

Extracorporeal Shockwave Therapy (ESWT) and Radial Pulse Therapy (RPT)

July 2021

Commissioning Summary

NHS Herefordshire & Worcestershire CCG (also termed “the Commissioner” in this document) has undertaken a review of the evidence and circumstances associated with use of Extracorporeal Shockwave Therapy (ESWT) and Radial Pulse Therapy (RPT) and concluded that for Herefordshire & Worcestershire CCGs responsible patients:

Plantar Fasciitis and Achilles Tendinopathy

Services involving use of Extracorporeal Shockwave Therapy and Radial Pulse Therapy are not supported for use within the NHS for the Herefordshire & Worcestershire CCGs’ responsible population.

Other Indications

No other indications for use of ESWT or RPT will be funded for use within the NHS for the Herefordshire & Worcestershire CCGs’ responsible population.

Any identified new indications for use require submission of a completed new technologies request form for consideration by the Clinical Commissioning Policy Collaboration.

Further clarity is required in relation to the optimum duration of use and long term benefit and the impact of either treatment on concomitant and future use of other interventions including progression to surgery.

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Please contact the Communications Team: 01905 681956

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Author(s)	Fiona Bates - Specialist Medicines and Clinical Policy Adviser Helen Bryant – Head of Acute Contracts Jennie Hammond - Medicines Commissioner and Clinical Policy Adviser
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Directorate Lead	Ruth Lemiech – Director of Strategy
Ratified by	Herefordshire & Worcestershire CCG Clinical Commissioning Executive Committee
Date Ratified	21 st August 2020
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Date of Next Formal Review:	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: 12 th July 2024
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Version No	Description of change	Reason for Change	Author	Date
Previous	Significant	New Policy – Worcestershire Clinical Commissioning Groups	Fiona Bates & Helen Bryant	August 2016
1.0	Minor	Adoption of policies from NHS Herefordshire Clinical Commissioning Group and NHS Worcestershire Clinical Commissioning Groups Updated relevant National Guidance and Facts and EIA.	Fiona Bates & Helen Bryant Jennie Hammond	August 2020
1.1	Minor	Application of new commissioning policy template, no change to policy statement, no requirement to update Clinical Commissioning Executive Committee as Template already approved.	Helen Bryant & Jennie Hammond	July 2021

Version No	Description of change	Reason for Change	Author	Date
		Change of Executive Lead to Ruth Lemiech	Helen Bryant	

Key individuals involved in developing the document:

Name	Designation	Version Reviewed
Paul Ryan	Associate Director of Contracting & Procurement	V1.0 (Worcs CCG) V1.0 (HWCCG)
Fiona Bates	Specialist Medicines and Clinical Policy Adviser	V1.0 (Worcs CCG) V1.0 (HWCCG) V1.1
Helen Bryant	Head of Acute Contracts	V1.0 (Worcs CCG) V1.0 (HWCCG) V1.1
Jennie Hammond	Medicines Commissioner and Clinical Policy Adviser	V1.0 (HWCCG) V1.1

Circulated to the following individuals/groups for comments:

Name	Date	Version Reviewed
Policy Alignment Task & Finish Group	Various	Version 1.0 (Worcs CCG)
Clinical Commissioning Policy Collaborative	14/07/2020	Version 1.0 (HWCCG)

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1. Definitions

- 1.1 **Exceptional** - refers to a person who demonstrates characteristics, which are highly unusual, uncommon or rare.
- 1.2 **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.
- 1.3 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 patient indicates that a decision regarding the commissioning of a **service development** or commissioning policy is required of the Commissioner.
- 1.4 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.
- 1.5 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.
- 1.6 The term “**where appropriate**” within this document means that clinical judgement is exercised in determining which aspects of the policy guidance can be applied to individual patients depending on their condition; ability to tolerate the listed treatment; and whether they have already undergone that treatment.
- 1.7 **Extracorporeal Shockwave Therapy (ESWT)** is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area.
- 1.8 **Achilles Tendinopathy** is a condition that causes pain, swelling, stiffness and weakness to the Achilles tendon, which attaches the calf muscle to the heel bone. It is thought to be caused by repeated small injuries to the tendon that do not heal and build up over time.
- 1.9 **Plantar fasciitis** is inflammation of the plantar fascia. This is a thick fibrous band of tissue at the bottom of the foot that lies between the toes and the heel. Repeated small injuries to the plantar fascia are believed to be the cause of the inflammation.

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: www.herefordshireandworcestershireccg.nhs.uk
- 2.2 This policy applies to all patients for whom Herefordshire & Worcestershire CCG has responsibility including:
- People provided with primary medical services by GP practices which are members of the CCG and
 - People usually resident in the area covered by the CCG and not provided with primary medical services by any CCG.
- 2.3 The clinical responsibility for applying this policy to a presenting patient rests with the clinician who is responsible for the patient at that point in the treatment pathway and should be done in consideration of the patient's individual clinical circumstances, their place on the management pathway and following discussion with the patient.
- 2.4 Where a patient's clinical presentation does not clearly meet the requirements for secondary care referral within the context of this policy, and where a GP is uncertain or concerned about the appropriate treatment/management pathway, referral for Advice & Guidance should be considered as an alternative to a referral for clinical assessment.
- 2.5 There may be occasions when a GP referral is made for specialist assessment which appears to meet the policy requirements, but which on specialist clinical examination either does not meet the clinical criteria for intervention or is not considered clinically suitable for intervention. Such patients should be discharged without intervention.
- 2.6 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.
- 2.7 The policy relates to Extracorporeal Shockwave Therapy (EWST) treatment and Radial Pulse Therapy (RPT) treatment used in the management of a variety of pain related conditions including but not limited to plantar fasciitis and Achilles tendinopathy.

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 Herefordshire & Worcestershire 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 to a particular patient's clinical condition or is related to the anticipated benefits to be derived from a proposed form of treatment.
- 3.3 NHS England/Improvement launched their Evidenced Based Interventions (EBI) programme in 2018 which aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate. Adoption of published EBI guidance is mandated in the NHS standard contract; commissioners have the freedom to implement criteria with local variations, provided that the decision to adopt varying criteria reflects the requirement to have regard to the national guidance. Where EBI guidance is available, this has been accommodated within the policy criteria.
- 3.4 Extracorporeal Shockwave Therapy (ESWT) is a relatively new development that has been trialled in the treatment of chronic heel pain, including but not limited to, pain caused by plantar fasciitis and Achilles tendinopathy.
- 3.5 In ESWT, acoustic pressure waves are delivered to the focus of pain on the heel, with a view to achieving a reduction in pain. Multiple treatments may be given. The mechanism of action is not yet known, although there are various hypotheses.
- 3.6 There are various machines manufactured currently that deliver ESWT, which generate shockwaves using electromagnetic, electrohydraulic, or piezoelectric power.
- 3.7 Radial Pulse Therapy (RPT) is a similar treatment but can be distinguished from focused ESWT as it differs both in the way it generates and delivers shock waves (using a ballistic source and delivering pressure pulses more superficially). However, not all clinicians make this distinction.
- 3.8 ESWT is proposed as a possible non-invasive alternative to surgery where conservative measures such as analgesia, heel supports and physiotherapy have been unsuccessful in significantly improving pain. Avoidance of surgery could prevent associated complications and morbidity for patients, and potentially reduce costs for CCGs, if the effect is maintained.

4. Relevant National Guidance and Facts

- 4.1 ESWT was originally evaluated by NICE in 2009 for both plantar fasciitis (IPG 311) and Achilles tendinopathy (IPG 312). At the time, ESWT had been shown to be safe to use in both conditions, but there had not been convincing evidence for its efficacy in treating either cause of heel pain. NICE Guidance therefore stated that ESWT 'should only be used with special arrangements for clinical governance, consent and audit or research.'
- 4.2 NICE IPG 571 (December 2016) replaces NICE IPG 312 (2009). The recommendations are:
- The evidence on extracorporeal shockwave therapy (ESWT) for Achilles tendinopathy raises no major safety concerns. Current evidence on efficacy of the procedure is inconsistent and limited in quality and quantity. Therefore, ESWT for Achilles tendinopathy should only be used with special arrangements for clinical governance, consent and audit or research.
 - Clinicians wishing to do ESWT for Achilles tendinopathy should:
 - Inform the clinical governance leads in their NHS trusts.
 - Ensure that patients understand the uncertainty about the procedure's efficacy and provide them with clear written information. In addition, the use of NICE's information for the public is recommended.
 - Audit and review clinical outcomes of all patients having ESWT for Achilles tendinopathy.
 - NICE encourages further research into ESWT for Achilles tendinopathy, which may include comparative data collection. Studies should clearly describe patient selection, treatment protocols, use of local anaesthesia and the type and duration of energy applied. Studies should include validated outcome measures and have a minimum of 1 year of follow-up. NICE may update the guidance on publication of further evidence.
- 4.3 The British Orthopaedic Foot & Ankle Society does not make mention of ESWT or RPT for the management of either plantar fasciitis or Achilles tendinopathy.
- 4.4 **Plantar Fasciitis:**
- Pain caused by wear and tear of plantar fascia (tissue in the sole of the foot) due to overuse, injury, or biomechanical predisposition
 - 10% lifetime prevalence
 - More common in athletes, high BMI, and 40-60 year-olds
 - Causes 80% of all heel pain
 - Differential diagnoses of heel pain may include Achilles tendinopathy, radiculopathy, peripheral nerve entrapment syndromes, stress fracture, tumour, "fat pad syndrome" and rheumatoid-like inflammatory enthesopathy.
 - No association with gender
 - 80% of people will have complete resolution of symptoms within one year- 90% of cases will resolve with non-surgical management
 - Usual Management:
 - First-line: analgesia, arch support, heel cushion, rest, plantar fascia stretches
 - Second-line: corticosteroid injection
 - Third-line: surgical release of plantar fascia (plantar fasciotomy)
- 4.5 **Achilles Tendinopathy:**
- Heel pain resulting from damage to the Achilles tendon, caused by injury, overuse, or biomechanical predisposition.

- It can be categorised according to the part of the Achilles tendon that is affected – eg. 'midportion' AT affects the middle of the tendon, whereas 'insertional' AT occurs where the tendon inserts into the heel.
- The treatment and prognosis is quite different depending on the part of the Achilles tendon affected.
- Insertional Achilles tendonitis is the second most common cause of heel pain
- 6% cumulative lifetime incidence in people who are not physically active; as much as 50% in elite athletes.
- Most common in men, especially athletes between 30-40 years of age.
- Usual Management:
- First-line: analgesia, rest, stretching exercises, strength training, physiotherapy, heel support. Not suitable for corticosteroid injection
- Second-line: surgical removal of adhesions/nodules or tendon decompression (up to 25% of refractory Achilles tendinopathy patients progress to surgery but the risk of progression to surgery for some sub-types is much higher)

5. Evidence Review

5.1 Two robust and most recent systematic reviews were available and analysed. Two further systematic reviews undertaken by the York Centre for Reviews and Dissemination were published prior to this and were also analysed. Two of the reviews incorporated ESWT (and RPT) for plantar fasciitis and 3 of the reviews incorporated ESWT for Achilles tendinopathy.

- The review by Speed (2013) includes patients with either plantar fasciitis or Achilles tendinopathy, primarily incorporating randomised controlled trials and assessed as high quality.
- The review by Mani-Babu (2014) was specific to Achilles tendinopathy and included a mix of randomised controlled trials and prospective studies, assessed as 50% high quality.
- Al-Abbad (2013) review focussed on Achilles tendinopathy with overall evidence assessed as satisfactory and concerns regarding the reliability of conclusions reached.
- Chang (2012) review focussed on plantar fasciitis but appears to be well-conducted and reported comparing different methods/intensity of shockwave delivery.
- Concerns across all reviews related to the inconsistent definition of ESWT in terms of high dose, low dose and RPT which is sometimes classified as low dose, the number of impulses, and the number of treatment sessions and intervals between; variable patient characteristics in terms of symptoms and use of co-interventions; variable outcome measures.

5.2 Plantar Fasciitis

- There is high quality evidence available to support the efficacy of high dose ESWT and RPT.
- There is limited evidence to suggest that ESWT
 - is comparable to physiotherapy and achieves quicker outcomes.
 - has a better long term outcome compared with corticosteroid injection.
 - is comparable to surgery, without the risks of an invasive procedure
- The available evidence involves short-term intervention of up to 3 sessions over a 3 month period, with follow-up of between 3-6 months.

5.3 Achilles Tendinopathy

- There is some degree of evidence supporting high dose ESWT in insertional Achilles tendinopathy, whereas low dose evidence is contradictory.
- There is insufficient evidence for ESWT in midportion Achilles tendinopathy.
- The available evidence involves short-term intervention of up to 4 sessions over a 4 month period, with medium term follow-up of between 1-2 years

5.4 No other evidence was found to indicate whether ESWT for any indication affects the following:

- Progression to surgical intervention
- Reduced need for concomitant intervention/healthcare contacts

5.5 There is insufficient evidence with which to support the use of either ESWT or RPT in clinical practice for either plantar fasciitis or Achilles tendinopathy. There is no clarity regarding the optimum duration of treatment and long-term benefit and the impact on the need for both concomitant and future use of other interventions.

It is evident from both trial data assessed and local audits of use that treatment is often undertaken early when there is a high chance of resolution without intervention and that other lifestyle changes may impact on symptom resolution in advance of intervention.

There is no evidence from either trial data or local audit data that ESWT/RPT delays the progression to surgical intervention.

5.6 A further piece of work reviewed both the need for and the evidence for use of ESWT in diabetic patients:

- Achilles tendinopathy is reported as more prevalent in diabetic patients but this could not be substantiated in the literature. There is conflicting evidence regarding an association between differences in Achilles tendon structure in the diabetic population.
- Plantar fasciitis has no association in the literature with diabetes.
- There are no published trials specifically investigating efficacy of shockwave therapy for Achilles tendinopathy or plantar fasciitis in the diabetic population.
- Speed et al specifically excludes patients with “co-existing disease”.
- There is no sub-group analysis of the diabetic population in any of the published systematic reviews.
- An earlier meta-analysis of 19 randomised controlled trials for the use of ESWT in plantar fasciitis involved 9 studies which excluded patients with diabetes.
- Just one cohort study of 225 patients identified 5 diabetic patients in whom treatment with ESWT for plantar fasciitis was significantly less likely to be successful.

6. Patient Eligibility

6.1 Plantar Fasciitis and Achilles Tendinopathy

Services involving use of Extracorporeal Shockwave Therapy and Radial Pulse Therapy are not supported for use within the NHS for the Herefordshire and Worcestershire CCGs' responsible population.

6.2 Other Indications

No other indications for use of ESWT or RPT will be funded for use within the NHS for the Herefordshire and Worcestershire CCGs' responsible population.

6.3 Any identified new indications for use require submission of a completed new technologies request form for consideration by the Clinical Commissioning Policy Collaboration.

6.4 Further clarity is required in relation to the optimum duration of use and long term benefit and the impact of either treatment on concomitant and future use of other interventions including progression to surgery.

7. Supporting Documents

- NHS Herefordshire & Worcestershire: Individual Funding Request Operating Procedure
- NHS Herefordshire & Worcestershire: Prioritisation Framework for the Commissioning of Healthcare Services
- WM01 – Ethical Framework
- WM02 – Orphan Drugs
- WM03 – Patients Leaving Industry Sponsored Trials
- WM05 – NICE Guidance
- WM07 – Choice
- WM08 – In Year Service Developments
- WM09 – Individual Funding Requests (to be read with local process document)
- WM10 – Patients Leaving Non Commercially Funded Trials
- WM11 – Patients Leaving a CCG Funded Trial
- WM12 – Patients Changing Responsible Commissioner
- WM13 – NHS Private Interface
- WM14 – Experimental Treatments
- WM15 – Trial of Treatment
- NHS Constitution, updated 27th July 2015
- Worcestershire CCPC: Brief Evidence Review of Shockwave Therapy for Heel Pain. October 2015
- Worcestershire CCPC: Report “Should Shockwave Therapy be Available To Patients with Diabetes Mellitus for Plantar Fasciitis and Achilles Tendinopathy?”. May 2016

8. Equality Impact Assessment

Equality Statement

- 8.1 All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on race equality. This obligation has been increased to include equality and human rights with regard to disability, age, gender, sexual orientation, gender reassignment and religion.
- 8.2 HWCCG endeavours to challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
- 8.3 All staff are expected to deliver services and provide care in a manner which respects the individuality of patients and their Carer's and as such treat them and members of the workforce respectfully, regardless of age, gender, race, ethnicity, religion/belief, disability and sexual orientation.
- 8.4 Providers are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. CCG staff and Providers will need to assess that the policy is applied fairly and equitably for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.
- 8.5 HWCCG must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the CCG aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, the CCG will consciously consider the extent to which any policy reduces inequalities of access and outcomes.
- 8.6 Any change to this policy will require a conscious effort from the HWCCG to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of this policy, HWCCG and the Providers, will seek to minimise such an impact and simultaneously carry out a full review.
- 8.7 HWCCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate

consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

Organisation	NHS Herefordshire & Worcestershire Clinical Commissioning Group		
Department	Contracting	Name of lead person	Fiona Bates, Helen Bryant, Jennie Hammond
Name of Policy being assessed	Extracorporeal Shockwave Therapy (EWST) and Radial Pulse Therapy (RPT) Commissioning Policy		
Aims of this Policy	To provide clarification on the NHS funding of EWST and RPT for Herefordshire & Worcestershire CCG registered patients		
Date of EIA	Original: March 2016 Review: June 2020 Revised March 2021 when update version of policy template applied	Other partners/stakeholders involved	Clinical Commissioning Policy Collaborative
Who will be affected by this this Policy?	Patients who wish to receive EWST and/or RPT, their GPs and Secondary Care Clinicians		
Did the Policy require Engagement or Consultation?	No.		

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. Include consultation with service users wherever possible
Age			Y	Plantar fasciitis is more common in athletes (who are likely to be younger) and 40-60 year olds. Achilles tendinopathy is more common in athletes and 30-40 year olds.
Disability			Y	The increased prevalence of heel pain in athletes will disadvantage the more able person; 6% cumulative lifetime incidence in people who are not physically active; as much as 50% in elite athletes.
Gender Reassignment		Y		No evidence of a general link between gender reassignment and heel pain
Marriage & Civil Partnerships		Y		There is no evidence that an individual's marital status or being in a civil partnership has an impact on heel pain
Pregnancy & Maternity			Y	There is some evidence that pregnant women can develop heel pain (plantar fasciitis) because of the extra weight and stress on the arches of the feet. Relaxin, a hormone produced by the body to prepare for childbirth, also relaxes the ligaments in the feet which can cause foot/heel pain, over-pronation and inflammation.
Race including Travelling Communities			Y	Achilles tendinopathy and plantar fasciitis are both more common in athletes and there may be varying prevalence of athletes by both race and sport.
Religion & Belief		Y		No evidence of a link between religion and heel pain
Sex			Y	Achilles tendinopathy is more common in men, who may be affected more by the limitations of this policy; there is no gender difference reported for plantar fasciitis.
Sexual Orientation		Y		No evidence of a general link between sexual orientation and heel pain
Carers		Y		No evidence of a general link between being a carer and heel pain
Care Leavers		Y		No evidence of a general link between being a care leaver and heel pain
Homeless			Y	Walking long distances, often carrying heavy bags, can cause heel pain (including plantar fasciitis), ankle and arch pain.
Socio/Economic Deprivation			Y	There are associations between social class and levels of physical activity. The Health Survey for England 2008 identified that males in the lowest income quintile had the lowest percentage that met the recommended amount of physical activity.

Equality Group	Potential Positive Impact	Potential Neutral Impact	Potential Negative Impact	Baseline data and research on the population that this piece of work will affect. What is available? E.g. population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. Include consultation with service users wherever possible
				For women, the top quintile demonstrates the highest level of physical activity. When work related activity is removed this disparity with men is increased.
Other Vulnerable and Disadvantaged Groups		Y		There is no evidence to confirm whether there are links between other vulnerable and disadvantaged groups other than those already listed within this review.
Health Inequalities		Y		In producing the policy, the commissioner's intention was to provide clear clinical information to patients and their responsible clinician, therefore improving the option for equitable access to treatment for clinically eligible patients.
Does this policy impact on an individual's Human Rights?		Y		This policy is not intended to impact on an individual's human rights, it should enhance the right to family life.

Equality Impact Assessment Action Plan

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead
Age	There are different age groups in whom heel pain is more prevalent.	As these indications are largely associated with "wear and tear", it is not possible to influence.	NA		
Disability	Able bodied people who undertake exercise more likely to be disadvantaged by policy	Unable to influence the extent to which exercise is undertaken	NA		
Pregnancy & Maternity	Carrying extra weight during pregnancy can cause heel pain or make existing heel/foot pain worse. The individual's centre of gravity and how they walk	Unable to influence the extent to which the advice from primary care and the midwifery teams is undertaken to help manage this short term issue.	NA		

Strand	Issue	Action required	How will you measure the outcome/impact	Timescale	Lead
	and stand are affected by the changes in their body, and these may cause problems with balance. Also. Relaxin, a hormone released to prepare for childbirth, relaxes the ligaments in the feet which can cause foot/heel pain.				
Race	Varying prevalence of different sports by race	No action - cannot influence prevalence	NA		
Sex	Higher prevalence Achilles tendinopathy in males	No action – cannot influence prevalence.	NA		
Homeless	Homeless individuals walking long distances, often carrying heavy bags, can develop heel pain (including plantar fasciitis), ankle and arch pain.	Unable to influence	NA		
Socio / Economic Deprivation	Level of income can influence the level of physical activity and therefore the likely incidence of heel pain.	Unable to influence	NA		