West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report				
Date of meeting: 1 October 2019		Agenda item: 48/19		
Report title:	**Shoulder Policy**			
Joint Committee sponsor:	Matt Walsh			
Clinical Lead:	James Thomas			
Author:	Catherine Thompson			
Presenter:	James Thomas			
Purpose of report: (why is this being brought to the Committee?)				
Decision	✓	Comment		
Assurance				

Executive summary
The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures. The purpose of the Clinical Thresholds workstream is to review and standardise the clinical thresholds for these procedures across the nine Clinical Commissioning Groups of West Yorkshire and Harrogate (WY&H). We present here a proposal for shoulder procedures for decision by the West Yorkshire and Harrogate Joint Committee of CCGs.
Recommendations and next steps
The West Yorkshire and Harrogate Joint Committee of CCGs is asked to agree the policy for adoption in the nine CCGs of West Yorkshire and Harrogate.
Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)
Health and Wellbeing: The programme adopts a 'right care, right place, right time' approach to the planning and delivery of planned care services. **Care and Quality:** The clinical thresholds and criteria are for procedures which provide benefit to only a limited number of people, or which should only be offered after other treatment options have been tried. Introducing this policy will ensure that only the people who will benefit from these procedures are offered them. Adoption across West Yorkshire and Harrogate will reduce the variation in treatment offered to people across our region. **Finance and Efficiency:** The financial impact of the shoulder policy will vary between places but we do not anticipate any significant change in costs across the WY&H HCP.

Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	7-14
Public involvement:	15-17
Finance:	27
Risk:	24-26

Conflicts of interest:	Dr James Thomas: GP Chair of NHS Airedale, Wharfedale and Craven CCG; partner of Modality GP partnership; Dr Kate Thomas (spouse) is also a partner of Modality GP partnership. Dr Matt Walsh: Chief Officer of NHS Calderdale CCG Catherine Thompson: none declared

West Yorkshire and Harrogate Health and Care Partnership Elective Care and Standardisation of Commissioning Policies Programme

Introduction

1. The West Yorkshire and Harrogate Elective Care and Standardisation of Commissioning policies programme addresses clinical thresholds and criteria for clinical procedures, including standardisation of clinical pathways. The purpose of the clinical thresholds workstream is to review and standardise the clinical thresholds for these policies across the nine Clinical Commissioning Groups of West Yorkshire and Harrogate (WY&H). This will reduce variation in access to care across WY&H and ensure that care is evidence based.

2. The Elective Care and Standardisation of Commissioning Policies (SCP) programme of the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) has considered the shoulder procedure policies across WY&H and developed a single set of policies from these. The WY&H Elective Care and SCP programme recommends the adoption of these policies across all CCGs within WY&H. The policies are presented here for consideration and recommendation by the WY&H HCP Elective Care and SCP programme board.

West Yorkshire and Harrogate Policy Development Process

3. The Elective Care and SCP programme has developed a governance process to support decision making through the Joint Committee of WY&H CCGs as set out in the scheme of delegation appended to the WY&H Memorandum of Understanding. This has been discussed during presentations of the Elective Care and SCP programme at the WY&H Clinical Forum and Joint Committee meetings and agreed as an acceptable approach. The process is detailed here for clarity. See also the governance diagram at appendix 1, which provides additional detail e.g. specific working groups.

    - Each policy or pathway is developed in the relevant working group using the ‘do once and share’ approach i.e. one place / CCG leads the development of the policy or pathway.
    - Clinical involvement is secured by the place leading the pathway / policy development, and the draft policy / pathway shared for comment and development with relevant clinicians across WY&H. Amendments are made in response to clinical feedback to reach a consensus position.
    - The developed policy or pathway is shared with members of the working group to ensure agreement of all working group members.
    - Mapping of the differences between the proposed pathway and the current pathway and policies in each of the nine WY&H CCGs and an assessment of issues and risks

- Mapping of engagement findings from across the nine WY&H CCGs and assessment of the need for consultation or further engagement
- Completion of the WY&H Quality and Equalities Impact Assessment (agreed at the January 2019 Joint Committee)
- The policy or pathway is presented at the Elective Care and SCP programme board to ensure representation and agreement from all nine CCGs within WY&H prior to recommendation to the Joint Committee.
- Development and discussion at Joint Committee and/ or Clinical Forum
- Decision at Joint Committee

Shoulder Pain

4. Shoulder pain is a common condition with a number of different causes, such as trauma, and 'wear and tear'. This policy does not cover acute shoulder pain from a recent injury, but does include shoulder pain following long standing injury. Shoulder pain can arise from the muscles and tendons around the shoulder (rotator cuff pain); from the joint itself (glenohumeral joint) having arthritis or being stiff, generally called a 'frozen shoulder'. Pain may also result from the joint being 'unstable' as a result of previous injury.

5. Each of these causes of shoulder pain would have a different treatment regimen but in almost all instances first line treatment would be conservative, including analgesia, physiotherapy and in some instances joint injection. Successful conservative management requires good participation from the patient in their programme of treatment (e.g. regular completion of exercises). Where comprehensive conservative management is not successful surgical / other invasive procedures may be indicated to treat the shoulder pain. For a successful outcome post intervention the patient will also need to participate fully in the rehabilitation programme (e.g. regular completion of exercises).

6. Shared decision making between the clinician and the patient is important when an individual is considering shoulder surgery / other invasive procedure, to understand the risks and benefits of the procedure and the post-procedure rehabilitation requirements and timeframe.

West Yorkshire and Harrogate Policies for Consideration

7. A WY&H policy for shoulder procedures has been developed. The proposed policy is included in appendix 2 and includes surgical and non-surgical interventions for rotator cuff pain, the glenohumeral joint and shoulder instability.

8. The policy requires that conservative management options are tried, and have shown no benefit in the individual's condition prior to referral for orthopaedic assessment. Conservative treatment would usually be tried for around 3 months before considering referral for surgical assessment.

9. All patients being referred for shoulder pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services, and those that would benefit from health improvement interventions should be made a meaningful offer of support.

10. A shared decision making conversation should be part of the referral process and decision to proceed with an invasive intervention.

11. Many people with shoulder pain will not gain benefit from surgical intervention beyond that offered through conservative management. Referral to pain management service will be required for this cohort of people.

12. The following interventions / procedures are commissioned for rotator cuff pain (in alphabetical order):
    - Balloon arthroplasty (https://www.nice.org.uk/guidance/ipg558)
    - Calcium excision for calcific tendinopathy
    - Cuff debridement (including long head of biceps tenotomy)
    - Distal clavicle excision
    - Reverse shoulder replacement
    - Rotator cuff repair / partial repair / augmented cuff repair
    - Subacromial decompression (NB. This is with prior approval as per local arrangements, in line with NHS England Evidence Based Interventions Policy)
    - Superior capsular reconstruction (https://www.nice.org.uk/guidance/ipg619)
    - Tendon transfer
    - Suprascapular nerve block / ablation
    - Ultrasound guided calcific barbatage

13. The following interventions are commissioned for arthritis:
    a. Total Shoulder Arthroplasty
    b. Hemiarthroplasty
    c. Reverse shoulder replacement
    d. Suprascapular nerve block / ablation

14. The following interventions are commissioned for adhesive capsulitis:
    a. Arthroscopic capsular release
    b. Manipulation under anaesthetic
    c. Hydrodistension / hydrodilatation

Engagement and Consultation

15. The development of the shoulder policies was led by the Bradford and Craven 'place' with involvement from the Bradford commissioning lead for planned care and the shoulder MDT in Bradford Teaching Hospitals Trust. A draft of the pathway was then shared with all the CCGs of WY&H, and through the WYAAT

PMO with all the acute NHS provider organisations. Each CCG also shared the pathway with local clinical staff and service providers as appropriate. A system-wide engagement event was held in May 2019 to refine the policy and ensure clinical agreement with it.

16. Advice was sought from the communications and engagement leads in each of the CCGs, asking them whether the changes that were proposed were of a nature that they would want to engage on locally. All replied that the changes were very minor, and should result in an improvement in service so they would not normally undertake local engagement. Local communication to provider organisations, clinicians and the local population will be necessary to support implementation.

17. The WY&H HCP engagement mapping exercise* from March 2018 provided information to inform the development of the policies. The key findings were that:
    - people felt that there should not be a postcode lottery for access to care
    - consideration needs to be given to the effectiveness of treatments.

    Creating a single set of shoulder policies for West Yorkshire and Harrogate will help increase standardisation of services and reduce variation in access and availability of care. Ensuring the clinical thresholds for the shoulder policies are consistently applied will mean that procedures will only be carried out when they will be clinically effective.

    *https://www.wyhpartnership.co.uk/application/files/3015/3797/5058/WYH_HCP_Engagement_mapping_-_March_2018_FINAL.pdf

Quality and Equality Impact Assessment

18. To support the governance processes for the Elective Care and SCP programme a single approach to Quality and Equality Impact Assessment (QEIA) has been developed by the WY&H CCG Chief Nurses, Quality Leads and Equality leads. This process, including a policy, document template and guidance notes were approved at the WY&H Joint Committee of CCGs in their public meeting on 8 January 2019.

19. The groups of people affected by this policy are :
    - Older people (OA shoulder) and women (frozen shoulder).
    - Primary care staff, in particular, General Practitioners, as they will need to take account of these policies when assessing and referring patients.
    - Community service and secondary care clinicians who also need to take account of this pathway when treating patients and making onward referrals.

20. The QEIA for the shoulder policies identified minor negative impacts from implementing these policies in comparison to the significant positive impacts. Positive impacts for patient experience, safety, clinical effectiveness, workforce and equality were identified. The QEIA summary is included at appendix 4.

21. A key consideration of Elective Care and SCP programme is equitable access to appropriate, evidence-based interventions. By implementing these policies and pathways, we aim to reduce variation of inequalities in health outcomes for the population of West Yorkshire and Harrogate by systematically offering the most up-to-date clinically proven treatments and making the most effective use of NHS resources.

Impact of Implementation in West Yorkshire and Harrogate

22. Implementation of the shoulder policies will simplify the administrative processes and clinical decision making for orthopaedic surgeons and provider organisations as the clinical thresholds will be standardised across all CCGs in WY&H.

23. The emphasis on shared decision making and supported self-management will require additional staff development to ensure all clinical staff within MSK and elective orthopaedic services have the required skills for this approach. The Personalisation Programme in conjunction with NHS England and Improvement are delivering a programme to support this. Places should also consider the use of Patient Activation Measures to assess the success of approaches to personalised care and SDM.

24. The shoulder policy indicates the need for people with shoulder pain to have access to holistic pain management services to support people to 'live with' shoulder pain where resolution of the condition may not be possible in the long term. The need to establish good pain management services across WY&H has previously been discussed as part of the WY&H MSK pathway which was agreed by the WY&H Joint Committee of CCGs at their meeting in public in May 2019.

25. There is a requirement in the shoulder policies that following steroid injection, the patient commences physiotherapy within 2 weeks and following hydrodistension injection within 72 hours. This is the timescale that the clinicians agreed was necessary for best clinical outcome. In many existing MSK / physiotherapy services waiting times for appointments are currently greater than two weeks. To achieve these timescales CCGs will need to work with referrers and service providers to articulate an appropriate process such as simultaneous booking of appointments for injection and physiotherapy so that clinical care is appropriately coordinated.

26. A change in demand for physiotherapy services (increase) should be anticipated with implementation of this policy. The scale of this will be dependent on the place, the service model and the local approach to implementation. It is anticipated that this could be managed within the existing allocation of resources to MSK and Orthopaedic services however some redistribution within this may be required.

27. There may be some limited reduction in surgical procedures of the shoulder. This would reflect the falling rates of shoulder surgery for some conditions in recent years as evidence from clinical trials had suggested equivocal outcomes. We do not expect this to be significant and anticipate the overall financial impact to be neutral. We anticipate that there will be variation between places of the impact of this policy but we are unable to accurately predict the financial impact of this.

Implementation Plans

28. The nine CCGs of WY&H have previously agreed a 12 month timescale for the implementation of new policies. This reflects the contract negotiation process with service providers.

29. Implementation of the WY&H shoulder policy should be monitored by regular local audit of clinical practice and patient experience.

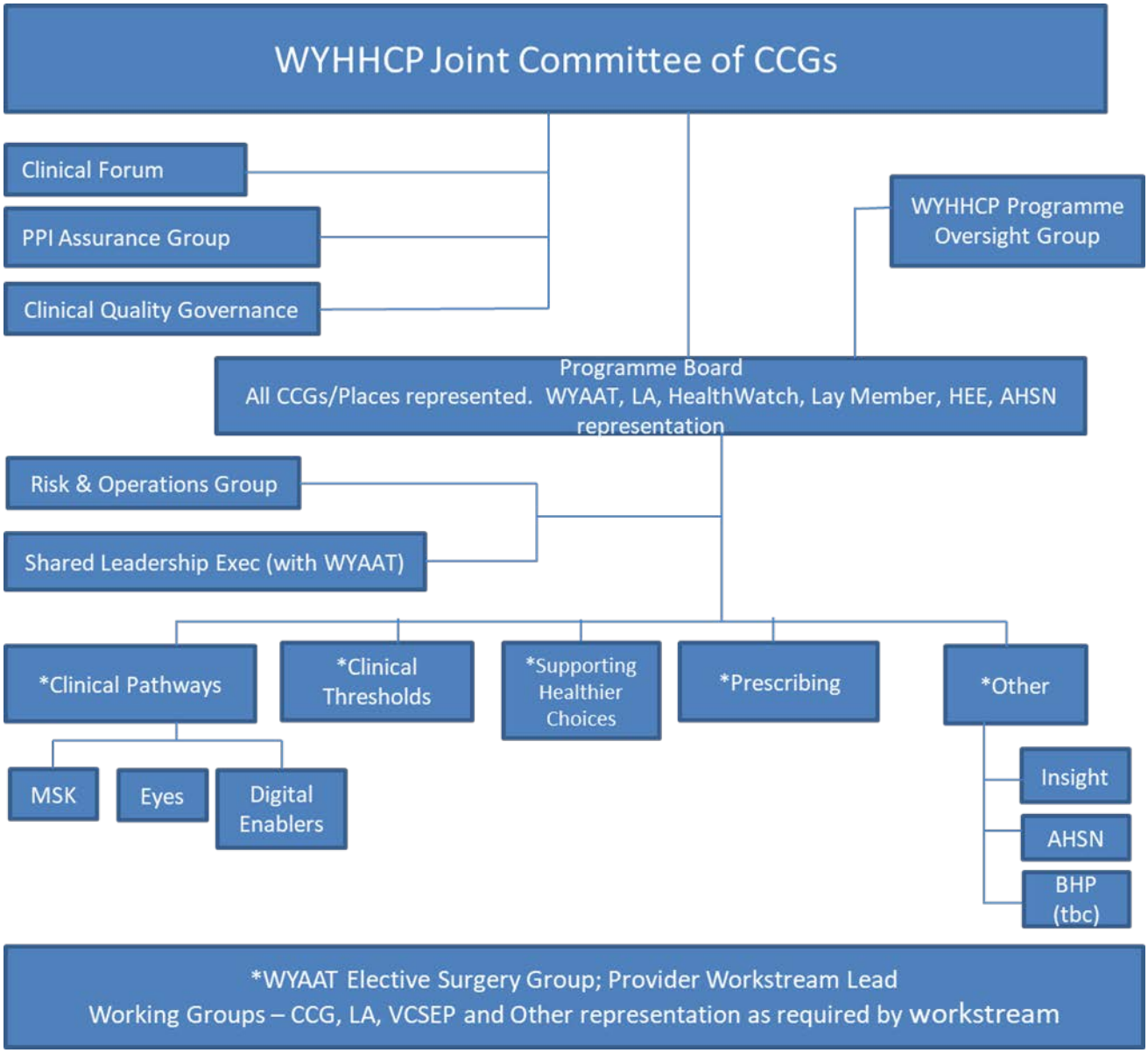
Summary and Recommendations

30. The West Yorkshire and Harrogate Joint Committee of CCGs is asked to agree the shoulder policy for adoption in the nine Clinical Commissioning Groups of West Yorkshire and Harrogate.

List of Appendices:

1. **Governance Structure**
2. **WY&H Shoulder Policy**
3. **Quality and Equality Impact Assessment**

Appendix 1. Governance Structure



West Yorkshire and Harrogate Health and Care Partnership					
Policy	**Referral for Shoulder Pain** (can include weblink to definition on CCG website, i.e. long version of policy)			**X CCG Ref**	X021(as per CCG policy library)
First Issue Date		**Current version:**		**Last reviewed:**	
Review date		**Contact**			
Clinical Reviewer		**Approved by**			

Policy exclusions

This policy does not apply to children under the age of 16.

Red flags – refer to A&E/ orthopaedics

- Cardiac/ upper respiratory/ gallbladder etc. symptoms giving visceral referral to shoulder
- Mass/ severe or atypical unremitting pain/ swelling/ malaise/ weight loss – Xray then refer 2 Week Wait
- Infection signs such as erythema, fever or systemically unwell- Immediate admission

Acute trauma

- History of significant trauma (including acute and traumatic recurrent dislocations): refer directly for orthopaedic clinical and radiological assessment and treatment.
- Fall on outstretched hand with loss of external rotation may indicate posterior dislocation and x ray with axillary view recommended along with urgent referral for surgical assessment.
- Acute trauma sign post to primary care via A&E or on call Orthopaedics

Policy inclusion criteria

- All patients being referred for shoulder pain should have an assessment of their BMI and smoking status, as well as other 'lifestyle factors' that may influence their long term health outcomes, as part of a 'making every contact count' approach to providing health care services.
- All patients who would benefit from a health improvement intervention to address weight management, smoking or other factors should be made a meaningful offer of support for this at appropriate stages in their conservative management and in all instances before referral is made for surgical assessment.
- Patients with shoulder pain, and without red flag or acute trauma indications, should be managed in line with the WY&H MSK pathway (see xxx) and should not normally be referred for surgical opinion before all appropriate non-surgical management options have been tried and have not been effective.
- Patients who have persistent or progressive symptoms, despite comprehensive non-operative management and good patient engagement and participation in therapy programmes, should have a shared decision making conversation to consider referral

for surgical assessment. This should include an understanding of rehabilitation requirements and likely duration. The evidence for risks, benefits and differences in outcomes between surgical intervention and continued non-operative management should be included in this conversation, with a discussion of the patient's treatment / outcome goals. The patient and the clinician should reach a shared decision whether to proceed with referral / surgical intervention.

- Patients who are symptomatically better or who are improving with non-surgical management should not usually be referred for surgical assessment.
- Patients should be offered referral to Pain Services, particularly those who have medical comorbidities that render them unfit for anaesthesia or those who do not wish to consider surgery as an option. (Living with pain – with psychological input, and/pain management for medication review and/or nerve blocks).

Rotator cuff-related pain syndrome
http://www.bess.org.uk/application/files/2914/8127/3402/Subacromial_Shoulder_Pain.pdf

- Painful arc, pain on abduction, worse with thumb down and resistance.
- Conservative treatment should in general include activity modification, exercise, physiotherapy, simple analgesia (NSAIDs and/or paracetamol) and no more than two corticosteroid subacromial joint injections.
- Refer to MSK services for physiotherapy and joint injection where these are not provided in primary care e.g. by GP or First Contact Practitioner Physiotherapist, or where highly specialist physiotherapy may be required e.g. in the presence of high pain scores and poor function.
- In the event of poor / no response after 12 weeks following initiation of treatment of current symptoms, consider additional imaging e.g. USS for differential diagnosis and X-Ray
- Where clear previous history of trauma and weakness, consider earlier imaging and referral. Referrals should follow the local imaging pathway.
- If specialized physiotherapy and unguided injection gives poor response consider referral for imaging guided injection.
- If symptoms persist after 6 months of comprehensive non-operative management and good patient engagement and participation with therapy, or with worsening pain and activities of daily living discuss option of referral for surgical assessment.
- The following interventions / procedures are commissioned (in alphabetical order):
  Surgical
    - Balloon arthroplasty (https://www.nice.org.uk/guidance/ipg558)
    - Calcium excision for calcific tendinopathy
    - Cuff debridement (including long head of biceps tenotomy)
    - Distal clavicle excision
    - Reverse shoulder replacement
    - Rotator cuff repair / partial repair / augmented cuff repair
    - Subacromial decompression (NB. This is with prior approval as per local arrangements, in line with NHS England Evidence Based Interventions Policy)
    - Superior capsular reconstruction (https://www.nice.org.uk/guidance/ipg619)
    - Tendon transfer

Non-surgical

- Suprascapular nerve block / ablation
- Ultrasound guided calcific barbatage

Glenohumeral joint http://www.bess.org.uk/application/files/9914/8127/3402/Frozen_Shoulder.pdf http://www.bess.org.uk/application/files/2314/8127/3403/Shoulder__Elbow-2016-Thomas-203-14.pdf

- Reduced passive external rotation, global pain and restriction of movement, deep joint pain
- Conservative treatment should in general include activity modification, exercise, physiotherapy, simple analgesia (NSAIDs and/or paracetamol) and no more than two corticosteroid glenohumeral joint injections.
- Refer to MSK services for physiotherapy and joint injection where these are not provided in primary care e.g. by GP or First Contact Practitioner Physiotherapist, or where highly specialist / advanced clinical practice shoulder physiotherapy may be required e.g. in the presence of high pain scores and poor function.
- Consider X-Ray AP and axillary view to confirm diagnosis if no improvement with conservative treatment
    - Frozen shoulder: more common, age 40-60, females and diabetics, normal x-ray
    - Osteoarthritis: less common, age 60+, abnormal x-ray
- If there is no improvement in symptoms after 3 months of comprehensive non-operative management and good patient engagement and participation with therapy, or with worsening pain and activities of daily living discuss option of referral for surgical assessment, with X-Ray performed prior to referral for orthopaedic assessment)
- The following surgical interventions are commissioned for arthritis:
    - Total Shoulder Arthroplasty
    - Hemiarthroplasty
    - Reverse shoulder replacement
- The following non-surgical interventions are commissioned for arthritis:
    - Suprascapular nerve block / ablation
- The following surgical interventions are commissioned for adhesive capsulitis:
    - Arthroscopic capsular release
    - Manipulation under anaesthetic
- The following non-surgical interventions are commissioned for adhesive capsulitis:
    - Hydrodistension / hydrodilatation
      Referral for hydrodistention should only occur after MDT discussion, however the patient does not need to have been seen by the orthopaedic surgeon in all instances. This will be subject to local clinical governance arrangements and the skills of the MDT.

Instability
http://www.bess.org.uk/application/files/1914/8127/3404/Traumatic_Anterior_Instability.pdf

- History of dislocation or subluxation
- If non-traumatic, refer to physiotherapy with access to advanced clinical practice

(specialist) physiotherapy where required e.g. in the event of poor response.

- For recurrent, or history of traumatic instability refer to physiotherapy with access to advanced clinical practice (specialist) physiotherapy where required.
- In all of the above if after 3 months of comprehensive non-operative management and good patient engagement and participation with therapy if still ADL limiting and apprehensive then refer for surgical assessment.
- The following surgical interventions are commissioned:
    - Soft tissue stabilisation e.g. labral repair, SLAP repair, remplissage, capsular plication
    - Bone block stabilisation e.g. Bristow-Latarjet procedure, Iliac crest graft

General points

Imaging

- MRI scans should not be requested by primary care.
- USS of the rotator cuff are rarely required in primary care and may lead to a delay in treatment for rotator cuff related pain syndrome.
- USS should only be requested by an appropriately trained / skilled clinician e.g. GPwSI, Advanced Clinical Practitioner Physiotherapist, Orthopaedic Surgeon.
- US scans should be undertaken by level 1 RCR practitioners in MSK ultrasound performed to RCR service provision requirements (see links below):

  https://www.rcr.ac.uk/publication/standards-provision-ultrasound-service
  https://www.rcr.ac.uk/publication/ultrasound-training-recommendations-medical-and-surgical-specialties-third-edition

Shoulder Injection

- Where clinically indicated a single joint injection should be used. A second joint injection may be indicated in patients who received good initial benefit from their first injection and who need further pain relief to continue their physiotherapy treatment. The second injection may be ultrasound guided.
- Where more than two injections are required (e.g. for long term management when surgery not possible) the patient should have a shared decision making conversation prior to continuing treatment outlining the risks, benefits and alternative approaches.
- Joint injections should be performed by an appropriately trained / skilled clinician e.g. GPwSI, Advanced Clinical Practitioner Physiotherapist.
- Guided injections should be performed by practitioners to level 2 RCR MSK ultrasound standards.
- All patients who receive a joint injection for pain relief must be referred for physiotherapy, (prior to the injection being administered), and treatment must commence as soon as possible and within 2 weeks whilst benefits are in action following the joint injection.
- Physiotherapy following distention injection should happen as soon as possible and within 1 week (ideally 72 hours) in order to capitalize on the stretch gains made by the distension.

Patient Information

- Shoulder Pain ARC leaflet useful for

all. https://www.arthritisresearchuk.org/arthritis-information/conditions/shoulder-pain.aspx • The British Elbow and Shoulder Society website has a useful patient information section which includes links to videos of basic exercises which may help patients experiencing subacromial pain - http://www.bess.org.uk/index.php/public-area/shpi-videos	
Summary of evidence / Rationale	**http://www.bess.org.uk/application/files/3815/5023/4929/Subacromial-Shoulder-Commissioning-Guide_final1.pdf** **http://www.bess.org.uk/application/files/9914/8127/3402/Frozen_Shoulder.pdf** **http://www.bess.org.uk/application/files/2314/8127/3403/Shoulder__Elbow-2016-Thomas-203-14.pdf** **http://www.bess.org.uk/application/files/2914/8127/3402/Subacromial_Shoulder_Pain.pdf** **http://www.bess.org.uk/application/files/1914/8127/3404/Traumatic_Anterior_Instability.pdf** **https://www.bmj.com/content/364/bmj.l294**
Reference	
Addendum	**Outcome of NHS E's consultation on EBIs insert weblink**
Prior approval/referral management process for this procedure	**Arthroscopic shoulder decompression for subacromial shoulder pain** We propose that arthroscopic subacromial decompression for pure subacromial shoulder impingement is 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.

West Yorkshire and Harrogate Health and Care Partnership

This summary sheet provides an overview of the staff involved, proposed change and a summary of the findings. This assessment consists of five domains: Patient Experience, Patient Safety, Effectiveness, Equality and Workforce.

Title of Scheme:	West Yorkshire and Harrogate HCP Shoulder Pathway and Policies		
Project Lead:	Ian Wallace, Bradford City and Districts CCGs		
Clinical Lead:	James Thomas, Clinical Chair, AWC CCG	Programme Lead:	Catherine Thompson, WY&H HCP
Senior Responsible Officer:	Matt Walsh, Calderdale CCG	Date:	26.06.2019

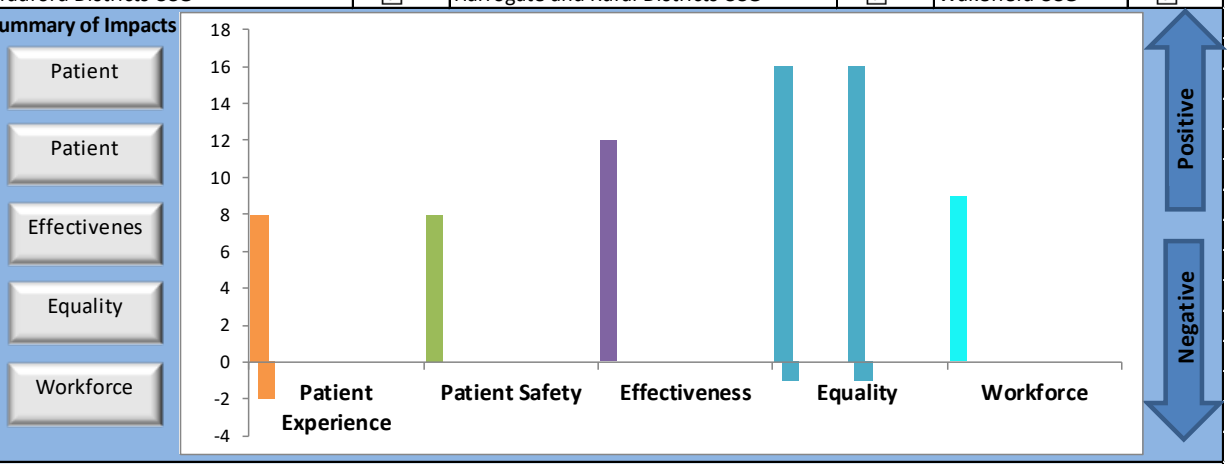
Proposed change:

This is a revision of the shoulder pathways and policies from the nine CCGs to create a single pathway and policy for West Yorkshire and Harrogate. It standardises processes for people and service providers, and optimises the use of resources within the specialist services.

Which areas are impacted?

Airedale, Wharfedale and Craven CCG	☑	Calderdale CCG	☑	Leeds CCG	☑
Bradford City CCG	☑	Greater Huddersfield CCG	☑	North Kirklees CCG	☑
Bradford Districts CCG	☑	Harrogate and Rural Districts CCG	☑	Wakefield CCG	☑

Summary of Impacts



Summary of findings:

The Policy and Service specification will ensure a consistent approach across West Yorkshire and Harrogate HCP and make optimal use of limited resources. There is a positive impact on patient experience and safety. Clinical effectiveness may be increased by referral for specialist advice at the most appropriate point in the pathway, however the impact is unlikely to be significant had has been scored as neutral. The impact on equality is neutral. People who hold one or more protected charachteristic will not be negatively impacted by this policy in that the policy will standardise care for the population of WY&H. However, there may be minimal negative impacts where people living in socially and economically deprived areas, from certain ethnic groups, religions and beliefs may be less likely to engage with exercise programmes or therapies. The impact on workforce is neutral.

Summary of Next Steps:

There are no adverse impacts to mitigate. The final policy and service specification will be presented to the WY&H Joint Committee of CCGs for approval in October 2019.

Has this been incorporated into the project documentation?	**Yes**	Incorporated into the paper for Clinical Forum