NHS
Redditch and Bromsgrove
Clinical Commissioning Group

NHS
South Worcestershire
Clinical Commissioning Group

NHS
Wyre Forest
Clinical Commissioning Group

Commissioning Policy

Musculoskeletal Surgery and Therapeutic Interventions

June 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

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COMMISSIONING SUMMARY

Besides funding healthcare interventions that tackle ill health and save lives there is a growing demand for a range of orthopaedic procedures, some of which are considered to be low priority when it comes to allocating limited NHS resources. However, NHS Redditch & Bromsgrove Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group and NHS Wyre Forest Clinical Commissioning Group (also termed "the Commissioner" in this document) recognise that in some cases the purpose of a low priority procedure will be to meet an appropriate and justifiable clinical need. This policy provides commissioning statements regarding the following interventions, which are split by surgical, non-surgical and anatomical site:

Anatomical Site	Surgical (S) or Non-surgical (NS)	Status	Last Updated
Feet			
Bunions and hallux valgus	*S*	*Criteria for use, page 8*	*Under Review*
Hands			
Carpal Tunnel Syndrome	S	Criteria for use, page 8	March 2018
Dupuytren's Contracture	S	Criteria for use, page 9	December 2018
Ganglion Surgery	S	Not routinely funded, page 10	August 2011
Trigger Finger Surgery	S	Criteria for use, page 10	August 2011
Hip			
Hip Replacement Surgery	S	Criteria for use, page 10	February 2017
Therapeutic arthroscopic procedures: hip impingement syndrome, labral tear and other hip pathologies.	S	Not routinely funded, page 11	January 2015
Knee			
Arthroscopy - Diagnostic	S	Not routinely funded, page 12	May 2018
Arthroscopy - Pre-Operative Assessment	S	Criteria for use, page 12	May 2018
Arthroscopy - Debridement and Lavage	S	Not routinely funded, page 12	May 2018
Arthroscopy – Therapeutic Intervention	S	Criteria for use, page 12	May 2018
Knee Replacement Surgery	S	Criteria for use, page 13	February 2017
Intra-articular Hyaluronic Acid Injections for Osteoarthritis	NS	Not routinely funded, page 14	June 2016
Magnetic Resonance Imaging (MRI) Knee	NS	Secondary care only, page 14	May 2018
Miscellaneous			
Exogen Therapy for Non Union Fractures of Long Bones	NS	Criteria for use, page 15	September 2014
Joint Injections (including Corticosteroid)	*NS*	*Criteria removed*	*Under Review*
Therapeutic Ultrasound in Physiotherapy	*NS*	*Not routinely funded, page 15*	*Under Review*
Shoulder			
Excision of Acromi-Clavicular Joint/or Surgical Decompression of Subacromial Space	*S*	*Criteria for use, page 15*	*Under Review*
Spine			
Diagnostic Imaging	NS	Criteria for use, page 16	September 2017
Disc Replacement Surgery	S	Not routinely funded, page 16	September 2017
Facet Joint Injections (FJI)	NS	Not routinely funded, page 16	September 2017
Radiofrequency Denervation	NS	Criteria for use, page 17	March 2018
Spinal Decompression	NS	Criteria for use, page 17	September 2017
Spinal Epidural Injections (SEI)	NS	Criteria for use, page 17	September 2017
Spinal Fusion Surgery	S	Not routinely funded, page 18	September 2017

Document Details:

Version:	V 1.9.7
Ratified by (name and date of Committee):	1st April 2013 – this policy was formally adopted by: NHS South Worcestershire CCG NHS Redditch & Bromsgrove CCG NHS Wyre Forest CCG V1.9.4 endorsed by CCG Board Meetings: NHS South Worcestershire CCG – 12th Sept '17 NHS Redditch & Bromsgrove CCG – 12th Sept '17 NHS Wyre Forest CCG – 12th Sept '17 V1.9.5 endorsed by Clinical Executive Committee in Common December 2017 V 1.9.6 endorsed by Clinical Executive Committee in Common April 2018 V 1.9.7 endorsed by Clinical Executive Joint Committee May 2018
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Internal Review Date:	Documents will be reviewed as a minimum every 3 years. However, earlier revisions to the policy may be made in light of published updates to local and national evidence of effectiveness and cost effectiveness and/or recommendations and guidelines from local, national and international clinical professional bodies. Date to Initiate Review: May 2021
Lead Executive/Director:	Chris Emerson, PMO Specialist Adviser
Name of originator/author:	Originators: Chris Emerson, Head of Commissioning & Service Redesign Stuart Bourne, Head of Health Protection and Population Healthcare Updates: Various via Clinical Commissioning Policy Collaborative Fiona Bates, Medicines Management and Public Health Liaison
Target audience:	Patients, GPs, Secondary Care and Primary Care (Community) Providers, Independent Sector Providers
Distribution:	Patients, GPs, Secondary Care and Primary Care (Community) Providers, Independent Sector Providers
Equality & Diversity Impact Assessment	Original Review: November 2009 Updated and endorsed: November 2015 Updated and endorsed: September 2017 Reviewed: December 2017 no change required Updated and endorsed: April 2018, May 2018

Key individuals involved in developing the document:

Name	Designation
Secondary Care Clinicians	NHS Worcestershire Planned Care Programme Orthopaedic Working Group
Director of Operations (secondary care)	NHS Worcestershire Planned Care Programme Orthopaedic Working Group
Public Health Consultants	NHS Worcestershire Planned Care Programme Orthopaedic Working Group
PBC Leads	NHS Worcestershire Planned Care Programme Orthopaedic Working Group
PBC Cluster Clinic Leads	NHS Worcestershire Planned Care Programme Orthopaedic Working Group
Commissioning leads (Acute Care, Community Services)	NHS Worcestershire Planned Care Programme Orthopaedic Working Group

Name	Designation
PPI representative	NHS Worcestershire Planned Care Programme Orthopaedic Working Group

Circulated to the following individuals/groups for comments:

Name	Date
Clinical Commissioning Policy Collaborative, which includes: GPs, Commissioners, Medicines Commissioning, Public Health, Patient and Public Representatives	At each Policy Update
Clinical Innovation Group	January 2018 onwards

Version Control:

Version No	Type of Change	Date	Description of change
V1.1	Amendment	October 13	Update of Hip Arthroscopy section following updated review by Public Health
V1.2	Addition	March 14	• Inclusion of agreed pathway and eligibility criteria for Synvisc One (as per APC and CCG agreements in 2013). • Commissioning Stance moved to the start of each category for ease of reference • Arthroscopic Debridement and Lavage for Knee – updated to reflect the British Orthopaedic Association Guidelines November 2013
V1.3	Amendment	January 15	Update of Hip Arthroscopy section following application for service development and subsequent public health evidence review
V1.4	Amendment	February 15	Reformatting of document to make it easier to read, move detailed statements into Appendix A and put into body site and alphabetical order for ease of reference. Highlight areas under review
V1.5	Update	September 15	Amendment to the Synvisc-One© recommendations based on clinical discussions to provide clarity to patients and clinicians.
V1.6	Update	November 15	Reformatting onto the new policy format. Update to wording in relation to hip and knee replacement.
V1.7	Update	May 16	Update to wording in relation to Facet Joint Injections
V1.8	Update	December 16	Update to Intra-articular Hyaluronic acid for Osteoarthritis of the Knee (including Synvisc-One®) Commissioning Statement as ratified by Worcestershire APC
V1.9	Update	March 17	Update to clinical criteria for Hip and Knee replacement surgery in line with other West Midlands CCGs
V1.9.4	Update	May 17	Update to clinical criteria for Facet Joint Injections and Spinal Epidural Injections following publication of NICE Guideline 59
V1.9.5	Update	December 17	Update to commissioning statement for Dupuytren's Contracture following publication of NICE TA459

Version No	Type of Change	Date	Description of change
V 1.9.6	Update	April 2018	Update to commissioning statement for: Carpal Tunnel Syndrome -Development of pathway Joint injections – removal of statement while review undertaken Spine - Radiofrequency Denervation (review of repeat injections) Inclusion of date that policy sections were last reviewed and updated
V 1.9.7	Update	May 2018	Update to commissioning statement for: Knee - Development of pathway - Arthroscopic Interventions - Magnetic Resonance Imaging

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1. Definitions

1.1 **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.

1.2 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.

1.3 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.

1.4 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 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.

2.4 The policy applies to all contracted service providers in secondary care or the community that offer these orthopaedic interventions. Service providers must apply the criteria within this policy before carrying out the treatment

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. Musculo-skeletal Integrated Clinical Assessment and Treatment Service (MSK ICATS):
MSK ICATS are primary care based services that provide GPs with the opportunity to refer to an accessible, specialist diagnosis service, which also provides, where clinically appropriate, medical treatment for adults (age 18 and above) with symptomatic musculoskeletal conditions who require additional orthopaedic assessment/treatment.

3.4. Whilst ICATS provision varies across the Clinical Commissioning Groups (CCGs), the primary aims of the ICATS service is to manage patients within primary and community based services rather than refer the patient into secondary care. ICATS will also be expected to take account of the provisions of this policy before considering making a referral into secondary care.

3.5. Current ICATS provision extends to:
NHS South Worcestershire CCG
Could we add something in about services in Wyre Forest and developments in R&B?

3.6. Any patient being considered for treatment, must meet the eligibility criteria identified within this policy before being referred into secondary care

4. Relevant National Guidance and Facts

4.1 A Cochrane review suggests active educational interventions involving secondary care consultants and structured referral sheets are the only interventions proven to impact on referral rates. Structured referral sheets are checklists to be completed at the time of referral that prompt the GP about important elements of pre-referral investigation and management. The Commissioner requires its orthopaedic providers to develop these referral sheets and utilise recognised tools such as the Oxford Hip score to determine the need for surgery.

4.2 National guidance where available has been used/considered in determining the recommendations within this policy.

5. Patient Eligibility

5.1 **This policy applies to the following INTERVENTIONS:**

FEET	
Bunions and hallux valgus OPCS-4.7 Codes: W151-154, W157, W441, W451, W591-594	The Commissioner **WILL SUPPORT** funded treatment if there is clear evidence that: • there is severe deformity (overriding toes); and/or • severe pain that prevents normal activity **NO OTHER SURGERY IS ROUTINELY FUNDED** ***Rationale****: Local resources are limited and therefore priority is given to patients with greatest need.*
HANDS	
Carpal Tunnel Syndrome Surgery OPCS-4.7 Codes: A651, A658, A659, A692	The Commissioner **WILL SUPPORT** surgical intervention for patients in accordance with the Management Pathway in Appendix A. This can be summarised as follows: 1. Symptoms consistent with SEVERE disease 2. Symptoms consistent with MILD or MODERATE disease PROVIDING that the patient has: a. Failed wrist splints (12 weeks assured use at night) AND b. Temporary improvement (< 6 weeks) following corticosteroid injection OR Positive Nerve Conduction Study (moderate or severe) AND c. Assured value and need for surgery on the basis of symptoms AND d. Patient willing to proceed to surgery ***Rationale****:* *i. The agreed pathway seeks to minimise invasive surgery for patients who can be adequately managed with conservative treatments, but ensures that patients in whom these measures fail receive timely referral and intervention where appropriate.* *ii. National guidance supports the pathway approach to conservative management of patients with mild and moderate symptoms and there is no evidence that the timescales within the pathway will adversely influence outcomes.*

UNDER REVIEW

Dupuytren's Contracture

Procedure Codes:
T521
T522
T525
T526
T528
T529
T541
T549
T561
T562

Dupuytren's disease is a benign painless condition that develops over time. Not all patients develop a contracture. Approximately 50% of patients with an isolated nodule will go on to develop a cord, of whom 9% will progress to meet criteria for surgery. The normal progression of the disease means that it could be between 5 and 10 years before a patient's disease has reached the stage at which clinical intervention is considered appropriate.

The British Society for Surgery of the Hand (BSSH) have classified Dupuytren's disease and this together with the recommended action for management should be followed in Worcestershire:

Classification and Primary Care Management of Dupuytren's Disease		
Severity	**Description**	**Action**
Mild	No functional problems No contracture (there may be nodules) Mild MCP or PIP joint contracture < 30°	Watchful Waiting (There are no effective conservative measures)
Moderate	Functional problems AND MCP joint contracture 30° to 60° +/- PIP joint contracture +/- First web contracture	Referral to specialist hand surgeon when functional problems become significant.
Severe	MCP contracture > 60° AND PIP contracture > 30°	Referral to specialist hand surgeon

The Commissioner WILL SUPPORT the following treatment options:

Treatment Modality	**Eligible patients:**	
Collagenase (Xiapex®) Injection (within licensed indications)	➢ Meet the requirements for surgery AND (not requiring skin grafting and PNF inappropriate) ➢ Primary disease in up to 2 joints AND ➢ 30° ≤ MCP ≤ 60° AND ➢ PIP < 30° **OR** 1st web contracture AND ➢ Administration in an Out-Patient setting	
Needle Fasciotomy (where considered safe and appropriate)	➢ Primary disease in up to 2 joints AND ➢ 30° ≤ MCP ≤ 60° AND ➢ PIP < 30° **OR** 1st web contracture AND ➢ Administration in an Out-Patient setting	
Fasciectomy Palmar (segmental) or Digital (regional/selective) depending on circumstances)	Moderate to severe disease as defined above with functional problems and all contractures > 40° in a single joint or > 60° total contracture in one digit (2 joints)	Where collagenase not appropriate or contra-indicated AND 2 or more digits on the same hand
Dermofasciectomy		Aggressive/extensive disease involving 3 or more joints/cords OR Severe recurrent disease following prior surgical intervention

Rationale: *Local resources are limited and therefore priority is given to patients with greatest need.*

Ganglion Surgery OPCS-4.7 Code: T591-599	The Commissioner **WILL SUPPORT** funded treatment if there is clear evidence of: • Clear neurovascular compromise in patients with a ganglia of the wrist; • Significant pain resulting from a seed ganglia at the base of a digit; • Disturbance of nail growth or discharging mucoid cysts at the DIP joint Routine dorsal and palmer ganglions **SHOULD NOT RECEIVE SURGERY** as they normally spontaneously resolve within 6 months of onset. **NO OTHER SURGERY IS ROUTINELY FUNDED.** ***Rationale**: Local resources are limited and therefore priority is given to patients likely to benefit most.*
Trigger Finger Surgery OPCS-4.7 Codes: T711,T723, T744	The Commissioner **WILL SUPPORT** funded treatment if there is clear evidence that the patient: • Has a fixed deformity that cannot be conservatively corrected ; • Has failed to respond to some/all of the conservative treatment options available within primary care including injections/analgesia/non-steroidal anti-inflammatory drugs (NSAIDs)/splinting at night for at least 6 months. **NO OTHER SURGERY IS ROUTINELY FUNDED** ***Rationale:** Local resources are limited and therefore priority is given to patients with greatest need.*
HIP	

Hip Replacement Surgery (THR)
 	
OPCS-4.7 Codes: Primary Hip replacement W371 Cement W381 Uncemented W391 Unspecified
	The Commissioner **WILL ONLY SUPPORT** joint replacement surgery for patients who have:
	
	1. **Failed conservative measures** in primary care to alleviate the patient's pain and disability; each treatment should be attempted for 12 weeks (where appropriate) to determine efficacy. These should include:
	  ○ Advice and engagement in weight loss and exercise
	  ○ Analgesics up to Step 3, NSAIDs
	  ○ Physiotherapy
	  ○ Use of recommended walking aids, home adaptation
	  ○ Engagement in modified behaviour to reduce aggravating the condition
	AND
	2. An **Oxford Hip Score (OHS) of less than 30** (e.g. patient's pain and disability should be sufficiently severe that it interferes with the patient's daily life and/or ability to sleep).
	AND
	3. a **BMI of below 35** supported by a primary care and/or community MSK service referral;
	AND
	4. Following provision of information regarding the potential risks and benefits of joint replacement, the **patient would accept surgery and is considered fit for surgery**.
	
	Patients Not Meeting Clinical Eligibility Criteria for Surgery:
	
	Where a patient's BMI is above 35, the Commissioner **will consider** joint

	replacement surgery ONLY if there is evidence the patient has: • **Mobility** so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat. **OR** • **Joint destruction** of such severity that delaying surgical correction would increase the technical difficulty of the procedure if delayed. **OR** • **Engaged actively with a weight management programme** and achieved a 10% reduction in their weight. ***Rationale:*** *Local resources are limited and therefore priority is given to patients with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use.* ***Failed Conservative Measures:*** *Royal College of Surgeons guidance.* ***OHS:*** *There are no validated tools that assess which patients are either most in need of surgery or who would benefit most from surgery. However, the OHS is a validated patient-reported measure with which disease burden and impact on a patient's quality of life can be measured. It is evident that the level of health gain from surgery is greatest for those patients with lower pre-operative OHS, which has guided the threshold for referral and intervention.* ***BMI:*** *To maximise the chances of the most beneficial patient outcomes, referring clinicians should actively engage patients with a BMI of 35 or more into existing weight management pathways. Surgery on patients with a BMI of less than 35 will maximise the functional benefit of surgery and reduce the risk of complications during and/or following surgery. There is evidence of compromised surgical success in patients who are morbidly obese (BMI >40) and super obese (BMI >50) arising from complication profiles that may outweigh the functional benefits of total joint arthroplasty.* Further details of the Oxford Hip Scoring Tool can be found at the following website addresses: **http://www.orthopaedicscore.com/scorepages/oxford_hip_score.html**
Therapeutic arthroscopic hip procedures – for hip impingement syndrome, labral tear and other hip pathologies	The Commissioner **DOES NOT SUPPORT** the funding of this intervention. ***Rationale:*** *This decision was made based on a full evidence review, which includes the current NICE Interventional Procedure Guidance relating to this procedure in hip impingement syndrome IPG 408, published in 2011 and a Cochrane review published in 2014. Further details on this can be found in Appendix B.*

KNEE		
Arthroscopy of the Knee *(non-Trauma*)* *Updated OPCS codes to be verified* ** including incidents that occur during routine activities*	***Diagnostic*** *W879*	The Commissioner **DOES NOT SUPPORT** the funding of diagnostic arthroscopy. *Rationale: A clinical examination (history and examination) by a competent clinician will give a diagnosis and demonstrate if internal joint derangement is present. If there is diagnostic uncertainty despite competent examination then an MRI scan might be indicated (see below); this decision should be made by secondary care specialists. MRI is rarely necessary but when appropriate, is a less invasive diagnostic procedure for the investigation of knee pain.*
	Pre-operative assessment	The Commissioner **WILL SUPPORT** the funding of arthroscopy as part of pre-operative assessment prior to definitive surgery. ***Rationale:*** *For a small number of patients pre-operative arthroscopy may be considered necessary to determine the nature of surgery to be undertaken ie. high tibial osteotomy, uni-compartmental or total knee replacement.*
	Debridement and Lavage W802, W808	The Commissioner **DOES NOT SUPPORT** the funding of arthroscopic debridement and/or lavage. ***Rationale:*** *The evidence has consistently demonstrated that in patients with osteoarthritis debridement +/- lavage has little, if any, effect on short-term outcomes, satisfaction, or pain compared to non-operative treatment. The evidence of benefit for younger patients is weak.*
	Therapeutic Intervention (including repair and resection) W822, W823	The Commissioner **WILL ONLY SUPPORT** referral for consideration of arthroscopic intervention when: 1. Red flags necessitating URGENT referral OR 2. True mechanical symptoms OR 3. Failure of non-operative interventions over 6 months without significant functional improvement WITH **no** evidence of osteoarthritis **Note:** The Suspected Meniscal Tear Pathway in Appendix C provides further definition of these circumstances. ***Rationale*** *(supported by various authorative bodies/guidelines)**:*** *i. Red flags may be indicative of more sinister pathology and require specialist review and evaluation.* *ii. The evidence to support intervention in patients with mechanical symptoms is inconsistent and poor, therefore intervention should only be considered in severe circumstances as defined on the pathway.*

		iii. There is overwhelming evidence demonstrating that conservative management produces comparable results to arthroscopic intervention in patients with degenerative knee pathology. *iv. There is evidence that arthroscopic intervention in patients with evidence of osteoarthritis may worsen/increase the risk of symptomatic knee osteoarthritis.* *v. Evidence indicative of osteoarthritis (OA):* *Radiographic reporting features indicative of OA (including osteophytes, joint space narrowing, degenerative joint disease (DJD)* *Age 45 years of age or more with symptoms & signs clearly suggesting OA (NICE 2015):* • *Affected joints are painful when used (+/- pain at rest, crepitus, limited range movement)* • *Affected joints become stiff after resting*
Knee Replacement Surgery (TKR) OCPS-4.7 codes: Primary Knee Replacement W401 Cemented W411 Uncemented W421 Unspecified	The Commissioner **WILL ONLY SUPPORT** joint replacement surgery for patients who have: 1. **Failed conservative measures** in primary care to alleviate the patient's pain and disability; each treatment should be attempted for 12 weeks (where appropriate) to determine efficacy. These should include: ○ Advice and engagement in weight loss and exercise ○ Analgesics up to Step 3, NSAIDs ○ Physiotherapy ○ Use of recommended walking aids, home adaptation ○ Engagement in modified behaviour to reduce aggravating the condition **AND** 2. An **Oxford Knee Score (OKS) of less than 30** (e.g. patient's pain and disability should be sufficiently severe that it interferes with the patient's daily life and/or ability to sleep). **AND** 3. A **BMI of below 35** supported by a primary care and/or community MSK service referral; **AND** 4. Following provision of information regarding the potential risks and benefits of joint replacement, the **patient would accept surgery and is considered fit for surgery**. **Patients Not Meeting Clinical Eligibility Criteria for Surgery:** Where a patient's BMI is above 35, the Commissioner **will consider** joint replacement surgery ONLY if there is evidence the patient has: • **Mobility** so compromised that they are in immediate danger of losing their independence and that joint replacement would relieve this threat. **OR** • **Joint destruction** of such severity that delaying surgical correction would increase the technical difficulty of the procedure if delayed. **OR** • **Engaged actively with a weight management programme** and achieved a 10% reduction in their weight. ***Rationale:*** *Local resources are limited and therefore priority is given to patients*	

	with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use. ***Failed Conservative Measures:*** *Royal College of Surgeons guidance.* ***OKS:*** *There are no validated tools that assess which patients are either most in need of surgery or who would benefit most from surgery. However, the OKS is a validated patient-reported measure with which disease burden and impact on a patient's quality of life can be measured. It is evident that the level of health gain from surgery is greatest for those patients with lower pre-operative OKS, which has guided the threshold for referral and intervention.* ***BMI:*** *To maximise the chances of the most beneficial patient outcomes, referring clinicians should actively engage patients with a BMI of 35 or more into existing weight management pathways. Surgery on patients with a BMI of less than 35 will maximise the functional benefit of surgery and reduce the risk of complications during and/or following surgery. There is evidence of compromised surgical success in patients who are morbidly obese (BMI >40) and super obese (BMI >50) arising from complication profiles that may outweigh the functional benefits of total joint arthroplasty.* Further details of the Oxford Knee Scoring Tool can be found at the following website addresses: **http://www.orthopaedicscore.com/scorepages/oxford_knee_score.html**
Intra-articular Hyaluronic acid for Osteoarthritis of the Knee (including Synvisc-One®)	**Area Prescribing Committee Commissioning Statement** The current arrangements **SUPPORT RESTRICTED USE** of Synvisc-One® within a defined pathway of care managed within a secondary care pathway at Worcestershire Acute Hospitals NHS Trust (Appendix D). ***Notes:*** *Synvisc-One® is only endorsed for administration by specialist clinicians within this secondary care clinical pathway.* Where this intervention is used, Commissioners expect clinicians to record use and outcomes in order to demonstrate compliance with commissioning statement. Use of any other hyaluronic acid preparation (e.g. Durolane®, Ostenil®) is **NOT SUPPORTED** in any setting within Worcestershire. Use of any hyaluronic acid preparation (including Synvisc-One®) in any other joints is **NOT SUPPORTED** within Worcestershire. ***Rationale:*** *The Area Prescribing Committee (APC) together with the Clinical Commissioning Policy Collaborative (CCPC) have reviewed the evidence for and use of these products; the evidence is limited and weak. The longer term benefits of this intervention will continue to be evaluated and criteria for use refined as appropriate.*
Magnetic Resonance Imaging (MRI) Knee	Referral for knee MRI **should only** be made by secondary care consultants ***Rationale:*** *i. MRI is rarely indicated for the degenerative knee. A degenerative knee is poorly associated with symptoms and should be considered a feature indicative of early stage knee osteoarthritis and the patient treated accordingly.* *ii. Knee radiography should be used as a first line imaging tool to support a diagnosis of osteoarthritis or to detect certain rarer pathologies of the knee. Therefore, anteroposterior weight-bearing (, lateral radiography is required. Skyline patella x-ray may be undertaken if there is suspicion of*

	patellofemoral osteoarthritis. *iii. Knee MRI may be indicated in selected patients with refractory symptoms or in the presence of 'warning flags' or localised symptoms indicating a rarer disease that needs to be ruled out. These circumstances would be determined by secondary care consultants.*
MISCELLANEOUS	
Exogen Therapy for Non Union Fractures of Long Bones	The Commissioner **WILL SEPARATELY FUND**: • use of Exogen® ultrasound bone healing system to treat long bone fractures with non-union, in accordance with defined clinical and process criteria (see page 7 of Exogen policy, link below) The Commissioner **WILL NOT SEPARATELY FUND**: • use of Exogen® ultrasound bone healing system to treat long bone fractures with delayed union • any other indications for use of Exogen® ultrasound bone healing system Please refer to the separate policy on this treatment, which can be accessed using the following website link: http://www.redditchandbromsgroveccg.nhs.uk/about-us/strategies-policies-and-procedures/commissioning-ifr/ ***Rationale:*** *Local resources are limited and therefore priority is given to patients with greatest need. This determination has been undertaken following a review of the evidence and consideration of the local circumstances for use.*
Joint Injections (excluding facet joint injections): Corticosteroids (steroid) injections OPCS-4.7 Codes: W903, W904	*This section has been temporarily removed while a review is undertaken. The intention is to develop joint specific guidance for incorporation in this section.*
Therapeutic Ultrasound in Physiotherapy	The Commissioner **DOES NOT SUPPORT** funding of this treatment due to lack of evidence of clinical efficacy.
SHOULDER	
Excision of Acromi-Clavicular Joint/or Surgical Decompression of Subacromial Space	The Commissioner **WILL SUPPORT** funded treatment if there is clear evidence that: • There has been a 6 month trial of conservative treatment, or if • A temporary improvement has been demonstrated using injection surgery. ***Rationale:*** *Local resources are limited and therefore priority is given to patients*

UNDER REVIEW
UNDER REVIEW

OPCS-4.7 Codes: Z812 - acromioclavicular joint O291 – subacromial decompression	*with greatest need.*

SPINE

For management of low back pain and sciatica, NICE Guideline 59 recommends:

1. Consideration of alternative diagnosis
2. Risk stratification using for example STarT Back tool for each new episode of low back pain with or without sciatica
3. Non-Invasive self-management involving education, exercise and manual therapy as part of a treatment package including exercise with or without psychological therapy.
4. Appropriate pharmacological interventions (see https://www.sps.nhs.uk/wp-content/uploads/2017/01/NICE-Bites-Low-back-pain-and-sciatica-No-93-Jan-2017.pdf in consideration with Worcestershire Joint Medicines Formulary http://www.worcsformulary.nhs.uk/ and Worcestershire Area Prescribing Committee guidance http://www.southworcsccg.nhs.uk/about-us/area-prescribing-committee/)
5. Promote and facilitate return to work or normal activities of daily living.
6. **Do not offer** traction, belts, corsets, foot orthotics, rocker sole shoes, acupuncture (including PENS and TENS), ultrasound or interferential therapy.

Diagnostic Imaging	Imaging including X-ray, MRI or CT (where MRI contra-indicated) for people with low back pain with or without sciatica: - **Should NOT** routinely be offered by primary care - MRI may be requested by primary care for patients who have a history of malignancy to **exclude sinister underlying pathology** - May be considered in a specialist care setting **only if the outcome will change management** ***Rationale:*** *NICE Guidance (NG59) Low back pain and sciatica in over 16s: assessment and management, published November 2016 states that imaging is not necessary unless the outcome will change management and where there are new or changed signs and symptoms which could suggest alternative diagnoses and may be an indication of possible serious underlying pathology. This decision should be made in a secondary/specialist care setting.*
Disc Replacement Surgery	The Commissioner **DOES NOT SUPPORT** the funding of disc replacement surgery ***Rationale:*** *NICE Guidance (NG 59) identifies that there is limited evidence of effectiveness alongside concerns in relation to long-term outcomes and potential for harm, and thus conclude that disc replacement surgery is not recommended in people with low back pain with/without sciatica.*
Facet Joint Injections (FJI)	The Commissioner **DOES NOT SUPPORT** the funding of facet joint injections.

OPCS-4.7 Code: V544	***Rationale**: NICE Guidance (NG59) states that Facet Joint Injections (FJI) should not be offered, in accordance with evidence of best practice and guidance of limited effectiveness. The National Back Pain Pathway (Greenough, 2017) concurs with this and recommends that FJI are not offered.*
Radiofrequency Denervation	The Commissioner **WILL SUPPORT** a single treatment with radiofrequency denervation for chronic pain (> 2 years) when: • Non-surgical treatment has failed AND • The pain originates from structures supplied by the medial branch nerve (evidenced by a positive response to a diagnostic medial branch block) AND • Localised back pain is moderate to severe (> 5 on VAS) **Repeat treatments with radiofrequency denervation are not routinely commissioned** **Notes:** 1. Imaging for people with specific facet joint pain is not a prerequisite for radiofrequency denervation 2. Patients who experienced prolonged pain relief from medial branch blocks (i.e. an analgesic effect outlasting the expected duration of local anaesthesia) should be offered radiofrequency denervation rather than repeated medial branch blocks ***Rationale:*** ***i.*** *NICE Guidance (NG59) identifies that these criteria are consistent with the population of patients involved in the trials that demonstrate efficacy for radiofrequency denervation.* ***ii.*** *The evidence for use of repeat treatment with radiofrequency denervation is limited, the duration of benefit and cost-effectiveness is unclear. NICE identify this as an area for further research.*
Spinal Decompression	The Commissioner **WILL SUPPORT** spinal decompression for people with sciatica when: • Non-surgical treatment has not improved pain or function (including a single spinal epidural injection where appropriate) AND • Radiological findings are consistent with sciatic symptoms ***Rationale:** NICE Guidance (NG59) identifies that that sciatic symptoms usually improve over the course of the first 3 months in the majority of people without treatment. Further evidence identifies that 50% of people who have an epidural do not go on to have surgery. Beyond this, discectomy for people suffering from sciatica offers a good prognosis and is successful in providing long-term pain relief for the subgroup of people who have failed to respond to conservative management.*
Spinal Epidural Injections (SEI) OPCS-4.7 Codes: A521 A522	The Commissioner **WILL SUPPORT a single SEI** of local anaesthetic and steroid in the following circumstances: • For severe, non-controllable radicular pain in prolapsed intervertebral disc early in the clinical course for symptom control • For treatment of lumbar radicular pain with the aim of avoiding surgery **Repeat SEI are not routinely commissioned**

	SEI are NOT SUPPORTED for patients with neurogenic claudication in people who have central spinal canal stenosis. ***Rationale**: The national back pain pathway states that the utility of diagnostic lumbar nerve root injections has not been fully established and they should not be used for neurogenic claudication with central spinal stenosis. NICE Guidance (NG59) recommends use to avoid surgery as stated above. NICE considered that as the indication is for an acute sciatica population, then multiple injections would not usually be performed.*
Spinal Fusion Surgery OPCS-4.7 Codes: V371-379 V381-389	The Commissioner **DOES NOT SUPPORT** the funding of spinal fusion surgery for patients with low back pain. ***Rationale:** NICE Guidance (NG 59) identifies that there is a lack of evidence of clinical effectiveness to recommend spinal fusion for people with low back pain other than in the context of a randomised controlled trial.*

5.2 Appendices A, B, C and D of this policy sets out additional information as outlined in the table above.

6. Supporting Documents

- Stoke on Trent Primary Care Trust and NHS North Staffordshire – Acute Service – Exclusions and Prior Approvals Guidelines 2008/9
- NHS Warwickshire Commissioning Policy: Treatments considered Low Priority
- Bristol North, Bristol South & West and South Gloucestershire Primary Care Trusts - Commissioning services for people with orthopaedic problems August 2006
- West Sussex Primary Care Trust – Commissioning for Clinical Effectiveness Procedures where Thresholds Apply August 2007
- Coventry & Rugby Clinical Commissioning Group policy
- Northern, Eastern and Western Devon Clinical Commissioning Group policy
- NICE IPG 408 (2011) Arthroscopic femoro–acetabular surgery for hip impingement syndrome. [Available at: http://publications.nice.org.uk/arthroscopic-femoroacetabular-surgery-for-hip-impingement-syndrome-ipg408]
- Papalia R, Del Buono A, Franceschi F, Marinozzi A, Maffulli N, Denaro V. Femoroacetabular impingement syndrome management: arthroscopy or open surgery? International Orthopaedics, May 2012, vol./is. 36/5(903-14), 0341-2695;1432-5195 (2012 May) Publication Date: May 2012
- Is Access To Surgery A Postcode Lottery? The Royal College of Surgeons of England (Hip Replacement Section) – July 2014
- 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 England: Individual Funding Requests
- NHS Constitution, updated 27th July 2015
- NICE Guidance (NG59): Low back pain and sciatica in over 16s: assessment and management, published November 2016
- Clinical Commissioning Policy Collaborative: Specific evidence reviews in relation to clinical areas

APPENDIX A

Management of Carpal Tunnel Syndrome in Adults

Guidance for General Practitioners 2018

(based on BOA guidance 2017 and views of local orthopaedic hand surgeons)

		Mild to Moderate		Severe	
Presentation - Signs/symptoms consistent with both the history and examination - Consider Differential Diagnosis		**History**	**Examination**	**History**	**Examination**
		Intermittent paraesthesia in the correct distribution (thumb, index, middle) AND Exacerbation of symptoms at night AND No persistent hypoaesthesia	Subjective (mild) or Objective (moderate) sensory impairment in the correct distribution AND Subjective (mild) or Objective (moderate) weakness in the thumb/loss of coordination	Persistent paraesthesia in the correct distribution AND Persistent numbness and weakness in the correct distribution AND Daily symptoms with frequent night waking	Reduced vibration and 2-point discrimination AND Objective thenar muscle weakness AND Thenar muscle wasting (visible)
Investigations		➢ Blood test is only needed if the history and examination suggests a specific secondary cause eg. hypothyroidism, rheumatoid arthritis.			
MANAGEMENT	**STEP 1** *0 weeks*	○ **Patient information** ○ **Wrist splint at night** (12 weeks; with review after 6 weeks where necessary)		○ **REFER to 2ndry Care** ○ Patient information ○ Wrist splint at night ○ NCS ONLY if diagnosis in doubt	
	STEP 2 *12 weeks*	**Corticosteroid (CSC) injection** - GP or Intermediate provider - 40mg methylprednisolone or 40mg triamcinolone acetonide with local anaesthetic		**"Red Flags" – emergency referral to A&E** • Fracture • Onset of tingling/numbness after injury • Nerve /other suspected tumour (Syringomyelia)	
		No Benefit ↓ **Nerve Conduction Study** (at least 6 weeks after CSC inj[n])	**Sustained Improvement** ↓ **Repeat CSC injection every 6 months as necessary**	**Temporary Improvement** (significant symptom recurrence within 6 weeks) ↓ **REFER to 2ndry Care** Assuring:	**"Yellow Flags" – urgent speciality referral (< 2 wk)** • Neurological diseases(MS, MND) • Active inflammatory joint diseases (eg. Gout, RA) • Peripheral limb ischaemia (eg thoracic outlet syndrome or Raynaud's disease) • Cervical nerve root entrapment
	STEP 3 *16+ weeks*	**Negative, Borderline or Mild NCS** Conservative Mx/ Consider Alternative Dx **Moderate, or Severe NCS** →	**REFER to 2ndry Care** Assuring: →	↓ 1. Value of and need for surgery on the basis of symptoms 2. Patient willing to proceed to surgery	**Remember Alternative Diagnosis:** • Ulnar neuropathy (at the elbow - cubital tunnel syndrome, or wrist - canal of Guyon) • Peripheral neuropathy (all forms, diabetic neuropathy) • Trigger digits • Restless limb syndrome (Restless legs; may begin in arm) • De Quervain's tenosynovitis (and other tendonitides) • Writers cramp (focal dystonia of the forearm)

APPENDIX B

Therapeutic arthroscopic hip procedures – for hip impingement syndrome, labral tear and other hip pathologies	The Commissioner **DOES NOT SUPPORT** the funding of this intervention. Requests on an exception basis should be made by the treating clinician through the Individual Funding Request route. **Rationale:** This decision was made based on a full evidence review, which includes the current NICE Interventional Procedure Guidance relating to this procedure in hip impingement syndrome IPG 408, published in 2011 and a Cochrane review published in 2014. IPG 408 concluded that there were few controlled studies comparing the procedure with other interventions, or natural history. There was a range of hip scales used in the published material and often no validation. The hip pathology was often not well described or classified. The interventions used are usually individualised to each patient and therefore results may not be generalisable. Study quality was generally poor with little prospective data. NICE IPG 408 concluded that current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief only in the short to medium term. Therefore this procedure should only be used where arrangements are in place for clinical governance, consent and proper audit with local review of outcomes. IPG 408 does not specifically endorse hip arthroscopy on the grounds of cost-effectiveness. A Cochrane review of evidence in 2014 on the efficacy of arthroscopy for FAI identified similar issues to those in NICE IPG 408, especially with regards to the poor of quality evidence. 9 case series and 2 randomised-controlled studies were reviewed but were deemed to have unsuitable controls, varying end-points and scoring systems. However, 4 on-going randomised controlled studies were identified, 3 of which were comparing efficacy vs physiotherapy and 1 of which is comparing the intervention against a 'sham' procedure. The results of these 4 RCTs are to be published after 2017. An additional search of the peer reviewed literature echoes the lack of available data; the need for more studies examining impact on quality of life and symptom control, as well as the subsequent need for total hip replacement, which would increase costs significantly.2 Although there is growing evidence for the use of hip arthroscopy for femoro-acetabular impingement and for labral pathology, this has not been considered by NICE and is insufficient to make an informed recommendation. IPG 408 suggests arthroscopy may delay the progression to osteoarthritis however there is only limited epidemiological evidence for this association, and there is no direct evidence suggesting arthroscopy prevents future hip replacements. This association may only be determined through further long term trials and regular evidence reviews.

APPENDIX C

Symptomatic Knee Pain Pathway

Knee swelling - Point tenderness - Jointline

TRAUMA Related
Following a significant event without prior related presentation

Non-Traumatic (degenerative?)
including incidents occurring during routine activities

Urgent Trauma Referral

RED FLAGS (4)
(clinically or on X-ray)

GP: Conservative Management (4-6 weeks) (1, 2)
X-ray

Evidence of Osteoarthritis (3)

Secondary Care Referral (8)
Assessment & further investigations

True Mechanical Symptoms? (5)

NO Evidence of Osteoarthritis (3)

Osteoarthritis Pathway & Management Of Risk Factors (9)
If appropriate, please use "Referral form For Consideration of Hip or Knee Replacement Surgery"

Early referral

Intermediate Provider (6)

Management: Non Operative
± Injection
6 months total
Skyline patella x-ray if suspicion of patellofemoral OA (7)

Significant Functional Improvement?

Yes → **No Further Action**

No

Secondary Care Referral (8)
Using "Referral Form for Consideration of Symptomatic Knee Pain"
Assessment & further investigations

Knee MRI:
- Is rarely indicated
- Should only be requested by secondary care consultants
- Exceptions to this will only be considered via the "Advice and Guidance" pathway

For clinical uncertainty or concern at any stage consider "Advice and Guidance"

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APPENDIX C Continued

Symptomatic Knee Pain Pathway Definitions

May 2018

1 GP Conservative Treatment (4 to 6 weeks):

- Pain Management (NSAID/paracetamol)
- Home exercises
- Risk Factor Management (see 9)
- Physiotherapy
- Intra-articular injection

2 X-rays:

- To exclude non-meniscus related disease
- Require anteroposterior weight bearing (*with ? OA on order form*), lateral
- Skyline patella x-rays may only be ordered by MSK specialists in intermediate and secondary care

3 Evidence Indicative of Osteoarthritis (OA):

Radiographic reporting features indicative of OA (including osteophytes, joint space narrowing, degenerative joint disease (DJD))

Age 45 years of age or more with symptoms & signs clearly suggesting OA (NICE 2015):

- Affected joints are painful when used (+/- pain at rest, crepitus, limited range movement)
- Affected joints become stiff after resting

4 RED FLAGS (clinically or on X-ray):

- ❖ Suspicion of septic arthritis, osteonecrosis or slipped capital femoral epiphysis
- ❖ Fracture cannot be excluded
- ❖ Severe soft tissue injury with gross instability

5 True Mechanical Symptoms:

- ❖ Knee giving way with pain daily or near daily for at least 1 month, **OR**
- ❖ Episodes of locking in FLEXION (true locking)

6 Intermediate Care Provider:

Redditch & Bromsgrove CCG – Community Based Physiotherapy Service
South Worcestershire CCG – MSK Extended Scope Physiotherapist (WH&CT)
Wyre Forest CCG – Practice Based Extended Scope Physiotherapist

7 Non-Operative Management:

3 phased programme, in accordance with ESSKA guidance, over 6 months aiming to:

- control the pain and swelling
- restore the range of motion (ROM)
- restore or maintain isolated muscle function and
- optimize lower extremity neuromuscular coordination and muscle strength

8 Indications for Arthroscopic Partial Meniscectomy (APM):

- ❑ Acute traumatic (non-degenerative) tears
- ❑ Degenerative meniscal tear with:
  - Meniscal fragment in tibial gutter (± adjacent bone oedema)
  - Parameniscal cyst
  - True mechanical symptoms

Indications for Chondroplasty:

- ❑ Patellofemoral osteoarthritis with recurrent swelling

9 Lifestyle Advice/Risk Factors:

- ❖ Maintain a healthy weight; excess weight can increase biomechanical load and may worsen the condition
- ❖ Maintain a level of regular activity to maintain good joint function; plan increases in activity methodically
- ❖ Quit smoking; there is an established link between smoking and musculoskeletal pain

Worcestershire Clinical Commissioning Policy Collaborative

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APPENDIX D

Intra-articular Hyaluronic acid for Osteoarthritis of the Knee (including Synvisc-One®)

Secondary Care Investigations for New Treatment

Patients with Mechanical Symptoms:

- Appropriate investigations e.g. Plain x-rays, Possibly an MRI Scan
- If loose bodies or meniscal pathology, then treat with **Arthroscopy and Debridement** and **DISCHARGE if condition improves**
- If condition remains, then consider
  - **Unicompartmental Replacement** if appropriate; OR
  - ***Synvisc-One®** for patients considered unsuitable for surgery and **DISCHARGE** following treatment with no secondary care follow up arrangement

Patients with No Mechanical Symptoms:

- **Medical management of Osteoarthritis** to include Weight Loss, Analgesics, Advice. **DISCHARGE if condition improves**
- **Severe Osteoarthritis** – Total Knee Replacement – if patient is within appropriate age group
- **Acute Flare Up of Osteoarthritis** Symptoms (swelling and pain), consider corticosteroids
- **Significant Pain** - consider ***Synvisc-One®** if:
  - Preserved joint space
  - Patients not suitable for Total Knee Replacement (think about likely future surgery)
  - Significant comorbidities
  - High risk of anaesthetic

  DISCHARGE following treatment with no secondary care follow up arrangement

Repeat *Synvisc-One® Treatment

- Repeat administration of *Synvisc-One® is **not routinely supported** UNLESS the patient has experienced symptomatic benefit for a minimum of 9 to 12 months post treatment.
- **Review** should be undertaken **by the Patient's GP** when required; eligible patients may be **referred into Secondary Care** for consideration of repeat ***Synvisc-One®**.
- **If less** than 9 months benefit (or no benefit) achieved, **Total Knee Replacement** may be reconsidered **within a Secondary Care** treatment pathway.

*** NOTES:**

1. The clinical decision to **initiate/repeat Synvisc One®** within an NHS funded secondary care pathway should only be done by an **Orthopaedic Consultant working under the Worcestershire Acute Hospitals NHS Trust contract**.
2. Any patient being considered for NHS funded Synvisc One® treatment should be assessed against this policy statement and, if clinically eligible, referred on to the Orthopaedic Consultants at the aforementioned Trust for further review.
3. Where this intervention is used, **Commissioners expect secondary care clinicians to:**
   - **supply and administer Synvisc-One® and**
   - **record use and clinical outcomes** in order to demonstrate compliance with the commissioning statement.
4. Use of any other hyaluronic acid preparation (e.g. Durolane®, Ostenil®) is **NOT SUPPORTED** in any setting within Worcestershire.
3. Use of any hyaluronic acid preparation (including Synvisc-One®) in any other joints is **NOT SUPPORTED** within Worcestershire.

Rationale: *The evidence base around the clinical efficacy of Synvisc One® remains small and all Worcestershire patients receiving this treatment need to be included in the local pathway to ensure their clinical outcomes form part of the essential evidence review being conducted by Worcestershire Acute Hospitals NHS Trust Orthopaedic Consultants.*

Expires June 2019

Equality Impact Assessment

Organisation	NHS Redditch & Bromsgrove CCG, NHS South Worcestershire CCG, NHS Wyre Forest CCG		
Department	Commissioning	Name of lead person	
Piece of work being assessed	Musculoskeletal Surgery and Therapeutic Interventions Policy		
Aims of this piece of work	Revise to include changes made to the previous guidelines for patients and for clinicians in both primary and secondary care on the medical/clinical requirements against which musculoskeletal procedures/interventions will be funded on the NHS within Worcestershire.		
Date of EIA	18th April 2018	Other partners/stakeholders involved	Clinical Commissioning Policy Collaboration
Who will be affected by this piece of work?	Individuals with musculoskeletal problems requiring further investigation and possible interventions as part of an NHS pathway of care		

Clinical Area → / Equality Strand ↓	Bunions and hallux valgus	Carpal Tunnel Syndrome	Dupuytren's Contracture	Trigger Finger Surgery	Hip Replacement Surgery	Knee Replacement Surgery
Gender	More prevalent in women than men.	More prevalent in women but variability between studies	More aggressive form of disease prevalent in Caucasian males < 50	More common among women than men in the fifth or sixth decade of life.	Various studies suggest that the rates are higher in women than men but suggest that this may be linked to higher rates of obesity.	
Race	No issue	Whites have the highest risk of developing CTS. The syndrome appears to be very rare in some racial groups (eg, nonwhite South Africans).	More aggressive form of disease prevalent in Caucasian males < 50	Prevalence higher among patients with diabetes mellitus, rheumatoid arthritis, or conditions that cause systemic deposition of protein such as amyloidosis. Some of these conditions are influenced by race	Caucasians have the highest annual age-standardized rates Blacks, Japanese, Hispanics, Chinese and Filipino have lower rates in decreasing order compared to Caucasians.	Caucasians have higher rates than African-Americans. Rates are around a third lower among blacks. The ethnic/racial disparity appears lower among women (23% and 28%) than among men (63% and 60%).
Disability	No issue	The nature of the disease may disadvantage patients with a disability. However, policy provides guidance on optimal treatments at key stages of disease pathway.			No issue	No issue
Religion/ belief	No issue	No issue	No issue	No issue	No issue	No issue
Sexual orientation	No issue	No issue	No issue	No issue	No issue	No issue
Age	Prevalence 23% in adults aged 18 to 65 years. It becomes more frequent with increasing age.	Peak age range for development is 45-60 years. Only 10% of patients are younger than 31 years.	More common in men aged over 50 and women aged over 60. More aggressive form of disease prevalent in Caucasian males < 50	2 % in the general population, and more common among women than men in the fifth or sixth decade of life	Osteoarthritis, a disease of age, is the commonest underlying condition for both TKA and THA. Other conditions leading to TKA and THA include inflammatory arthritis, fracture, dysplasia, malignancy	
Social deprivation	Rare in unshod populations but associates with wearing high-heeled or narrow shoes	Higher incidence in overweight patients.	No issue	No issue	No issue	No issue
Carers	No issue	Some evidence that CTS may be commoner in people who use hands for strenuous, repetitive tasks and in those making extensive use of vibrating tools.	The nature of the disease may disadvantage carers in undertaking their role.	No issue	The nature of the disease may disadvantage carers in undertaking their role.	
Human rights	No issue	No issue	No issue	No issue	No issue	No issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery					

Clinical Area → / Equality Strand ↓	Therapeutic arthroscopic procedures: hip impingement syndrome, labral tear and other hip pathologies.	Knee Arthroscopic Debridement and Lavage	Knee Diagnostic Arthroscopy	Intra-articular Hyaluronic Acid Injections for Osteoarthritis	Joint Injections (including Corticosteroid)	Exogen Therapy for Non Union Fractures of Long Bones	Diagnostic Imaging for Low Back Pain (including sciatica)
Gender	There is evidence to support a higher prevalence in high level athletics during adolescence eg. football, soccer, ice hockey, which are more male orientated sports.	Undertaken to determine nature of injury, usually related to acute injury. Only provided as part of pre-operative assessment prior to definitive surgery or as a therapeutic intervention in patients with significant clinical issues.		Females have a higher prevalence and more severe OA.		See separate policy for completed EIA.	Patient.co.uk a higher prevalence of low back pain in women due to changes in posture associated with adolescence and pregnancy
Race	There is insufficient evidence to support a genetic cause	No issue	No issue	Hip & hand OA is reported less frequently among Chinese than in whites but Chinese women have significantly higher prevalence of both radiographic and symptomatic knee OA than white women in. Prevalence of hip OA in African American women (23%) was similar to that in white women (22%), and prevalence was slightly higher in African American men (21%) than that in white men (17%).			NICE note that more Western European people report this issue.
Disability	No issue	No issue	No issue	The nature of the disease may impact more on those with disabilities.			No issue
Religion/ belief	No issue	No issue	No issue	No issue	No issue		No issue
Sexual orientation	No issue	No issue	No issue	No issue	No issue		No issue
Age	Mainly affects young and middle-aged adults.	Of benefit for patients following acute injury to determine nature and extent of injury. Likely to be more common in younger, more active adults. Evidence suggests limited benefit in patients with OA who subsequently progress to knee replacement surgery.		Prevalence increases with age.			Prevalence increases with age
Social deprivation	No issue	No issue	No issue	No issue	No issue		No issue
Carers	No issue	No issue	No issue	No issue	No issue		No issue
Human rights	No issue	No issue	No issue	No issue	No issue		No issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery						

Clinical Area → / Equality Strand ↓	Therapeutic Ultrasound in Physiotherapy	Excision of Acromi-Clavicular Joint/or Surgical Decompression of Subacromial Space	Ganglion Surgery	Spinal Facet Joint Injections	Spinal Epidural Injections	Spinal Fusion Surgery	Radiofrequency Denervation
Gender	Non site specific intervention used on a variety of soft tissue and sports injuries. It is not possible to define how these may impact on the different equality strands.	More common in men.	The prevalence in women is three times that in men. Mucous cysts more common in females than in males.	Unclear whether there is a gender related variance. There may be issues for women associated with osteoporosis, menstruation and pregnancy.			Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)
Race		Uncertain	No issue	No reported variance			
Disability		No issue	No issue	No issue	No issue	No issue	No issue
Religion/ belief		No issue	No issue	No issue	No issue	No issue	No issue
Sexual orientation		No issue	No issue	No issue	No issue	No issue	No issue
Age		Most commonly associated with age but also throwing sports which would suggest a younger cohort.	Most ganglions occur in persons aged 10-40 years, with a range from childhood to the ninth decade of life. Mucous cysts (ganglions of the distal interphalangeal joint) occur primarily in persons aged 40-70 years.	Incidence of low back pain is highest in the third decade, and overall prevalence increases with age until the 60-65 year age group and then gradually declines.			
Social deprivation		No issue	No issue	Low back pain is associated with low educational status and smoking both common in areas of social deprivation.			
Carers		Occurrence may be related to work involving lifting.	No issue	Lifting may contribute to low back pain			
Human rights		No issue	No issue	No issue	No issue	No issue	No Issue
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery						

Clinical Area → **Equality Strand ↓**	**Disc Replacement Surgery**	**Spinal Decompression**					
Gender	Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)	Patient.co.uk notes that there may be a higher prevalence of low back pain in women due to changes in posture associated with body changes (adolescence and pregnancy)					
Race	No reported variance						
Disability	No issue	No issue					
Religion/ belief	No issue	No issue					
Sexual orientation	No issue	No issue					
Age	Incidence of low back pain is highest in the third decade, and overall prevalence increases with age until the 60-65 year age group and then gradually declines.						
Social deprivation	Low back pain is associated with low educational status and smoking both common in areas of social deprivation.						
Carers	Lifting may contribute to low back pain						
Human rights	No Issue	No Issue					
SUMMARY: differential impact?	No differential impact for any aspect in terms of policy delivery						

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead