NHS
Leeds
Clinical Commissioning Group

Hips, Hands, Shoulders, Knees and Feet Commissioning Policy

Version:	2019-22
Ratified by:	NHS Leeds Clinical Commissioning Group Quality and Performance Committee – 13 March 2019
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Name of responsible committee/individual:	Dr Simon Stockill, Medical Director, NHS Leeds CCG Governing Body
Date issued:	March 2019
Review date:	December 2022
Target audience:	Primary and secondary care clinicians, individual funding request panels, and the public
Document History:	Leeds CCG Targeted Interventions Policy Feb 2014 Leeds CCG Hips, Hands, Shoulders Knees and Feet Commissioning Policy 2016-19

Produced on behalf of NHS Leeds Clinical Commissioning Group

Executive Summary

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

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

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

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

This policy relates specifically to :

This policy relates specifically to hips, hands, shoulders, knees and feet commissioning.

Contents

1 Introduction

The Clinical Commissioning Groups (CCGs) (NHS Leeds West CCG, NHS Leeds North CCG and NHS Leeds South and East CCG) were established on 1 April 2013 under the Health and Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006. As at 1 April 2018 these three CCGs have merged to become NHS Leeds Clinical Commissioning Group

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

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

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

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

2 Purpose

The purpose of the IFR policy is to enable officers of NHS Leeds CCG to exercise their responsibilities properly and transparently in relation to IFRs, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions in relation to IFRs are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCG.

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

The policy is underpinned by the following key principles:

- The decisions of the IFR panels outlined in the policy are fair, reasonable and lawful, and are open to external scrutiny.

- Funding decisions are based on clinical evidence and not solely on the budgetary constraints.
- Compliance with standing financial instructions / and statutory instruments in the commissioning of healthcare in relation to contractual arrangements with providers.

Whilst the majority of service provision is commissioned through established service agreements with providers, there are occasions when services are excluded or not routinely available within the National Health Service (NHS). This may be due to advances in medicine or the introduction of new treatments and therapies or a new cross-Leeds Clinical Commissioning Group statement. The IFR process therefore provides a mechanism to allow drugs/treatments that are not routinely commissioned by the NHS Leeds CCG to be considered for individuals in exceptional circumstances.

3 Scope

Policy development and review: consultation and engagement

The policy was developed to:

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

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

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

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

This policy relates specifically to hips, hands, shoulders, knees and feet commissioning.

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

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

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

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

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

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

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

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

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

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

Endpoints

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

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

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

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

4 Definitions

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

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

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

5 Duties

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

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

6 Main Body of Policy

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

6.1 Carpal tunnel syndrome release

Status: routinely commissioned in specific circumstances[1]

Mild cases with intermittent symptoms causing little or no interference with sleep or activities require no treatment.

- Cases with intermittent symptoms which interfere with activities or sleep should first be treated with: a. corticosteroid injection(s) (medication injected into the wrist: *good evidence for short (8-12 weeks) term effectiveness*) **or** b. night splints (a support which prevents the wrist from moving during the night: *not as effective as steroid injections*)
- Surgical treatment of carpal tunnel should be considered if one of the following criteria are met: a. The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks; **or** b. There is either: i. a permanent (ever-present) reduction in sensation in the median nerve distribution; ***or*** ii. muscle wasting or weakness of thenar abduction (moving the thumb away from the hand).

Nerve Conduction Studies if available are suggested for consideration before surgery to predict positive surgical outcome or where the diagnosis is uncertain.

6.2 Dupuytren's contracture release in adults

Status: routinely commissioned in specific circumstances[2]

- Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20°) contractures, or one which is not progressing and does not impair function.
- An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) should be considered for: a. finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. **or** b. severe thumb contractures which interfere with function

- NICE concluded that collagenase should only be used for: a. Participants in the ongoing clinical trial (HTA-15/102/04) **or** b. Adult patients with a palpable cord if: i. there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected

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

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

joints; **and** ii. needle fasciotomy is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon

6.3 Painful deformed great toe Hallux Valgus Surgery
Status: routinely commissioned in specific circumstances

One of the main causes of painful deformed great toe is hallux valgus, also known as a bunion. Hallux valgus is caused by the deviation of the big toe towards the toes, the metatarsal head moves towards the midline and develops an overlying bursa and inflamed soft tissue. This can cause pain and can the deformity can impair balance. The pain and disability that can be caused by hallux valgus can impact on quality of life.

Hallux valgus can be managed conservatively as part of a multi-disciplinary team. Surgical management involves realignment of the bones, most often by osteotomy (removal of a portion of the bone).

According to the current MSK Toe Pain or Deformity pathway the patient must first be referred to Tier 1 podiatry (LCH) for hallux valgus. If symptoms persist or if there is diagnostic doubt the podiatry service will refer onwards to the MSK MDT (which may lead to surgery).

In terms of the criteria for referral to tier 1 podiatry from primary care the following criteria apply:

- Appropriate footwear is being worn; and
- Pain is occurring in the bunion joint
- There is significant concern of foot posture
- Specialist footwear advice is required
- Patient is not a candidate for surgery, but a second opinion is required

Referral to Secondary Care:

Patients should not be referred solely for prophylactic or cosmetic reasons

Surgery for hallux valgus will be routinely commissioned in the following circumstances in line with the ‘Commissioning Guide: Painful deformed great toe in adults ’ (2013) Royal College of Surgeons (2013):

- Deteriorating symptoms
- Failure of appropriate conservative measures after three months
- Persistent pain and disability not responding to up to 12 weeks of evidence based treatments including any treatment received in primary care
- Patient must be prepared to undergo surgery understanding that they will be out of sedentary work for 2-6 weeks and physical work for 2-3 months and they will be unable to drive for 6-8 weeks

Surgery will not be routinely commissioned solely for prophylactic or cosmetic reasons

6.4 Hip resurfacing and simultaneous replacement

Status: Routinely commissioned in specific circumstances

Hip resurfacing arthroplasty involves removing and replacing the surface of the femoral head with a hollow metal hemisphere, which fits into a metal cup fixed into the acetabulum.

Patient selection for total hip replacement or resurfacing arthroplasty depends on various factors, including but not limited to: patient characteristics (for example a patient's age, activity and underlying hip physiology); the surgeon's choice; and the surgeon's experience of using a particular class of prosthesis.

Prostheses for total hip replacement and resurfacing arthroplasty are recommended as treatment options for people with end-stage arthritis of the hip only if the prostheses have rates (or projected rates) of revision of 5% or less at 10 years, as per NICE guidance[3].

6.5 Femoro-acetabular arthroscopic surgery (hip arthroscopy).
Status: routinely commissioned in specific circumstances

Hip arthroscopy is routinely commissioned for patients presenting with;

- Diagnosis of definite labral pathology and/or hip impingement syndrome and/or other conditions where a minimally invasive approach is preferred as defined through clinical and radiological investigation (e.g. X-rays, MRI, CT scans) AND
- A recognised Orthopaedic Surgeon who specialises in young adult hip surgery has made the diagnosis, which should include discussion of each case with a specialist musculo-skeletal radiologist, AND
- Severe symptoms with compromised function measured by objective scoring tools and with a duration of at least six months where diagnosis has been made (see scoring tools below) AND
- Failure to respond to conservative treatment including activity modification, specialist physiotherapy and maximal pharmacological interventions for a period of 6 months AND
- Treatment with hip replacement, resurfacing or other more established procedure is not clinically viable AND
- Patient is aged between 18 and 50 years (clinical experience has shown that these patients are likely to gain the greatest benefit).

If agreed, the procedure should be carried out under general anaesthesia. The hip is subluxed using leg traction. An arthroscope and surgical instruments are inserted into the hip through two or three portals.

Hip arthroscopy is not routinely funded for patients with the following conditions:

- Patients with advanced degenerative OA on a preoperative X-ray (Tonnis grade 2 or more) or severe cartilage injury (Outerbridge grade III or IV).

[3] https://www.nice.org.uk/guidance/ta304 accessed 11/7/16

- Patients with joint space on plain radiograph of the pelvis that is less than 2mm wide anywhere along the sourcil.
- Patients who are candidates for total hip replacements.
- Patients who have hip dysplasia or considerable protrusion unless they have mechanical symptoms
- Patients with Osteonecrosis with femoral head collapse
- Patients with grade III or IV heterotopic bone formation
- Patients with sepsis and accompanying osteomyelitis or abscess formation
- Patients with joint ankylosis
- Patients with generalised joint laxity syndromes associated with hypermobility of the joints such as Marfan and Ehlers-Danlos syndromes
- Patients with osteogenesis imperfecta

6.6 Trigger Finger Release in Adults

Status: routinely commissioned in specific circumstances[4]

Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with: a. one or two steroid injections which are typically successful *(strong evidence)*, but the problem may recur, especially in diabetics; **or** *b.* splinting of the affected finger for 3-12 weeks *(weak evidence)*. Surgery should be considered if: a. the triggering persists or recurs after one of the above measures (particularly steroid injections); **or** b. the finger is permanently locked in the palm; **or** c. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate nonoperative methods; **or** d. diabetics. Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

6.7 Ganglion Excision

Status: routinely commissioned in specific circumstances[5]

Wrist ganglia

- no treatment unless causing pain or tingling/numbness or concern (worried it is a cancer);
- aspiration if causing pain, tingling/numbness or concern
- surgical excision only considered if aspiration fails to resolve the pain or tingling/numbness and there is restricted hand function.

Seed ganglia that are painful

- puncture/aspirate the ganglion using a hypodermic needle
- surgical excision only considered if ganglion persists or recurs after puncture/aspiration.

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

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

Mucous cysts
- no surgery considered unless recurrent spontaneous discharge of fluid or significant nail deformity.

6.8 **Knee arthroscopy for patients with osteoarthritis**

Status: Not routinely commissioned[6]

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective. Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after nonoperative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

For further information, please see:
- https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf492463117
- https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance
- https://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clearhistory-of-mechanical-locking-not
- http://www.escape-pain.org/

6.9 **Arthroscopic shoulder decompression for subacromial shoulder pain**

Status: routinely commissioned in the following circumstances[7]

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, ‘pure subacromial shoulder impingement’ means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases. For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

7 Equality Impact Assessment (EIA)

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

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

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

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

8 Implications and Associated Risks

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

9 Education and Training Requirements

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

10 Monitoring Compliance and Effectiveness

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

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

11 Associated Documentation

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

12 Additional References

Hyaluronic acid

Trojian TH, Concoff AL et al. AMSSM scientific statement concerning viscosupplementation injections for knee osteoarthritis: importance for individual patient outcomes.Br J Sports Med. 2016 Jan;50(2):84-92.

Bellamy, Campbell et al. April 2006. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Collaboration: Cochrane Musculoskeletal Group DOI: 10.1002/14651858.CD005321.pub2

Hip Arthroscopy

Hip Surgery Procedures for Treatment of Femoroacetabular Impingement Syndrome. Washington State Health Technology Assessment. July 2011 http://www.hta.hca.wa.go accessed 14/7/16

NICE. Arthroscopic femoro–acetabular surgery for hip impingement syndrome. IPG 408 Sept 2011.

Carpal Tunnel Syndrome

Royal College of Surgeons (2013) Commissioning Guide: Treatment of painful tingling fingers

NICE Clinical Knowledge Summary carpal tunnel syndrome http://cks.nice.org.uk/carpal-tunnel-syndrome accessed 14/7/16

Dupuytren's

NICE Clinical Knowledge Summaries – Dupuytren's disease http://cks.nice.org.uk/dupuytrens-disease accessed 14/7/16

NICE Interventional procedure guidance (IPG368) Radiation therapy for early Dupuytren's disease

Townley, W.A., Baker, R., Sheppard, N. and Grobbelaar, A.O. (2006) Dupuytren's Contracture unfolded. British Medical Journal 332: 397-400

Ganglia

The British Society for Surgery to the Hand. Evidence for Surgical Treatment 1 – Wrist Ganglion (updated September 2012)
http://www.bssh.ac.uk/education/guidelines/ganglion.pdf accessed 14/7/16

Wrist Ganglia (Bandolier) 2003.
http://www.medicine.ox.ac.uk/bandolier/booth/miscellaneous/wristgang.html
accessed 14/7/16

NHS England (November 2013) Interim Clinical Commissioning Policy: Ganglion Cyst Removal
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/11/N-SC014.pdf (accessed 15/07/2016)

Trigger Finger

Bionka et al. (2014) Multidisciplinary Consensus Guideline for Managing Trigger Finger: Results from the European HANDGUIDE Study. *Physical Therapy* 94 (10) 1421- 1433

http://www.nhs.uk/Conditions/Trigger-finger/Pages/Introduction.aspx (accessed 15/07/16)

Appendices

A Equality Impact Assessment

Title of policy	Hips, Hands, Knees and Feet Policy	
Names and roles of people completing the assessment	Fiona Day Consultant in Public Health Medicine, Helen Lewis, Head of Acute Provider Commissioning	
Date assessment started/completed	26.6.16	25.7.16

1. Outline	
Give a brief summary of the policy	The purpose of the commissioning policy is to enable officers of the Leeds CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to general practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs. This policy relates to requests for hips, hands, knees and feet services.
What outcomes do you want to achieve	We commission services equitably and only when medically necessary and in line with current evidence on cost effectiveness.

2. Evidence, data or research	
Give details of evidence, data or research used to inform the analysis of impact	See list of references

3. Consultation, engagement	
Give details of all consultation and engagement	Discussion with clinicians and patient representatives on the principles of decision making. Discussion with patient leaders relating to changes in the content of the policy and advice on proportionate engagement.

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

4. Analysis of impact

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to;

eliminate unlawful discrimination; advance equality of opportunity; foster good relations

	Are there any likely impacts? **Are any groups going to be affected differently?** **Please describe.**	**Are these negative or positive?**	**What action will be taken to address any negative impacts or enhance positive ones?**
Age	No		
Carers	No		
Disability	No		
Sex	No		
Race	No		
Religion or belief	No		
Sexual orientation	No		
Gender reassignment	No		

Pregnancy and maternity	No		
Marriage and civil partnership	No		
Other relevant group	No		
If any negative/positive impacts were identified are they valid, legal and/or justifiable? **Please detail.**			

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

6.Sign off			
Lead Officer			
Director on behalf of the 3 Leeds CCG Medical Directors	Dr Simon Stockill, Medical Director, Leeds West CCG	**Date approved:**	24.8.16

B Policy Consultation Process:

Title of document	Hips, Hands, Knees and Feet Commissioning Policy
Author	F Day, M Everitt, Leeds City Council
New / Revised document	New
Lists of persons involved in developing the policy List of persons involved in the consultation process:	F Day Consultant in Public Health Medicine, M Everitt, Leeds City Council M Emerton, S Anand, LTHT See appendix a

C Version Control Sheet

Version	Date	Author	Status	Comment
1.0	14/7/16	F Day, M Everitt	Draft	Painful deformed big toe- new policy in line with Royal College of Surgeons (2013) Commissioning Guide: Painful deformed great toe in adults New trigger finger surgery policy, current map of medicine reports if symptoms persist following trial of injection then refer to surgeon; put in time of 2 months for symptoms to be ongoing prior to referral based on European guidelines; New ganglion policy -Surgical removal of a ganglion will only be commissioned if any of the following conditions are met: 1) Ganglion which is causing severe pain OR 2) A ganglion which is causing a significant impairment in function and activities of daily living OR 3) There is diagnostic uncertainty or concerns about the diagnosis The removal of asymptomatic ganglions for cosmetic reasons is NOT routinely commissioned. Carpal Tunnel Syndrome Surgery: No changes to current policy; RCS guidance largely matches up to map of medicine. Dupuytren's Disease Surgery: No changes to current policy. Hip resurfacing and simultaneous replacement:New policy based on NICE Hip arthroscopy:New policy based on evidence agreed with orthopaedic surgeons

2.0	5.2.19	F Day	Updated and amended	Addition of knee arthroscopy and shoulder decompression; updates to carpal tunnel, ganglion, trigger finger, Dupuytrens in line with NHS England Evidence Based Interventions : Response to the public consultation and next steps (November 28th 2018)