NHS
Suffolk and
North East Essex
Integrated Care Board

# Suffolk and North East Essex ICB Clinical Priorities Policy

**NOT YET ALIGNED**

Updated Document: June 2026

**The Following policies are harmonised or retired:**

Acne Vulgaris - Retired ( within Benign Skin Lesions policy)
Abdominoplasty - retired (within Body Contouring policy )
Arthroscopic Shoulder Decompression for Subacromial Shoulder Pain
Benign Skin Lesions
Blepharoplasty
Body Contouring
Bone healing ultrasound system - EXOGEN
Breast Implants - Surgery to remove or replace
Breast Reduction
Breast surgery (excluding cancer-related surgery)
Carpal Tunnel Syndrome Surgery
Cataract Surgery
Chalazia Removal
Complementary and Alternative Therapies
Cosmetic Interventions: General Principles - retired
Cryopreservation of Sperm, Oocytes and Embryos
Dilatation and curettage (D&C) for heavy menstrual bleeding
Diagnostic Medial Branch Block +/- Radiofrequency Denervation (within Facet Joint Policy )
Diagnostic Sacroiliac Joint Injection, +/- Radiofrequency Denervation of the Sacroiliac Joint
Dupuytren's Contracture
Dysthyroid Eye Disease
Ear Lobe Repair
Epiphora
Face Lift
Female Sterilisation
Fenton's Procedure - Retired
Functional Electrical Stimulation
Ganglion Excision
Grommets for Otitis Media with Effusion in Children
Gynaecomastia Surgery - (retired within breast policy)
Haemorrhoids – Surgical Treatment
Hallux Valgus (Bunions) or Hallux Rigidus Surgery
Hernias - Surgical Repair Elective
Hip Arthroscopy
Hip Injections ( within policy Corticosteroid injections for Chronic Hip pain) Hip Resurfacing
Hysterectomy for Heavy Menstrual Bleeding Interim
Knee Arthroscopy for conditions other than OA
Knee Arthroscopy for patients with OA
Labiaplasty and Vaginoplasty - retired ( within body contouring policy)
Lymphoedema Services
Male Circumcision
Misophonia
Nasal Surgery including Septorhinoplasty and Rhinoplasty
Nipple Inversion - retired( within breast policy)
Pinnaplasty in Children
Reversal of Sterilisation
Rhinophyma

Spinal Surgery for Non-Acute Lumbar Conditions - retired ( within Surgical Discectomy
Temporomandibular Joint Replacement
Temporomandibular Joint Retainers and Appliances
Therapeutic Spinal Injection for Non-Specific Low Back Pain without Radiculopathy ( within Facet Joint Policy )
Tattoo Removal ( Within Benign Skin Lesions Policy)
Therapeutic Epidural Injection or Nerve Root Block for Radicular Pain (Sciatica) ( within Epidural Steroid Injection Policy )
Tinnitus
Tonsillectomy
Trigger Finger - Surgical Release
Urinary Incontinence and Symptomatic Pelvic Organ Prolapse in Secondary Care (Treatment of Female) - Retired (within Female Genital Prolapse Policy)
Uterine Artery Embolisation - Retired
Varicose Vein Interventions
Vasectomy under General Anaesthetic
Vision Therapy and Related Interventions, Coloured Filters and Tinted Lenses
Weight Management and Smoking Cessation Prior to Elective Surgery - Retired
Wide Bore and Open/Upright MRI
Wireless Capsule Endoscopy and Double Balloon Enteroscopy - Retired

**Current policies awaiting harmonisation or retirement**

Ear Wax Removal in Secondary Care
Hip Replacement
Interim Complex Obesity Service
Knee Replacement
Shoulder Arthroscopy for conditions other than pure Subacromial Shoulder Impingement Specialist
Fertility Services including Assisted Conception
Standing Frames (Bespoke)
Subfertility Investigation and Treatment in Secondary Care

Statement of Overarching Principles

All Policies, Procedures, Guidelines and Protocols of the SNEE ICB are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

## Executive Summary, Purpose and Definitions

This policy sets out the funding arrangements for treatments/ interventions/ procedures not currently included in commissioned established care pathways or identified for funding through the commissioning process and are not routinely funded.

This policy covers the following types of treatments/ interventions/ procedures:

**Threshold & Prior Approvals** – Those procedures which may be offered on a routine basis but only for patients who meet defined criteria agreed in a clinical protocol.

The responsibility for adherence to these policies lies with the referring and accepting clinicians and prior approval should be sought from the ICB (see below) where this is part of the contracting arrangements.

**Individual Funding Requests (IFR)** - Those procedures which are not routinely provided by the ICB and where provision is only possible on an individual patient basis.

For these procedures, the criteria listed form provide guidance to referring clinicians and the ICB commissioner. In instances in which eligibility is unclear the final decision is made through the application of the Exceptional Cases process.

**Exceptional Clinical Circumstances (ECC)** – These are procedures which are only funded in exceptional circumstances, (e.g. breast augmentation).

Applications for these procedures should be made to the Clinical Priorities Team and should only be made where the patient demonstrates exceptionality.

The Exceptional Clinical Process cannot be offered where legal restrictions apply (e.g. Surrogacy).

Principles

Please read before making any referral.

In line with national health promotion messages and the Heath Education England messages in making every contact count the ICB policy is to promote the message that individuals can make changes to their own lifestyle which will significantly reduce the risk of ill health in the long and short term not just in relation to a referral for any elective treatments. We therefore actively encourage the promotion of stop smoking services, weight management opportunities and alcohol support services as part of all contacts for primary and secondary health services. Please refer to the Weight Management and Smoking Cessation Prior to Elective Surgery Policy.

General

The use of scoring tools prior to referral should be undertaken as a guide only however we request that the tool accompany referrals as part of a holistic understanding of the patient's symptoms and impacts on the activities of daily living.

All patients being considered for joint replacement must be offered at least the core treatments for osteoarthritis (as per NICE guidance see recommendation 1.2.5), and give them information about:

- the benefits and risks of surgery and the potential consequences of not having surgery

- recovery and rehabilitation after surgery
- how having a prosthesis might affect them
- an understanding of how care pathways are organised locally to support their recovery

Please be advised that revision/cosmetic surgery will not be funded for purely aesthetic reasons or for predictable changes following pregnancy, including revisions following surgery as the result of pregnancy. Please refer to the "**Cosmetic Interventions: General Principles**" Commissioning Statement within this Policy Document. on the SNEE ICB website. Applications for these procedures should be made to the Exceptional Clinical Case Team and should only be made where the patient demonstrates exceptionality.

## Ear Wax Removal in Secondary Care

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Ear Wax Removal in Secondary Care |
| Policy type | Threshold |
| Included intervention(s) | Ear wax removal in secondary care |
| Included indication/ condition(s) | Impacted ear wax |
| Date produced | January 2021 |
| Planned review date | July 2027 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T52: Ear wax removal in secondary care |
| NEE CCG policy | Microsuction/ ear wax removal |

**Interventions covered by this policy**

Referral to secondary care for removal of ear wax.

**Conditions to be considered for treatment under this policy**

Earwax is a normally-occurring substance made up of dead cells, hair, external material such as dust, and cerumen wax. In some people earwax can become impacted and cause problems including pain, loss of hearing, itching, tinnitus and vertigo.

**Eligibility criteria for provision of the intervention**

Patients with impacted earwax giving rise to symptoms may be referred for removal in secondary care if they meet either of the following criteria:

- Irrigation or microsuction has been attempted twice (after the use of ear drops) but has not been successful
  OR
- Irrigation is not clinically appropriate for this patient for one of the following reasons:
  - The person has (or is suspected to have) a chronic perforation of the tympanic membrane.
  - There is a past history of ear surgery.
  - There is a foreign body, including vegetable matter, in the ear canal.
  - There is a visible tympanic membrane perforation
  - Ear drops have been unsuccessful and irrigation is contraindicated because the patient has one of the conditions listed below:
    - A history of any previous problem with irrigation (pain, perforation, severe vertigo).
    - Current perforation of the tympanic membrane.
    - A history of perforation of the tympanic membrane in the last 12 months.
    - Grommets in place.
    - A history of any ear surgery (except extruded grommets within the last 18 months, with subsequent discharge from an Ear Nose and Throat department).
    - A mucus discharge from the ear (which may indicate an undiagnosed perforation) within the past 12 months.
    - A history of a middle ear infection in the previous 6 weeks.
    - Cleft palate, whether repaired or not.
    - Current symptoms of acute otitis externa with an oedematous ear canal and painful pinna.
    - Hearing in only one ear if it is the ear to be treated, as there is a remote chance that irrigation could cause permanent deafness.

- Confusion or agitation, as they may be unable to sit still.
- Inability to cooperate, for example young children and some people with learning difficulties.

NOTE: urgent advice from an ENT specialist should be sought if:

- Infection is present and the external canal needs to be cleared of wax, debris, and discharge
- The patient experiences severe pain, deafness, or vertigo occur during or after irrigation.

**Exclusions**

None

**Additional notes**

Removal of ear wax by irrigation after the use of ear drops can usually be carried out in primary care or a community setting (including non-NHS provision), but in some cases this is unsuccessful or contraindicated. Self-care should be the first line of treatment and the need for irrigation may be avoided by the use of drops. Occasional complications of irrigation include otitis externa, perforation of the tympanic membrane, damage to the external auditory meatus, pain, vertigo and nausea, and otitis media due to water entering the middle ear when there is a previous perforation. Procedures for removal in secondary care include microsuction and removal under direct vision.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for ear wax removal in secondary care.

**Compliance with NICE guidance**

There is no relevant NICE guidance.

**References**

*References included in original Suffolk / North East Essex policy / policies.*


- NICE Clinical Knowledge Summary. Scenario: Management of earwax. May 2012. Available athttp://cks.nice.org.uk/earwax#!scenario
- NICE Clinical Knowledge Summary. Scenario: Ear irrigation http://cks.nice.org.uk/earwax#!scenariorecommendation:5


*Additional guidance referred to in production of ICS policy.*


- National Institute for Health and Care Excellence, 2016. Clinical Knowledge Summary: Earwax. https://cks.nice.org.uk/earwax

## Hip Replacement

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Hip Replacement |
| Policy type | Threshold |
| Included intervention(s) | Hip replacement surgery |
| Included condition/ indication(s) | Osteoarthritis of the hip |
| Date produced | January 2021 |
| Planned review date | July 2025 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T18a: Hip replacement |
| NEE CCG policy | Hip replacement |

**Interventions covered by this policy**

Hip replacement surgery

**Conditions to be considered for treatment under this policy**

Osteoarthritis of the hip

**Eligibility criteria for provision of the intervention**

Patients should only be referred for consideration of hip replacement surgery for osteoarthritis if:

- They experience joint symptoms that have a substantial impact on their quality of life, as demonstrated by:
  - Intense to severe persistent pain (defined in Appendix Table 1) leading to severe functional limitation (defined in Appendix Table 2) for a period of at least 3 months

    OR
  - moderate to severe functional limitation (defined in Appendix Table 2) affecting quality of life (in the opinion of the clinician(s) on the local SNEE ICB Hip Pathway) for a period of at least 3 months

AND

- they have completed 'Stage 2 – Preparation for Surgery' of the local SNEE ICB Hip pathway

AND

- they have completed all the following core treatments:
  - Patient education: such as elimination of damaging influence on hips, activity modification (avoid impact and excessive exercise), good shock-absorbing shoes and lifestyle adjustment for at least 3 months

  AND
  - Activity and exercise: e.g. physiotherapy for at least 3 months

  AND
  - They have a BMI ≤35kg/m$^2$ (*see below)

  OR

  They have a BMI>35kg/m$^2$ and have evidence of participating in a weight management programme in line with Policy 'Weight management and smoking cessation prior to elective surgery'.

  AND
  - they have trialled appropriate pain relief for a minimum of 3 weeks: paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered first, Other treatment options, depending on response and the

consideration of possible side-effects, may include oral NSAIDs, COX-2 inhibitors or opioids.

AND

- if the patient currently smokes they should have been offered advice and support to help stop smoking as an opt-out, in line with Policy 'Weight management and smoking cessation prior to elective surgery'

* Patients whose BMI is >30 but ≤35kg/m$^2$ should be advised that there is evidence that the outcomes of joint replacement surgery are better in people whose BMI is ≤30, and be offered support to lose weight.

Clinical exceptions to this policy (patients who are not required to meet the above criteria) are:

- □ Patients whose pain is so severe and/or mobility is so compromised that they are in immediate danger of losing their independence, and joint replacement would help prevent this.
- □ Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

*Second joint replacement*

If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

**Exclusions**

This policy does not apply to:

- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.
- □ Patients with a recent history of trauma or an injury
- □ Patients for whom hip replacement is being considered for indications other than osteoarthritis

**Additional notes**

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for hip replacement.

**Compliance with NICE guidance**

This policy complies with relevant NICE guidance, except with respect to the following: NICE Clinical Guideline 177 recommends that 'Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. However, in acknowledgement of the evidence of increased risk of post-operative complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review, and some of which was published since NICE completed their review (Pozzobon et al, 2019)) and with metabolic syndrome (Glance et al, 2010), and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

## References

*References included in original Suffolk / North East Essex policy / policies.*


- Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54.
- Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502.
- The International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2006. http://www.idf.org/webdata/docs/MetS_def_update2006.pdf.
- National Institute for Health and Care Excellence. Osteoarthritis: Care and management in adults (NICE CG177). 2014. https://www.nice.org.uk/guidance/cg177/evidence/full-guideline-191761309.
- National Institute for Health and Care Excellence. Osteoarthritis (NICE QS87). 2015. https://www.nice.org.uk/guidance/qs87.
- British Orthopaedic Association, Royal College of Surgeons, British Hip Society. *Commissioning Guide: Pain Arising from the Hip in Adults*. 2013. http://www.boa.ac.uk/pro-practice/pain-arising-from-the-hip-in-adults-commissioning-guide/.
- Glance L, Wissler R, Mukamel D, et al. Perioperative outcomes among patients with the modified metabolic syndrome who are undergoing noncardiac surgery. *Anesthesiology*. 2010;113(4):859-872.


*Additional guidance referred to in production of ICS policy.*


- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: pain arising from the hip in adults. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018;**8:**e017689. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf


## Appendix

*Table 1: Classification of Pain Level **

| Classification | Description |
|---|---|
| Slight | Sporadic pain. (May be daily but comes and goes 25% or less of one's day)<br>Pain when climbing/descending stairs.<br>Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house)<br>Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects. |
| Moderate | Occasional pain. (May be daily and occurs 50-75% of one's day)<br>Pain when walking on level surfaces (half an hour, or standing).<br>Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects. |
| Intense | Pain of almost continuous nature. (Occurs 75-100% of one's day)<br>Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance)<br>Continuous use of NSAIDs for treatment to take effect.<br>Requires the sporadic use of support systems (walking stick, crutches). |
| Severe | Continuous pain. (Occurs 100% of the time)<br>Pain when resting.<br>Daily activities significantly limited constantly. (Requires assistance to |

| | |
|---|---|
| Severe cont. | maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response. Requires more constant use of support systems (walking stick, crutches). |

*Based on: Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54

*Table 2: Classification of Functional Limitations***

| **Classification** | **Description** |
|---|---|
| Minor | Functional capacity adequate to conduct normal activities and self-care.<br>Walking capacity of more than one hour.<br>No aids needed. |
| Moderate | Functional capacity adequate to perform only a few of the normal activities and self-care.<br>Walking capacity of between half and one hour.<br>Aids such as a cane are needed occasionally. |
| Severe | Largely or wholly incapacitated.<br>Walking capacity of less than half an hour.<br>Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required. |

**Based on: Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502

## Interim Complex Obesity Service

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Interim Complex Obesity Service Policy |
| Policy type | Threshold |
| Included intervention(s) | Weight management interventions |
| Included indication/ condition(s) | Management of obesity. |
| Date produced | December 2025 |
| Planned review date | December 2026 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | NA |
| NEE CCG policy | NA |

**Interventions covered by this policy**

Referral to the Complex Obesity Service provides access to a comprehensive care pathway, including:

- Specialist dietary advice
- Multidisciplinary team (MDT) support
- Clinical assessment and preparation
- Access to both medical and surgical treatment options, where patients are eligible and prioritised.
    - Where these treatment options are initiated, patients will be enrolled in long-term outcome monitoring to evaluate effectiveness, ensure safety, and support ongoing care planning.

The pathway includes:

- □ Initial desktop triage to determine eligibility for entry into the service
- □ Assessment period involving tailored and specialist dietary support and MDT input
- □ Access to NICE-approved pharmacological treatments where clinically appropriate, including:
    - Wegovy® (semaglutide) (TA875)
    - Mounjaro® (tirzepatide) (TA1026)
- □ Consideration for bariatric surgery, where clinically appropriate.

All professional and clinical weight management referrals for SNEE patients must be processed via the Weight Management and Complex Obesity Service Single Point of Access (WMCOS SPoA). There are no direct referral routes available into medical or surgical treatment options. NHS choice for access to bariatric surgery is incorporated into the pathway at the point of entry into the Complex Obesity Service and captured via the patient surveys as part of WMCOS SPoA. Agreeing entry into COS patient signs a disclaimer which indicates that they are aware that their choice under the NHS Choice Framework is exercised at the outset of the pathway and that they have opted for the ESNEFT COS.

**Conditions to be considered for treatment under this policy**

Obesity disease

**Eligibility criteria for provision of the interventions**

It's important to note that a referral does not guarantee entry into the service, all patients must

undergo clinical prioritisation via the WMCOS SPoA before accessing any obesity treatment options. Access is prioritised based primarily on clinical need, with those who have the greatest clinical need receiving priority for MDT assessment and treatment. This means that treatment is not necessarily given to the person who has waited the longest, but to the person who is clinically assessed as being most in need of that treatment.

The patient must meet the eligibility and prioritisation criteria of this access policy at the point of referral, triage and assessment to enter any service that treats obesity disease and be considered for any subsequent obesity treatments and service options. All referrals that meet the minimum entry requirement will be assessed for access via the WMCOS SPoA for all NHS funded obesity services.

The patient must meet the eligibility and prioritisation criteria at the point of referral, triage and assessment to enter the service and be considered for any subsequent complex obesity treatments options. All referrals that meet the minimum entry requirement will be assessed for access via the WMCOS SPoA.

All patients will undergo a clinical assessment prior to any obesity treatment options being considered. Patients must meet the treatment option eligibility criteria, and must be clinically suitable for treatment options, before they commence that treatment option.

Across all access criteria set out in this policy, please note a lower BMI threshold (reduced by 2.5 kg/m2) for people from South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds and people with a Mixed ethnic background*.

**Access to enter the Complex Obesity Service:**

The Complex Obesity Service supports access to intensive behavioural interventions, bariatric surgery, specialist psychological and dietetic support and the higher strength GLP-1 RAs treatment options, including Saxenda® (liraglutide), Wegovy® (semaglutide), and Mounjaro® (tirzepatide).
For all people requesting referral, clinicians should use shared decision making to determine with the individual that they feel ready to engage with the programme and would like to be referred at this time. Ability to adhere to weight loss programmes correlates with weight loss achieved. People living with obesity and medical conditions such as malabsorption syndrome or nutritional deficiencies from other causes should have access to dietary advice prior to weight management intervention to ensure that these are appropriately addressed prior to weight management intervention.
Currently, it is not possible to provide access to Complex Obesity Service for all eligible people in line with NG246. To address this, a joint position statement was developed by national clinical bodies, building on the 2023 guidance and incorporating more detailed prioritisation criteria and new therapies such as tirzepatide (Mounjaro®), approved under NICE TA1026. This policy supports a prioritisation framework approach to enabling prioritised access to Specialist Weight Management Services based on clinical need, in line with NHSE phased implementation guidance and the joint position statement ensuring those with the greatest need can access treatment first.
**Inclusions:**

Patients aged 18 and over who meet the criteria can be considered for referral to the Weight Management Complex Obesity Service (WMCOS).

**Please note:** Meeting the minimum criteria thresholds to be considered by the Complex Obesity Service does not guarantee treatment.

All referred patients will be assessed using the prioritisation framework outlined below. Only patients who are clinically prioritised through the scoring process will be approved to receive care via the Complex Obesity Service.

Key prioritisation factors include BMI, the impact of overweight and obesity on an individual's daily life, the presence of obesity-related complications, the length of time someone has been waiting (with

longer waits contributing to prioritisation), and any previous weight management interventions completed. An adjustment of 2.5 BMI units is applied for individuals from Black, Asian, and other ethnic minority backgrounds.

**Patients can be considered for access to the Complex Obesity Service if they have:**

- **BMI of ≥35 kg/m2** (reduced by 2.5 kg/m2 for people from Black, Asian and ethnic minority backgrounds and people with a Mixed ethnic background)

**OR**

□ **BMI between 30-34.9 kg/m$^2$** (reduced by 2.5 kg/m$^2$ for people from Black, Asian and ethnic minority backgrounds and people with a Mixed ethnic background) with at least 1 of the weight related complications listed below.

Prioritisation is based upon national policy and guidance, including 'A joint position statement by the Society for Endocrinology and Obesity Management Collaborative UK' and 'Proposed referral criteria for Specialist Weight Management'; providing a nationally endorsed, multidisciplinary consensus on prioritisation criteria for specialist weight management referrals – aiming to reduce variation and improve equity in service access across the system.

**Key Prioritisation Factors**

- □ Body Mass Index
- □ Obesity-related comorbidities, weighted by clinical severity and impact on health outcomes.
- □ Waiting time, with longer waits contributing to a higher prioritisation.
    - o If a patient doesn't yet meet the threshold for COS, they are placed in a "Waiting Well" group - with ongoing monitoring until they are prioritised.
- □ Previous weight management interventions, recognising prior engagement and readiness.
- □ Ethnicity adjustment, with a BMI reduction of 2.5 points applied for individuals from Black, Asian, and other ethnic minority backgrounds to account for differential risk profiles.

**Comorbidity Weighting Categories:**

**Priority 1 Conditions**

- □ Type 2 Diabetes Mellitus (T2DM)
- □ T2DM with complications (e.g. retinopathy, neuropathy, diabetic foot)
- □ Obstructive Sleep Apnoea (OSA)
- □ Obesity Hypoventilation Syndrome (OHS)
- □ Heart Failure
- □ Ischaemic Heart Disease (IHD)
- □ Myocardial Infarction (MI)
- □ Stroke (CVA)
- □ Metabolic Steatohepatitis (MASH)
- □ Metabolic Cirrhosis
- □ Infertility (weight loss required for assisted conception in women only where under the care of a fertility service via a consultant-to-consultant referral).

- □ Obesity-related Cancer

**Priority 2 Conditions**

- □ Pre-diabetes
- □ Hypertension (HTN)
- □ Hyperlipidaemia
- □ Peripheral Vascular Disease (PVD)
- □ Metabolic Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD)
- Chronic Kidney Disease (CKD stages 3–5)
- □ Lymphoedema
- □ Intracranial Hypertension (IIH)
- □ Abdominal wall failure / hernia (BMI-related)
- □ Surgery preclusion due to BMI >35

**Priority 3 Conditions**

- □ Asthma
- □ Atrial Fibrillation (AF)
- □ Polycystic Ovary Syndrome (PCOS)
- □ Gastro-oesophageal Reflux Disease (GORD)
- □ Osteoarthritis (OA)

All eligible patients will undergo the process of clinical prioritisation to determine the level of clinical need and to ensure that those with the most urgent or complex needs are seen first. This is overarching of all clinical assessments and treatment options available under this policy. This approach ensures all nationally and internationally recognised obesity-related complications are considered, enabling clinically robust, equitable, and inclusive prioritisation for treatment.
Those who are prioritised into the service will all receive a clinical assessment, specialist dietary advice and MDT support, the maximum duration this is offered to a patient without onward triage into obesity management medications and/or surgical treatment is 12-months.

**Obesity Management Medication access within Complex Obesity Service**

**Access to Wegovy® treatment option:**

In line with NICE TA 875 Weogyv® can only be prescribed within specialist services wit comprehensive management and oversight via an MDT. Therefore, patients can only be considered for this treatment option if they satisfy all below eligibility criteria:

- □ Be prioritised for (in line with section Access to enter the Complex Obesity Service prioritisation framework) and actively engaged in the Complex Obesity Service, which includes:
  - o A reduced-calorie diet
  - o Increased physical activity
  - o Behavioural support
  - o MDT input and assessment

- Have a BMI of ≥30 kg/m² with at least one qualifying obesity disease complication, set out in section 3.1 of this policy
- □ Treatment must be discontinued if <5% weight loss is achieved after 6 months, following individual patient review
- □ Maximum treatment duration is 2 years, in line with NICE TA875.

Each patient will undergo an individual assessment to determine the appropriate duration of Wegovy® treatment for overweight or obesity. Outcomes will be reviewed at 6 and 12 months to guide ongoing prescribing decisions.

**Access to Mounjaro® treatment option:**

In line with NICE TA 1026 Mounjaro® can only be prescribed by the Complex Obesity Service, either via the core service or via the primary care setting Community Outreach.

Mounjaro® cannot be initiated or prescribed by GPs in Suffolk and North East Essex for overweight and obesity. Mounjaro® will only be made available to those who meet the NHS England 'priority cohort' groups in Community Outreach settings, details set out in section Access to Bariatric Surgery section of the policy.

Patients can only access this treatment option within their core service if they satisfy all below eligibility criteria:

- □ Be prioritised for (in line with section Access to enter the Complex Obesity Service prioritisation framework) and actively engaged in the Complex Obesity Service, which includes:
  - o A reduced-calorie diet
  - o Increased physical activity
  - o Behavioural support
  - o MDT input and assessment
- Patients must have a BMI of ≥35 kg/m² with at least one qualifying obesity disease complication, set out in section 3.1 of this policy.
- Each patient will receive individual assessments to determine the appropriate duration of Mounjaro® treatment for overweight or obesity. Outcomes will be clinically reviewed, with the option to extend treatment based on ongoing assessments.

**Access to bariatric surgery treatment option**

Eligibility criteria for provision of the intervention bariatric surgery will only be considered as a treatment option for people with obesity disease if they meet all the following criteria:

- □ Be prioritised for (in line with section Access to enter the Complex Obesity Service prioritisation framework) and actively engaged in the Complex Obesity Service, which includes:
  - o A reduced-calorie diet
  - o Increased physical activity
  - o Behavioural support
  - o MDT input and assessment

**AND**

- BMI ≥40kg/m2

**OR**

- BMI ≥35kg/m2 **AND** at least one obesity related complication that would be improved by weight loss (obesity related complications set out in section Access to enter the Complex Obesity Service

The following two groups, may be expedited for assessment for bariatric surgery:

- BMI >50kg/m2
- BMI ≥30kg/m2 and have Type 2 diabetes diagnosed in the last ten years

**Access to the Complex Obesity Service Community Outreach Service**

To be considered for obesity management medications within primary care settings, patients must fall within NHS England's defined priority cohorts and be prioritised for treatment within the Complex Obesity Service (in line with section Access to enter the Complex Obesity Service prioritisation framework). Access is enabled through this framework, with those identified as having the greatest clinical need receiving priority for treatment. Meeting the criteria does not guarantee immediate access nor a particular treatment option. All eligible patients will undergo a process of clinical prioritisation to determine the level of clinical need and to ensure that those with the most urgent or complex needs are seen first.

| **nding Variation Year** | **timated Cohort Duration** | **horts** | **alifying Obesity Disease Complications**** | **I** |
|---|---|---|---|---|
| ar 1 (2025/26) | months | hort 1 | 'qualifying' obesity disease complications<br>• hypertension<br>• dyslipidaemia<br>• obstructive sleep apnoea<br>• cardiovascular disease<br>• type 2 diabetes mellitus | 0 |
| ar 2 (2026/27) | nonths | hort 2 | 'qualifying' obesity disease complications<br>• hypertension<br>• dyslipidaemia<br>• obstructive sleep apnoea<br>• cardiovascular disease<br>• type 2 diabetes mellitus | 5 – 39.9 |
| ar 3 (2026 and 2027/28) | months | hort 3 | qualifying' obesity disease complications<br>• hypertension,<br>• dyslipidaemia,<br>• obstructive sleep apnoea,<br>• cardiovascular disease,<br>• type 2 diabetes mellitus | 0 |

*Funding Variation year refers to the financial year.
** Definition of each of the qualifying obesity disease complications can be found in the NHS England Interim Commissioning Guidance, page 8.

- In the Community Outreach service, each patient will receive individual assessments to determine the duration of Mounjaro® prescribing for overweight and obesity. Patient outcomes will be reviewed at 6 and 12 months, with continuation to 18 and 24 months in exceptional circumstances, supported by structured clinical reviews.

**Exclusions this policy does not cover:**

**All treatment options** covered by this policy exclude:

- Children and young people (aged below 18 years)
- Patients not registered with a SNEE practice.

- Patients who do not meet the clinical access policy, unless proven clinically exceptional to the policy.
- Patients who have been previously referred into the service and have left the pathway early or have disengaged from the services, who are seeking to re-enter as a re-referral within a 12-month period.
- Pregnant women
- Those diagnosed with active substance abuse
- Self-harm/suicidal behaviours within the last 12 months.
- Severe cognitive impairment/uncontrolled mental health/personality disorders
- Diagnosed eating disorder - active and/or no previous interventions in eating disorder service.

**Exclusions for Obesity Management Medications:**

**Exclusions for Wegovy®:**

- Wegovy® will not be offered to patients with a BMI below 35 kg/m², even if they meet national criteria, as they do not meet the local access threshold for the Complex Obesity Service. Wegovy® cannot be prescribed without the Complex Obesity Service management and oversight in Suffolk and north east Essex.
- Wegovy® will not be offered to patients who meet or exceed the BMI threshold but do not have any qualifying obesity disease complications, as this group does not meet the eligibility requirements set out in NICE TA875.

□ History of type 1 diabetes.

□ Uncontrolled type 2 diabetes.

□ History or presence of chronic pancreatitis or previous acute pancreatitis (unless MDT decision that cause of pancreatitis, e.g. gallstones, has been fully treated).

□ History or presence of medullary thyroid cancer (unless MDT decision that benefits outweigh risks).

□ History or presence of multiple endocrine neoplasia.

□ Pregnant, attempting pregnancy or breastfeeding

□ TSH >6.0 mIU $l^{-1}$ or <0.4 mIU $l^{-1}$

**Exclusions for Mounjaro®:**

□ History or presence of chronic pancreatitis or previous acute pancreatitis (unless MDT decision that cause of pancreatitis, e.g. gallstones, has been fully treated).

□ History or presence of medullary thyroid cancer (unless MDT decision that benefits outweigh risks).

□ History or presence of multiple endocrine neoplasia.

□ Pregnant, attempting pregnancy or breastfeeding

□ TSH >6.0 mIU $l^{-1}$ or <0.4 mIU $l^{-1}$

**Exclusions for surgical intervention:**

□ Those who have accessed bariatric surgery privately or abroad will not be supported by this service within 5 years of the date of surgery unless presenting as an emergency.

**Additional Notes:**

- All referrals for interventions which are primarily to improve the appearance should refer to Commissioning statement 'Cosmetic interventions: general principles'.

- □ Please refer to the Policy within this document that covers body contouring procedures.
    - o Body contouring procedures are not routinely funded by the NHS. Patients who experience significant weight loss may develop excess skin; however, such procedures to address this are generally considered non-essential and are therefore not typically commissioned.
- Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for complex obesity treatments – specialist dietary advice, MDT support, obesity management medications and bariatric surgery.
- □ The service is led by a professional with a specialist interest in obesity and includes bariatric surgeons, bariatric physicians, specialist bariatric dieticians, nurses, psychologists and physical exercise therapist, all of whom must also have a specialist interest in obesity.
- □ Infertility linked to weight-related issues is currently under consideration as an additional complication. The policy may be updated to reflect this in future.
- *The term *'people with a Mixed ethnic background'* is the recommended wording according to the Writing about ethnicity - GOV.UK on writing about ethnicity.

**Compliance with NICE guidance**

This policy is aligned with NICE guidance on weight management and obesity.
**References:**


- □ **NICE NG246: Overweight and obesity management - Referring adults to specialist services**
- □ Guidance for the phased introduction of new medical therapies for weight management: A joint position statement by the **Society for Endocrinology and Obesity Management Collaborative UK (Dec 2023)** https://www.omc-uk.org/sites/default/files/2024-01/2023-12-Joint-Position-Statement-on-Medical-Therapies-for-Obesity.pdf

  Revised guidance for the Proposed Referral Criteria for Specialist Weight Management Services in England: **A joint position statement by the Society for Endocrinology and Obesity Management Collaborative UK (June 2025)** proposed-referral-criteria-for-specialist-weight-management-services-in-england-june-2025.pdf
- □ People with SMI, and people with LD, are at particularly high risk for cardiometabolic disease and premature mortality, and for this reason, should be considered as having greater priority and fall into the phase above where they meet the eligibility criteria.
- *NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)*
- *Premature mortality in adults with severe mental illness (SMI) -GOV.UK*

- NHS England Interim Commissioning Guidance,: Implementation of the NICE Technology Appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity.
- National Institute of Health and Care Excellence, Technology Appraisal 875 (Wegovy®)
- National Institute of Health and Care Excellence, Technology Appraisal 1026 (Mounjaro®)
- Writing about ethnicity - GOV.UK: We have referred to the GOV.UK guidance on writing about ethnicity, which recommends using the phrase "people with a Mixed ethnic background" as the appropriate wording.

## Knee Replacement

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Knee Replacement |
| Policy type | Threshold |
| Included intervention(s) | Knee replacement surgery |
| Included condition/ indication(s) | N/A |
| Date produced | January 2021 |
| Planned review date | July 2025 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T18b: Knee replacement<br>PE118: Patella resurfacing as part of primary total knee replacement |
| NEE CCG policy | Knee replacement |

**Interventions covered by this policy**

Knee replacement surgery

**Conditions to be considered for treatment under this policy**

Osteoarthritis of the knee

**Eligibility criteria for provision of the intervention**

Patients should only be referred for consideration of knee replacement surgery for osteoarthritis if:

- They experience joint symptoms that have a substantial impact on their quality of life, as demonstrated by:
  - intense to severe persistent pain (defined in Appendix Table 1) leading to severe functional limitation (defined in Appendix Table 2) for a period of at least 3 months

    OR
  - moderate to severe functional limitation (defined in Appendix Table 2) affecting quality of life (in the opinion of the clinician(s) on the local SNEE ICB Hip Pathway) for a period of at least 3 months

AND

- they have completed 'Stage 2 – Preparation for Surgery' of the local SNEE ICB Knee pathway

AND

□ they have completed all the following core treatments:

  - ➢ Patient education: such as elimination of damaging influence on knees, activity modification (avoid impact and excessive exercise) and lifestyle adjustment for at least 3 months

  AND

  - ➢ They have received at least one additional non-operative therapy: e.g. manual therapy (e.g. physiotherapy), supports and braces, shock absorbing shoes or insoles, local heat and cold therapy. Intra-articular corticosteroid injections may also be provided (when facility is available in primary/intermediate care)

  AND

  - ➢ They have a BMI ≤35kg/m$^2$ (*see below)

  OR

  They have a BMI>35kg/m$^2$ and have evidence of participating in a weight management programme in line with Policy 'Weight management and smoking cessation prior to elective surgery'

  AND

  - ➢ they have trialled appropriate pain relief for a minimum of 3 weeks: paracetamol and/or topical non-steroidal anti-inflammatory drugs (NSAIDs) should be considered first, Other treatment options, depending on response and the consideration of possible side-effects, may include oral NSAIDs, COX-2 inhibitors or opioids.

  AND

  - ➢ if the patient currently smokes they should have been offered advice and support to help stop smoking as an opt-out, in line with Policy 'Weight management and smoking cessation prior to elective surgery'

* Patients whose BMI is >30 but ≤35kg/m$^2$ should be advised that there is evidence that the outcomes of joint replacement surgery are better in people whose BMI is ≤30, and be offered support to lose weight.

Clinical exceptions to this policy (patients who are not required to meet the above criteria) are:

□ Patients whose pain is so severe and/or mobility is so compromised that they are in immediate danger of losing their independence, and joint replacement would help prevent this.

□ Patients in whom the destruction of their joint is of such severity that delaying surgical correction would increase the technical difficulties of the procedure.

*Second joint replacement*

If more than one joint replacement is being considered EACH surgery requires evaluation against the criteria set forth on its own merits. Of particular note if a patient has completed a joint replacement and another joint replacement is being considered, a complete re-evaluation of their condition for functional limitations and pain will be required as part of the request.

**Exclusions**

This policy does not apply to:

- Patients with 'red flag' conditions requiring further investigation or referral, such as suspected inflammatory arthritis, or symptoms or signs suggestive of tumour or infection.

- Patients with a recent history of trauma or an injury
- Patients for whom knee replacement is being considered for indications other than osteoarthritis

**Additional notes**

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Patella resurfacing is considered a low priority procedure and should not currently be offered as part of primary total knee replacement. This position may be reviewed after the publication of NICE guidance on joint replacement which is due to be published in March 2020.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for knee replacement.

**Compliance with NICE guidance**

This policy complies with relevant NICE guidance, except with respect to the following: NICE Clinical Guideline 177 recommends that 'Patient-specific factors (including age, sex, smoking, obesity and comorbidities) should not be barriers to referral for joint surgery'. However, in acknowledgement of the evidence of increased risk of post-operative complications associated with increased BMI (which does not appear to have been given full consideration in NICE's evidence review, and some of which was published since NICE completed their review (Pozzobon et al, 2019)) and with metabolic syndrome (Glance et al, 2010), and also the risks associated with smoking, requirements for participation in weight loss and smoking cessation programmes have been added to the policy.

**References**

*References included in original Suffolk / North East Essex policy / policies.*


- Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991; 20:48-54.
- Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502.
- The International Diabetes Federation. The IDF consensus worldwide definition of the metabolic syndrome. 2006. http://www.idf.org/webdata/docs/MetS_def_update2006.pdf.
- National Institute for Health and Care Excellence. Osteoarthritis: Care and management in adults (NICE CG177). 2014. https://www.nice.org.uk/guidance/cg177/evidence/full-guideline-191761309.
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- British Orthopaedic Association, Royal College of Surgeons. *Commissioning Guide: Painful osteoarthritis of the knee*; 2013. http://www.boa.ac.uk/pro-practice/painful-osteoarthritis-of-the-knee-commissioning-guide-2/.
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- Swan, J. D., Stoney, J. D., Lim, K., Dowsey, M. M., & Choong, P. F. The need for patella resurfacing in total knee arthroplasty: a literature review. ANZ journal of surgery. 2010; 80(4): 223-233.
- Hsu RW. The management of the patella in total knee arthroplasty. Chang Gung Med J. 2006 Sep-Oct; 29(5):448-57.
- Shuzhen L, Yueping C, Wei S, Jinmin Z, Shunqing H, and Xiangping L. Systematic review of patella resurfacing in total knee arthroplasty. Int Orthop. 2011 Mar; 35(3): 305–316.

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*Additional guidance referred to in production of ICS policy.*


- Royal College of Surgeons & British Orthopaedic Association, 2017. Commissioning guide: painful osteoarthritis of the knee. https://www.boa.ac.uk/standards-guidance/commissioning-guides.html
- Pozzobon D, Ferreira PH, Blyth FM, Machado GC, Ferreira ML, 2018. Can obesity and physical activity predict outcomes of elective knee or hip surgery due to osteoarthritis? A meta-analysis of cohort studies
- *BMJ Open* 2018; **8:e017689**. doi: 10.1136/bmjopen-2017-017689 https://bmjopen.bmj.com/content/bmjopen/8/2/e017689.full.pdf
- National Institute for Health and Care Excellence, October 2019. Joint replacement (primary): hip, knee and shoulder. Draft for consultation. https://www.nice.org.uk/guidance/GID-NG10084/documents/draft-guideline
- National Institute for Health and Care Excellence, October 2019. Joint replacement (primary): hip, knee and shoulder. Evidence review for patella resurfacing. https://www.nice.org.uk/guidance/GID-NG10084/documents/evidence-review-12


## Appendix

*Table 1: Classification of Pain Level **

| Classification | Description |
|---|---|
| Slight | Sporadic pain. (May be daily but comes and goes 25% or less of one's day)<br>Pain when climbing/descending stairs.<br>Allows daily activities to be carried out (those requiring great physical activity may be limited). (Able to bathe, dress, cook, and maintain house)<br>Medication, aspirin, paracetamol or NSAIDs to control pain with no/few side effects. |
| Moderate | Occasional pain. (May be daily and occurs 50-75% of one's day)<br>Pain when walking on level surfaces (half an hour, or standing).<br>Some limitation of daily activities. (Occasionally has difficulty with self-care and home maintenance) Medication, aspirin, paracetamol or NSAIDs to control with no/few side effects. |
| Intense | Pain of almost continuous nature. (Occurs 75-100% of one's day)<br>Pain when walking short distances on level surfaces (>20ft) or standing for less than half an hour. Daily activities significantly limited. (unable to maintain home, cook, bathe or dress without difficulty or assistance)<br>Continuous use of NSAIDs for treatment to take effect.<br>Requires the sporadic use of support systems (walking stick, crutches). |
| Severe | Continuous pain. (Occurs 100% of the time)<br>Pain when resting.<br>Daily activities significantly limited constantly. (Requires assistance to maintain home, bathe, and dress) Continuous use of analgesics - narcotics/NSAIDs with adverse effects or no response.<br>Requires more constant use of support systems (walking stick, crutches). |

*Based on: Lequesne M. Indices of severity and disease activity for osteoarthritis. *Semin Arthritis Res*. 1991;20:48-54

*Table 2: Classification of Functional Limitations***

| Classification | Description |
|---|---|
| Minor | Functional capacity adequate to conduct normal activities and self-care.<br>Walking capacity of more than one hour.<br>No aids needed. |

| | |
|---|---|
| Moderate | Functional capacity adequate to perform only a few of the normal activities and self-care.<br>Walking capacity of between half and one hour.<br>Aids such as a cane are needed occasionally. |
| Severe | Largely or wholly incapacitated.<br>Walking capacity of less than half an hour.<br>Cannot move around without aids such as a cane, a walker or a wheelchair AND help of a carer is required. |

**Based on: Hochberg M, Chang R, Dwosh I, Lindsey S, Pincus T, Wolfe F. The American College of Rheumatology 1991 revised criteria for the classification of global functional status in rheumatoid arthritis. *Arthritis Rheum*. 1992;35:498-502

## Shoulder Arthroscopy for conditions other than pure Subacromial Shoulder Impingement

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Shoulder Arthroscopy for conditions other than pure Subacromial Shoulder Impingement |
| Policy type | Threshold |
| Included intervention(s) | Shoulder arthroscopy |
| Included condition/ indication(s) | Rotator cuff tear, Superior labrum anterior posterior (SLAP) tear, Adhesive capsulitis, Non-traumatic shoulder joint instability, Traumatic shoulder joint instability |
| Date produced | January 2021 |
| Planned review date | July 2025 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T49: Shoulder arthroscopy |
| NEE CCG policy | Shoulder arthroscopy |

**Interventions covered by this policy**

Shoulder arthroscopy to investigate and treat a number of different conditions, excluding pure subacromial shoulder impingement.

**Conditions to be considered for treatment under this policy**

- □ Rotator cuff tear.
- □ Superior labrum anterior posterior (SLAP) tear.
- □ Adhesive capsulitis
- □ Non-traumatic shoulder joint instability
- □ Traumatic shoulder joint instability

**Eligibility criteria for provision of the intervention**

Shoulder arthroscopy should be considered as part of the management of the following conditions in the following circumstances:

***Rotator cuff tear* as demonstrated by clinical symptoms and radiological imaging, either:**

- □ Full thickness rotator cufftear

OR

- □ Partial thickness rotator cuff tear which has not responded to 3 months of conservative management*

***Superior labrum anterior posterior (SLAP) tear* as demonstrated by clinical symptoms and radiological imaging, either:**

- □ Significant SLAP tear

OR

- □ Minor (type I #) SLAP tear which has not responded to 3 months of conservative management*

***Adhesive capsulitis* demonstrated by clinical symptoms**

- □ Which has not responded to 3 months of conservative management* including corticosteroid injection if clinically appropriate

*Non-traumatic shoulder joint instability*

- □ Which has not responded to 6 months of conservative management including a structured physiotherapy programme*****

AND

- □ If there is a clear target for surgical intervention

*Traumatic shoulder joint instability*

- □ When arthroscopy is considered clinically appropriate alongside relevant conservative management*****

**Conservative management*

The conservative management to be attempted prior to referral may include the following:

- □ Activity modification
- □ Physiotherapy
- □ Oral analgesics, including NSAIDs if appropriate
- □ Steroid injection to the affected part of the joint where clinically appropriate

# Type 1 SLAP tear was described as **'**The superior labrum had marked fraying with a degenerative appearance, but the peripheral labral edge remained firmly attached to the glenoid, and the attachment of the biceps tendon to the labrum was intact'. (Snyder et al, 1990)

**Exclusions**

This policy does not cover:

- □ The use of shoulder arthroscopy for diagnostic purposes.
- Patients with 'red flag' conditions requiring urgent referral, such as a history of acute trauma, signs suggestive of an unreduced dislocation, or symptoms or signs suggestive of tumour or infection.

**Additional notes**

Please refer to the policy that covers 'Arthroscopic shoulder decompression' in pure subacromial shoulder impingement.

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for shoulder arthroscopy.

**Compliance with NICE guidance**

No relevant NICE guidance.

**References**

*References included in original Suffolk/NEE policy / policies.*


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- □ NICE CKS revised April 2015 accessed online via http://cks.nice.org.uk/shoulder-pain#!scenariorecommendation on 01/06/2016
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- British Elbow and Shoulder Society, 2015. BESS/BOA patient care pathways: Traumatic anterior shoulder instability https://www.bess.org.uk/application/files/1914/8127/3404/Traumatic_Anterior_Instability.pdf
- British Elbow and Shoulder Society, 2015. BESS/BOA patient care pathways: Frozen shoulder https://www.boa.ac.uk/uploads/assets/221d74d9-2db0-40c6-ae113e5b1bef68e5/frozen%20shoulder.pdf

## Specialist Fertility Services including Assisted Conception

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Specialist Fertility Services including Assisted Conception |
| Policy type | Threshold |
| Included intervention(s) | Level 3 fertility services |
| Included indication/ condition(s) | Infertility |
| Date produced | 20th October 2021 |
| Planned review date | July 2025 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T39: Fertility |
| NEE CCG policy | 12: Assisted conception using IVF/ICS/IUI for infertility |

**Interventions covered by this policy**

Three levels of fertility treatment services are provided:

- Level 1 services, primary care: initial assessment and investigation and referral to the next level if necessary.
- Level 2 services, secondary and specialist care: specialist investigations, drug treatment and monitoring, other interventions as indicated
- Level 3 services, tertiary specialist care: further specialist investigations and treatment including assisted conception

This policy covers **Level 3 fertility services**, the key procedures being:
In Vitro Fertilisation (IVF): ovarian stimulation, the collection of the resulting eggs and fertilisation with sperm in the lab. If fertilisation is successful, the embryo is allowed to develop for between two and six days and is then transferred back to the woman's womb. Any remaining good quality embryos can be frozen to use later on in a frozen embryo transfer if the first transfer is unsuccessful.

Intracytoplasmic sperm injection (ICSI): instead of mixing the sperm with the eggs, IVF with ICSI involves injecting a single sperm into each mature egg, which maximises the chance of fertilisation.

**Conditions to be considered for treatment under this policy**

Infertility is defined in this policy as failure to conceive after frequent unprotected intercourse for 3 years in couples of reproductive age in the absence of known reproductive pathology.

For a woman of reproductive age who is using artificial insemination (AI) to conceive (with either partner or donor sperm) infertility is defined as failure to conceive after 12 documented cycles of treatment over a 3-year period.

**Eligibility criteria for provision of the intervention**

Patients should **only** be referred for level 3 fertility services if they meet **all** of the following criteria at the time of referral (or **all applicable** criteria for same sex couples, also see below*). The number of cycles and number of embryos to be transferred depend on age and number of previous cycles of IVF (see below**).

- □ They meet the definition of infertility and its duration above appropriate to their situation
- □ Age of female partner: between 23 and 42 years inclusive
- □ Age of male partner: between 23 years and less than 55 years

- □ Women aged 23-39 should have self-funded no more than 2 cycles of IVF previously; women aged 40-42 inclusive should not have had any self-funded cycles of IVF previously (see below**).
- They met the criteria in the Policy 'Subfertility investigation and treatment in secondary care' and have completed further assessments and investigations indicated. As a minimum these should have included:

*Female:*

- Laparoscopy and/or hysteroscopy and/or hysterosalpingogram or ultrasound scan where appropriate
- Rubella antibodies; the woman must be rubella immune
- Chlamydia screening
- Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
- HIV status
- AMH (anti-Mullerian hormone), which should be >5.4 pmol - Women referred for IVF assessment shall be offered an ovarian reserve test as per NICE guidance to identify and exclude those with low chance of conception. GPs should ensure the patient meets all of the initial criteria within the referral form in the first instance prior to the AMH request being sent to the Fertility Unit. Ovarian reserve testing should only be conducted within the overall context of a fertility assessment carried out by a specialist centre.

*Male:*

- Preliminary Semen Analysis and appropriate investigations where abnormal (including genetic analysis if indicated)
- Hepatitis B including core antibodies, and Hepatitis C, within the last 3 months
- HIV status

- BMI of female partner is 19 or more and less than 30 kg/m$^2$ at referral and throughout treatment
- BMI of male partner is less than 30 kg/m$^2$ at referral and throughout treatment
- Both partners are non-smokers at the time of referral from secondary care to specialist fertility services and throughout treatment. Smoking status should be ascertained by carbon monoxide testing in secondary care and specialist IVF services.
- Neither partner has undergone sterilisation in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)
- There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance.
- Both partners are registered with a SNEE ICB GP Practice (within Ipswich and East Suffolk, West Suffolk or North East Essex) and were eligible for NHS care for at least 12 months prior to the referral from primary to secondary care.
- Neither couple has a living child from the current or any previous relationships, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships.

**Same sex couples (female)*

- A woman who is using AI to conceive should meet the definition of infertility and its duration above. Fertile same sex couples will not be funded for assisted conception methods under this policy. Couples are encouraged to maximise opportunities within AI cycles by exploring the option of both partners undergoing AI.
- Same sex couples will be required to meet relevant eligibility criteria above.
- SNEE ICB will not routinely fund donor sperm, but will fund the associated IVF/ICSI treatment in line with the eligibility criteria within this policy, providing the sperm meets the criteria set out by the treating provider unit.
- The partner of a prospective mother who has undertaken NHS funded fertility treatment, whether successful or not, will be deemed to have received their entitlement

to NHS funded fertility treatment, in line with the criteria for heterosexual couples, and will not be eligible for additional cycles with their partner or any future partners.

*Same sex couples (male)*

- Same sex male couples will not be able to access fertility treatment within their relationship but will be eligible for appropriate investigation where there is evidence of subfertility. Surrogacy is not commissioned as part of this policy.

***Female partner age, previous cycles of IVF, number of cycles*[4] *and number of embryos transferred*:

*Age 23 years or more and less than 40 years:*

- will be eligible for TWO full cycles (for women who have self-funded no or one previous cycle of IVF); or ONE full cycle (for women who have self-funded two previous cycles of IVF). If the woman reaches the age of 40 years during treatment, the current cycle will be completed, but no further cycles will be offered.
- one embryo will be transferred during each cycle to reduce the risk of multiple pregnancies. A maximum of four embryo transfers (fresh plus frozen) will be funded. All frozen embryos should be used before a fresh cycle is funded. Where couples have previously self-funded a cycle then the couples must utilise the previously frozen embryos, rather than undergo ovarian stimulation, egg retrieval and fertilisation again.

*Age 40 years to 42 years inclusive:*

- will be eligible for ONE full cycle providing all the following criteria are met:
  - Never previously had IVF treatment
  - There is no evidence of low ovarian reserve
  - There has been a discussion of the additional implications of IVF and pregnancy at this age
- Up to two embryos may be transferred during each cycle. A maximum of two embryo transfers (one fresh plus one frozen) will be funded.

**Exclusions**

This policy does not cover:

- Gamete storage, preimplantation genetic diagnosis and intrauterine insemination
- Couples with a known clinical cause of absolute infertility which precludes any possibility of natural conception, and who meet other eligibility criteria, will have immediate access to NHS funded assisted reproduction services
- Treatment may be denied on other medical ground not explicitly covered in this policy

**Additional notes**

- Read in conjunction with the subfertility investigation and treatment in secondary care.
- Read in conjunction with the cryopreservation of sperm, oocytes or embryos for patients about to undergo treatments which pose a risk to their fertility.

Referral may be made to the ECC Panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for referral for specialist fertility services.

It is expected that 84% of couples in the general population having regular unprotected

[4] A full cycle comprises one round of ovarian stimulation and the transfer of resultant fresh embryo(s). Where an excess of embryos is available following a fresh cycle, these embryos may be frozen for future use, and subsequently thawed and transferred to the patient as a frozen cycle within the 'full cycle'.

intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment (NCCWCH 2013).

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- Unexplained infertility (no identified male or female cause) (25%)
- Ovulatory disorders (25%)
- Tubal damage (20%)
- Factors in the male causing infertility (30%)
- Uterine or peritoneal disorders (10%).

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. It is estimated that infertility affects 1 in 7 heterosexual couples in the UK (NICE, 2017).

***Criteria – additional information***

Women with a **BMI** over 30 kg/m$^2$ take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. The RCOG advises that losing weight will increase the chances of conception. NICE CG156 also recommends that 'men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility'. Couples who require it should be offered advice and support to achieve weight loss, and should be informed of the weight criterion in relation to NHS funded assisted reproduction services at the earliest appropriate opportunity in their progress through infertility investigations in primary care and secondary care.
Women with a low BMI are also likely to have reduced fertility and NICE recommend that 'women who have a BMI of less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception'.

Criteria for minimum maternal and paternal **age** in this policy have been set with reference to the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. The upper age limit of 42 years for women accessing infertility services is recommended by NICE.

There is significant association between reduced fertility and **smoking** in both men and women, and there are also risks associated with smoking and passive smoking during pregnancy. Couples who smoke will not be eligible for NHS funded specialist assisted reproduction assessment or treatment, and should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary care and secondary care, provided with information about the negative impacts of smoking, and offered support to stop.

NICE CG156 gives advice on initial **assessment and investigation** of patients with concerns regarding fertility. Prior to referral to level 2 or 3 services all patients should have been given advice about increasing the chances of conception (NICE CG 156 section 1.2) including with respect to the timing of sexual intercourse, lifestyle including smoking, alcohol and healthy weight, and offered initial assessment and investigations including semen analysis, review of menstrual cycle and maternal blood testing to determine ovulation.

Patients undergoing male or female **sterilisation** should have provided informed consent and been counselled that the procedures are regarded as permanent and irreversible.

The Human Fertilisation and Embryology (HFE) Act 1990 states that 'a woman shall not be provided with treatment services unless account has been taken of the **welfare of any child** who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth'.

*Treatment components – additional information*

Couples will not be allowed to pay for any **additional interventions** as part of the treatment within a cycle of NHS fertility treatment. This includes, but is not limited to, any drugs (including drugs prescribed by the couple's GP), recommended treatment that is outside the scope of the service specification agreed with the Secondary or Tertiary Provider or experimental treatments. Where a patient meets the SNEE ICB eligibility criteria, but agrees to commence treatment on a privately funded basis, they may not retrospectively apply for any associated payment relating to the private treatment.

The SNEE ICB will fund **embryo storage** as part of assisted conception treatment for one year only. Patients must be counselled by the clinician and infertility counsellor to this effect. Any costs relating to the continued storage of the embryos beyond the first calendar year of the retrieval date is the responsibility of the couple. If any fertility treatment results in a live birth, then the couple will no longer be considered childless and will not be eligible for further NHS funded fertility treatments, including the implantation of any stored embryos.

**Egg, sperm and embryo storage for patients undergoing cancer treatments** are covered under separate arrangements.

**Egg donation where no other treatment is available** will be available to women who have undergone premature ovarian failure (longer than six months amenorrhoea and AMH greater than 5.4 pmol due to an identifiable pathological or iatrogenic cause, before the age of 40 years, or to avoid transmission of inherited disorders to a child where the couple meets the other eligibility criteria. The patient may be able to provide an egg donor; alternatively, the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.

**Donor insemination** may be indicated where:

- the male partner is likely to pass on an inheritable genetic condition;
- severe rhesus incompatibility has been a problem because of the male partner's homozygous status;
- the male partner does not produce suitable sperms (quantity or quality) and, therefore, ICSI is not possible

Anovulatory women can have ovulation induction prior to donor insemination. A maximum of six cycles of donor insemination will be funded followed by IVF with donor sperm if all other eligibility criteria are met. The need to prevent transmission of sexually transmitted diseases (including HIV) by donor insemination has led to the mandatory quarantine of donor sperm for six months by cryopreservation prior to its use in the UK.

Due to poor clinical evidence, **intra uterine insemination** (IUI) will only be offered in exceptional circumstances.

Interventions to prevent the **transmission of blood borne viruses** in fertile serodiscordant couples (for example, where one partner has HIV or Hepatitis C) where all

other criteria are met is commissioned from specialist centres. Sperm washing will not be offered for men with Hepatitis B.

**Surrogacy** (including part funding) is not commissioned as part of this policy. As advised by the Department of Health 2018.

**Compliance with NICE guidance**

NICE CG 156 states that women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination), should be offered 3 full cycles of IVF, with or without ICSI.

The decision to maintain waiting times as per the previous policy (i.e. 3 years rather than 2) for women with unexplained fertility was made based upon moderate to low quality evidence presented by NICE and the difficulties in justifying additional spend in constrained NHS resources. The decision to reduce the number of cycles from 3 to 2 was made to partially mitigate the extra resource needed to increase the age limit. The decision to include access for women aged 40-42 who meet specific criteria was based on high to low quality evidence presented by NICE but recognizes the improved success rates of IVF. NICE CG156 also recommend that IUI can be used in some circumstances.

**References**

*References included in original Suffolk / North East Essex policy / policies.*


- Clinical threshold policy: Infertility. March 2014.
- National institute for clinical and health excellence. Fertility: assessment and treatment for people with fertility problems. Clinical guideline 156. February 2013.
- Kidd SA, Eskenazi B, Wyrobek AJ "Effects of male age on semen quality and fertility: a review of the literature" Fertil Steril (2001); 75(2):237
- De La Rochebrochard E, de Mouzon J, Thepot f, Thonneau P "Fathers over 40 and increased failure to conceive: the lessons of invitro fertilisation in France" (2006); 85(5):1420


*Additional guidance referred to in production of ICS policy*


- Human fertilisation and embryology authority, 2019. Commissioning guidance for fertility treatment.https://www.hfea.gov.uk/media/2920/commissioning-guidance-may-2019-final-version.pdf
- National Institute for Health and Care Excellence, 2017. Fertility problems: assessment and treatment (CG156) updated September 2017. https://www.nice.org.uk/guidance/cg156
- http://www.fertilityfairness.co.uk/wp-content/uploads/2018/10/England-FertilityFairness_FOI_2018.pdf
- JAMA 10/10/17 Steiner and Pritchard Biomarkers of ovarian reserve and infertility among older women of reproductive age.
- AJOG Ovarian reserve testing, user guide August 2017. Tal,Seifer

## Standing Frames (Bespoke)

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Standing Frames (Bespoke) |
| Policy type | Prior approval |
| Included intervention(s) | Bespoke standing frame |
| Included condition/ indication(s) | Patients with a neurological condition<br>Patients who have sustained a spinal cord injury |
| Date produced | January 2021 |
| Planned review date | July 2027 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | N/A |
| NEE CCG policy | Standing frames (bespoke) |

**Interventions covered by this policy**

A standing frame is an individualized piece of equipment with a rigid frame and a wide base that supports a person in the standing position.

**Conditions to be considered for treatment under this policy**

Patients who have a neurological condition and patients who have sustained a spinal cord injury who meet at least one of the criteria below.

**Eligibility criteria for provision of the intervention**

The provision of a bespoke standing frame may be considered for patients with a neurological condition and patients who have sustained a spinal cord injury who meet at least one of the following criteria:

- The patient is at risk of hip and knee contractures
- The patient requires a standing frame to compensate for the loss of muscle control
- The standing frame is the only way the patient can be supported in an upright position
- Supported standing would benefit other bodily functions and bone integrity
- There is evidence that a standing frame would benefit neuro-rehabilitation producing achievable outcomes for the patient in line with evidence-based interventions
- The patient has severe learning disabilities and/or co-morbidities that require continual postural and positioning management to prevent deterioration which could have an impact on respiratory and musculoskeletal health.
- Where a significant deterioration in posture is likely to increase risk of hospital admission and decrease life expectancy.

Evidence will be required that a trial of the suggested standing frame has proved of significant benefit to the patient in line with evidence based achievable outcomes.

**Exclusions**

None.

**Additional notes**

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for a bespoke standing frame.

**Compliance with NICE guidance**

There is no relevant NICE guidance.

**References**

*References included in original Suffolk/NEE policy/ies.*

None

*Additional guidance referred to in production of ICS policy.*


- Goodwin J, Lecouturier J, Basu A, Colver A, Crombie S, Smith J, Howel D, McColl E, Parr J R, Kolehmainen N, Roberts A, Miller K & Cadwgan J, 2018. Standing frames for children with cerebral palsy: a mixed-methods feasibility study. *Health Technology Assessment* Volume: 22, Issue: 50.
- https://www.journalslbrary.nihr.ac.uk/hta/hta22500#/full-report
- Paleg GS, Smith BA, Glickman LB, 2013. Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs. *Pediatr Phys Ther* 25:232–47. https://doi.org/10.1097/PEP.0b013e318299d5e7

## Subfertility Investigation and Treatment in Secondary Care

| Policy properties | Information relating to this policy |
|---|---|
| Policy name | Subfertility Investigation and Treatment in Secondary Care |
| Policy type | Threshold |
| Included intervention(s) | Level 2 fertility services |
| Included indication/ condition(s) | Subfertility |
| Date produced | January 2021 |
| Planned review date | July 2025 |
| Replaces: | N/A |
| Ipswich & East Suffolk and West Suffolk CCG policy | T34: Subfertility in secondary care |
| NEE CCG policy | N/A |

**Interventions covered by this policy**

Three levels of fertility treatment services are provided:

- Level 1 services, primary care: initial assessment and investigation and referral to the next level if necessary.
- Level 2 services, secondary and specialist care: specialist investigations, drug treatment and monitoring, other interventions as indicated
- Level 3 services, tertiary specialist care: further specialist investigations and treatment including assisted conception

**This policy covers Level 2 fertility services.**

**Conditions to be considered for treatment under this policy**

Subfertility is defined in this policy as failure to conceive after frequent unprotected intercourse for 1 year in couples of reproductive age in the absence of known reproductive pathology.

For a woman of reproductive age who is using artificial insemination (AI) to conceive (with either partner or donor sperm) subfertility is defined in this policy as failure to conceive after 6 documented cycles of treatment over at least a 12-month period.

Same sex male couples will be eligible for further investigation of male factor infertility where there is evidence of subfertility, for example failure to conceive through AI as above.

**Eligibility criteria for provision of the intervention**

Patients should **only** be referred for level 2 subfertility investigation and treatment if they meet **all** of the following criteria (or **all applicable** criteria for same sex couples):

□ They meet the definition of subfertility above appropriate to their situation

AND

□ BMI of female partner is 19 or more and less than 30 kg/m$^2$

AND

□ Age of female partner is between 23 and 42 years inclusive

AND

□ BMI of male partner is less than 30 kg/m$^2$

AND

□ Age of male partner is between 23 years and less than 55 years

AND

□ If either or both partners smoke they have taken part in and completed a recognised supportive smoking cessation programme. They have been informed that both partners will need to be non-smokers in order to access Level 3 fertility services, should they require them

AND

- □ Initial assessment and investigations have been initiated in primary care (semen test, blood tests to determine ovulation and lifestyle advice) as clinically appropriate, in line with NICE CG156

AND

- □ Neither partner has undergone sterilisation in the past (irrespective of whether they have undergone subsequent reversal of sterilisation)

AND

- □ There are no concerns regarding the welfare of the unborn child in accordance with the Human Fertilisation and Embryology Authority (HFEA) guidance

AND

- □ Both partners are registered with a SNEE ICB GP Practice (within Ipswich and East Suffolk, West Suffolk or North East Essex) and were eligible for NHS care for at least 12 months prior to the referral from primary to secondary care

**Exclusions**

This policy does not cover:

- □ Couples with a known clinical cause of absolute infertility
- □ Patients about to undergo treatment which will affect their fertility, such as some cancer treatments

**Additional notes**

All adult referrals for elective surgery should refer to Policy 'Weight management and smoking cessation prior to elective surgery'.

Please refer to the policy that covers specialist fertility services including assisted conception.
Please refer to the policy that covers cryopreservation of sperm, oocytes or embryos for patients about to undergo treatments which pose a risk to their fertility.

Referral may be made to the ECC panel for patients who do not meet the policy criteria in whom there are considered to be exceptional circumstances supporting the need for subfertility investigation and treatment in secondary care.

It is expected that 84% of couples in the general population having regular unprotected intercourse will conceive within one year and 92% within two years. However, a minority will be unable to conceive and may benefit from fertility treatment (NCCWCH 2013).

The main causes of infertility in the UK are (per cent figures indicate approximate prevalence):

- □ Unexplained infertility (no identified male or female cause) (25%)
- □ Ovulatory disorders (25%)
- □ Tubal damage (20%)
- □ Factors in the male causing infertility (30%)
- □ Uterine or peritoneal disorders (10%)

In about 40% of cases disorders are found in both the man and the woman. Uterine or endometrial factors, gamete or embryo defects, and pelvic conditions such as endometriosis may also play a role. It is estimated that infertility affects 1 in 7 heterosexual couples in the UK (NICE, 2017).

***Criteria – additional information***

Women with a **BMI** over 30 kg/m$^2$ take longer to conceive when compared with women with a lower BMI, adjusting for other factors such as menstrual irregularities. The RCOG advises that losing weight will increase the chances of conception. NICE CG156 also recommends that 'men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility'. Couples who require it should be offered advice and support to achieve weight loss, and should be informed of the weight criterion in relation to NHS

funded assisted reproduction services at the earliest appropriate opportunity in their progress through infertility investigations in primary care and secondary care.

Women with a low BMI are also likely to have reduced fertility and NICE recommend that 'women who have a BMI of less than 19 and who have irregular menstruation or are not menstruating should be advised that increasing body weight is likely to improve their chance of conception'.

Criteria for minimum maternal and paternal **age** in this policy have been set with reference to the average age of conception and cohabiting. The average age of first time mothers in 2014 ONS data was 28.5 years and a 2012 ONS short report found that people aged between 25-34 are the most likely group to be cohabiting. There is some suggestive evidence that the optimum age for conception and complications being less likely is between the ages of 23 and 31. The upper age limit of 42 years for women accessing infertility services is recommended by NICE.

There is significant association between reduced fertility and **smoking** in both men and women, and there are also risks associated with smoking and passive smoking during pregnancy. Couples who smoke will not be eligible for NHS funded specialist assisted reproduction assessment or treatment, and should be informed of this criterion at the earliest possible opportunity in their progress through infertility investigations in primary care and secondary care, provided with information about the negative impacts of smoking, and offered support to stop.

NICE CG156 gives advice on initial **assessment and investigation** of patients with concerns regarding fertility. Prior to referral to level 2 or 3 services all patients should have been given advice about increasing the chances of conception (NICE CG 156 section 1.2) including with respect to the timing of sexual intercourse, lifestyle including smoking, alcohol and healthy weight, and offered initial assessment and investigations including semen analysis, review of menstrual cycle and maternal blood testing to determine ovulation.

Patients undergoing male or female **sterilisation** should have provided informed consent and been counselled that the procedures are regarded as permanent and irreversible.

The Human Fertilisation and Embryology (HFE) Act 1990 states that 'a woman shall not be provided with treatment services unless account has been taken of the **welfare of any child** who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth'.

**Compliance with NICE guidance**

This policy complies with relevant NICE guidance.

**References**

*References included in original Suffolk/NEE policy / policies.*


- Clinical threshold policy: Infertility. March 2014.
- Fertility assessment and treatment for people with fertility problems. National Collaborating Centre for Women's and Children's Health February 2013. RCOG press.

- National institute for clinical and health excellence. Fertility: assessment and treatment for people with fertility problems. Clinical guideline 156. February 2013.
- Policy and Protocol for the management of fertility treatment in Shropshire and Telford and Wrekin, www.shropshireccg.nhs.uk/download.cfm?doc=docm93jijm4n3485.pdf&ver
- Bolumar F, Olsen J, Rebagliato M, Saez-Lloret I, Bisanti L. Body mass index and delayed conception: a European multicenter study on infertility and subfecundity. Am J Epidemiol 2000;151:1072–9.
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- Wentz AC. Body weight and amenorrhea. Obstet Gynecol 1980; 56:482–7.
- Kort HI, Massey JB, Elsner CW, Toledo AA, Mitchell-Leef D, Roudebush WE. Men with high body mass index values present with lower numbers of normal-motile sperm cells. Abstract no. P-355. Fertil Steril 2003; 80 Suppl 3; S238.
- Augood C, Duckitt K, Templeton AA. Smoking and female infertility: a systematic review and meta-analysis. Hum Reprod 1998; Vol13:-1539.
- Hughes EG, Brennan BG. Does cigarette smoking impair natural or assisted fecundity? Fertil Steril 1996; 66:679–89.
- Hull MG, North K, Taylor H, Farrow A, Ford WC. Delayed conception and active and passive smoking. The Avon Longitudinal Study of Pregnancy and Childhood Study Team. Fertil Steril 2000; 74:725–33.
- Human Fertilisation and Embryology (HFE) Act 1990. Section 13(5).

*Additional guidance referred to in production of ICS policy.*

- Human fertilisation and embryology authority, 2019. Commissioning guidance for fertility treatment. https://www.hfea.gov.uk/media/2920/commissioning-guidance-may-2019-final-version.pdf
- National Institute for Health and Care Excellence, 2017. Fertility problems: assessment and treatment (CG156) updated September 2017. https://www.nice.org.uk/guidance/cg156