly.

5.1.4 Colpocleisis is a surgical procedure available for people with **vault or uterine prolapse** who do not intend to have penetrative vaginal sex and who have a physical condition that

may put them at operative and post-operative complications. The operation involves closure of the vagina (front passage) partly or completely.

5.2 **Surgical Procedures for Pelvic Organ Prolapse with Stress Incontinence:**
Where co-existing incontinence predominates less invasive procedures should be considered before progressing to surgery (including medical management - see Area Prescribing Committee guidance "Overactive Bladder (OAB) Medicines Optimisation") http://www.southworcsccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=93619).

Some people with co-existing incontinence and pelvic organ prolapse may be offered concurrent surgery for stress urinary incontinence and prolapse. The following additional surgical interventions, for stress urinary incontinence, may be offered:

5.2.1 **Mid-urethral tapes or sling** (MUS) involve the passage of a small strip of synthetic tape/mesh through the vagina under the urethra and then through either the retropubic (using retropubic tape TVT) or obturator space (using transobturator tape TOT), with entry or exit points at the lower abdomen or groin, respectively.

5.2.2 **Colposuspension** is an operation which involves lifting the tissues around the junction between the bladder neck and proximal urethra using permanent synthetic stitches.

5.2.3 **Autologous slings** work in a similar way to mid-urethral tape procedures; the main difference being that autologous slings do not use synthetic mesh, but instead uses fascia from the body to construct an autologous sling. The sling is placed under the urethra via the vagina and is then passed through the muscles of the abdominal wall and tightened to provide support.

Usually both colposuspension and autologous slings are more major surgical procedures with longer recovery times than MUS procedures.

5.2.4 **Injectable therapy using bulking agents** composed of substances that augment the urethral wall and increase urethral resistance to urinary flow. The injection of bulking agents to treat a dysfunctional urethra is a minimally invasive method of correcting intrinsic sphincteric deficiency that results in stress urinary incontinence.

5.3 **Vaginal Mesh (and synthetic tape)**
At the time of writing this policy vaginal mesh is subject to a high vigilance restriction period; this restriction only applies to procedures for stress urinary incontinence and vaginally inserted mesh for pelvic organ prolapse. When surgically treating people with pelvic organ prolapse, Providers are required to adhere to national guidance on the use of surgical mesh/tape; the following is an abridged version of the recommendations issued by the Mesh Pause Clinical Advisory Group that are relevant to this policy:

5.3.1 Restricted practice applies to:
- Insertion of synthetic tape as a surgical intervention in SUI
- Vaginally inserted synthetic mesh in the treatment for prolapse

This will cause a delay to some procedures or an alternative non-mesh procedure performed if appropriate. Non-surgical interventions should continue to be offered where possible. On occasions, these procedures may be considered necessary as they cannot be delayed or there is no reasonable alternative; high vigilance scrutiny criteria apply in these circumstances.

5.3.2 Mesh procedures excluded from the restriction but which are the subject of high vigilance scrutiny include:
- Abdominally-inserted mesh for prolapse (such as sacrocolpopexy and hysteropexy)

5.3.3 Alternative non-mesh procedures that are also subject to high vigilance scrutiny include:

- Colposuspension
- Fascial sling procedures
- Periurethral injectable treatments

This is necessary because of the change in practice created by the restriction on use of mesh related procedures, in order to mitigate any risks or new harm.

5.3.4 Biological mesh should not be used as an alternative to synthetic mesh for the treatment of SUI or vaginal prolapse as there is insufficient evidence to support its routine use.

5.3.5 High vigilance scrutiny, where recommended, should involve:

- Trust Medical Director accountability
- Process to ensure patient awareness, involvement and support (including new, waiting list and those who had previous mesh surgery)
- Multidisciplinary team process and agreement
- Assurance of surgeon competence
- Recording of every procedure on a speciality database
- Documented evidence, for each patient, of adherence to the high vigilance process

6. Patient Eligibility

6.1 Surgery for asymptomatic or mild pelvic organ prolapse is not commissioned by the Worcestershire CCGs.

6.2 **Referral Criteria** (see Appendix 1 for GP Referral form)
Referral is appropriate for people with symptoms causing reduced quality of life or significant functional impairment that prevent the person from properly fulfilling work, domestic or carer activities or educational responsibilities, for whom conservative methods have failed. Including:

- pelvic floor muscle training for a minimum of 3 months
- topical vaginal oestrogen therapy, where clinically indicated
- specialist physiotherapy referral
- vaginal ring or other pessary, where clinically indicated and available

For people with BMI > 40 (> 45 if stress incontinence), there needs to be evidence of engagement with weight management strategies and exercise.

Direct referral, with or without a trial of conservative measures, may be appropriate for:

- Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven urinary tract infections and/or urinary or faecal incontinence

6.3 Surgical Criteria
The Commissioner **will fund** pelvic organ prolapse surgery when:

1. Following failure of conservative methods (as above, including failure of/declined vaginal ring or other pessary, where clinically indicated)
   WITH
   Symptoms causing reduced quality of life or significant functional impairment that prevent the person from properly fulfilling work, domestic or carer activities or educational responsibilities

   OR
2. Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven urinary tract infections and/or urinary or faecal incontinence

A Blueteq proforma (Appendix 2) should be completed for all eligible patients that proceed to surgery for pelvic organ prolapse.

6.4 Follow-Up Arrangements

All patients, who receive an intervention in secondary care, will be reviewed at 6 months following discharge; this ensures recording of outcomes on the national database to ensure compliance with national recommendations for use of these interventions and accreditation of providers.

7. Procedure codes

Procedure codes relevant to this policy:

P181, P182, P188. P189. P211, P212, P213, P214, P215, P218, P219, P221, P222, P223, P228, P229, P231, P232, P233, P234, P235, P236. P237. P238, P239, P241, P242, P243, P244, P245, P246, P247, P248, P249, Q544, Q545

8. Supporting Documents

- NICE Clinical Guideline 171 Urinary Incontinence in Women: Management, Published 2013 and amended September 2015
- NICE draft guidance "urinary incontinence (update) and pelvic organ prolapse in women: management" October 2018.
- Worcestershire CCGs: Operational Policy for Individual Funding Requests
- Worcestershire CCGs: Prioritisation Framework for the Commissioning of Healthcare Services
- NHS England: Ethical Framework for Priority Setting Resource Allocation
- NHS Constitution, updated 27th July 2015
- Epidemiology of pelvic organ prolapse https://patient.info/doctor/genitourinary-prolapse-pro
- Royal College of Obstetricians and Gynaecologists: High vigilance restrictions on use of vaginal mesh https://www.rcog.org.uk/en/guidelines-research-services/patient-safety/mesh/ (Webpage incorporates all relevant advice and guidance issued by different authorative bodies)

Appendix 1

REFERRAL FORM FOR SPECIALIST ASSESSMENT OF PELVIC ORGAN PROLAPSE

PATIENT DETAILS

Date of Referral:		Date Referral Received:	
GP Practice:		Referring GP:	
Patient Initials:		Patient DoB:	
NHS Number:		Hospital Number (if known):	

POLICY STATEMENT – extract from full policy, which is accessible via this link

http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/?assetdet1029359=39308

Referral is appropriate for people with:

Indication for Referral

1. Symptoms causing reduced quality of life or significant functional impairment that prevent the person from properly fulfilling work, domestic or carer activities or educational responsibilities for whom conservative methods have failed. Including (please indicate): ☐

   - pelvic floor muscle training for a minimum of 3 months — Yes ☐ N/A ☐
   - topical vaginal oestrogen therapy where clinically indicated — Yes ☐ N/A ☐
   - specialist physiotherapy referral — Yes ☐ N/A ☐ Declined ☐
   - vaginal ring or other pessary, where clinically indicated — Yes ☐ N/A ☐ Declined ☐
   - where BMI >40 (>45 if stress incontinence) patient has engaged with weight management strategies and exercise — Yes ☐ BMI ≤ 40 ☐

Direct referral, with or without a trial of conservative measures (please indicate above if any of these have been attempted)**, may be appropriate for:**

2. Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven urinary tract infections and/or urinary or faecal incontinence ☐

Note: Surgery for asymptomatic or mild pelvic organ prolapse is not commissioned by Worcestershire CCGs.

EXAMINATION/PMH/DH/ALLERGIES

REFERRAL CRITERIA	
Are there any co-morbidities that need to be considered before surgery? (Please provide details)	Yes ☐ No ☐
Have relevant co-morbidities been optimised as far as possible and the patient is willing to consider surgery at the time of referral?	Yes ☐ No ☐

PATIENTS NOT MEETING THE POLICY

For patients who do not fall within the eligibility criteria set out in the policy but where there is demonstrable evidence that the patient has clinically exceptional circumstances, an Individual Funding Request may be considered. The referring clinician should consult the Commissioner's "Operational Policy for Individual Funding Requests" document for further guidance on this process.
http://www.redditchandbromsgroveccg.nhs.uk/strategies-policies-and-procedures/commissioning-ifr-policies-a-z/

Appendix 2

Blueteq Proforma

Prior Approval Form - Pelvic Organ Prolapse - Surgical Intervention			
APPLICANT DETAILS			
Clinician Making Request:		GMC Code:	*
Clinician First Name:	*	Clinician Title	
Clinician Surname:	*	Telephone:	*
Clinician Designation:	*		
Email (nhs.net):	*		
PATIENT DETAILS			
Patient Name:	**********	GP Practice Name:	
NHS Number:	**********	GP Practice Code:	
Hospital Number:		Patient DOB:	__/__/____
Patient Age:			

1. PATIENT ELIGIBILITY

Please confirm that the patient meets the requirements for pelvic organ prolapse surgery within the Worcestershire CCG Policy "Surgical Management of Pelvic Organ Prolapse"

( ) Yes ( ) No

* Required

2. CLINICAL INDICATION

Please confirm the indication for surgical intervention:

( ) Failure of conservative measures including failure of/declined vaginal ring/pessary where indicated AND symptoms causing reduced quality of life or significant functional impairment (as defined within the policy)

( ) Severe symptomatic prolapse (at or below vaginal introitus) with or without recurrent, proven UTI and/or urinary or faecal incontinence

* Required

3. PRIOR INTERVENTIONS

Please confirm which of the following conservative measures have been attempted and failed:

- ☐ Pelvic floor muscle training
- ☐ Specialist physiotherapy support
- ☐ Topical vaginal ostrogen therapy
- ☐ Topical vaginal oestrogen therapy contra-indicated or declined

Please confirm whether a vaginal ring or other pessary has been attempted:

- ☐ Failed attempt
- ☐ Clinically inappropriate
- ☐ Patient declined

Note: All these measures should have been attempted unless the patient has severe symptomatic prolapse (at or below vaginal introitus)

4. ADDITONAL REQUIREMENTS

Please provide the patients BMI: * Required

Where BMI is above 40 (or 45 if stress incontinence), please confirm that there has been engagament with weight management strategies and exercise Please Select

Note: Where the patient has stress incontinence and BMI between 40 and 45 please state this in the "other information" box; the form should then be submitted for review and approval.

ANY OTHER INFORMATION

Please input any additional information (Documents must be added from the patient notes)

SUBMISSION DECLARATION

I confirm that the above information is complete and accurately describes the patient's condition.

Submitting User * Submitting User Email *

Date *

3. Equality Impact Assessment

Organisation	NHS Redditch & Bromsgrove CCG, NHS South Worcestershire CCG, NHS Wyre Forest CCG		
Department	Contracting	Name of lead person	Chris Emerson
Piece of work being assessed	Surgical management of pelvic organ prolapse		
Aims of this piece of work	To provide guidance to patients and clinicians in both primary and secondary care on the medical/clinical requirements against which surgical management of pelvic organ prolapse will be funded on the NHS within Worcestershire		
Date of EIA	09/05/2018	Other partners/stakeholders involved	Clinical Commissioning Policy Collaborative
Who will be affected by this piece of work?	Patients, GPs and Consultants		

Single Equality Scheme Strand	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. Include consultation with service users wherever possible	**Is there likely to be a differential impact?** Yes, no, unknown
Gender	Surgical treatment for pelvic organ prolapse is an exclusively female condition. The CCG policy endorses the provision of NHS funded surgery based on the individual's case presentation.	No
Race	Compared with African-American women, Latina and white women have four to five times higher risk of symptomatic prolapse, and white women had 1.4-fold higher risk of objective prolapse with leading edge of prolapse at or beyond the hymen. The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so an individual's race should not be a factor in the decision making process or the application of the policy.	No
Disability	A disability may make the symptoms of pelvic organ prolapse more difficult to manage without treatment but the range of available treatments and likely effectiveness remain the same. The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so having a disability should not be a factor in the decision making process or the application of the policy	No
Religion/ belief	There is no evidence to confirm whether being part of a specific religion or belief system increases the risk of	No

	urinary incontinence or pelvic organ prolapse . The CCG policy endorses the provision of NHS funded surgery based on the individual's disease history, so an individual's beliefs should not be a factor in the decision making process or the application of the policy.	
Sexual orientation	There is no evidence to confirm whether an individual's sexual orientation increases the risk of urinary incontinence or pelvic organ prolapse The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so an individual's sexual orientation should not be a factor in the decision making process or the application of the policy	No
Age	Urinary incontinence is a common symptom that can affect women of all ages. However the risk of pelvic organ prolapse increases with age, and it's more common in women who've given birth vaginally. Some women may have a genetic predisposition to the condition. The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so an individual's age should not be a factor in the decision making process or the application of the policy.	No
Social deprivation	There is no evidence to confirm whether there is a link between social deprivation and an increased risk of urinary incontinence / vaginal prolapse The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so their social deprivation should not be a factor in the decision making process or the application of the policy.	No
Carers	There is no evidence to confirm whether being a carer increases the risk of urinary incontinence / pelvic organl prolapse The CCG policy endorses the provision of NHS funded surgery based on the individual's case history, so being a carer should not be a factor in the decision making process or the application of the policy.	No
Human rights	The CCG policy does not seek to impact on an individual's human rights.	No

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead
Not Applicable					