SHOULDER IMPINGEMENT SURGERY FOR SUBACROMIAL PAIN

CRITERIA BASED ACCESS (CBA) POLICY

Version:	2223.v3c
Recommendation by:	Somerset ICB Clinical Commissioning Policy Forum (CCPF)
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Target audience:	**NHS Somerset ICB**: • NHS Providers • GP Practices • Contracts Team **Medical Directors:** • Somerset Foundation Trust • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT
Application Form	EBI Generic application form if appropriate to apply

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VERSION CONTROL

Document Status:	Current policy
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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1718.v2	July 2017	New policy template / amendment to wait time / inclusion of fact sheet links, CEC wording to include Orthopaedic Assessment Service and/or a Consultant to apply to EBIP on exceptionality. Change the name from IFR to EBI
1819.v2a	March 2021	3 year policy review, Amend 6 months to 6 weeks, inclusion of AOMRC EBI link & red flag
2021.v3	July 2022	Amendment from SCCG to NHS Somerset ICB. New PALS email address
2022.v3a	November 2022	Inclusion of NICE guidance in reference section
2223.v3b	March 2023	Wording change on 5.6

Equality Impact Assessment (EIA)	N/A
Quality Impact Assessment QIA	August 2018
Sponsoring Director:	Bernie Marden
Document Reference:	2223.v3c

1 GENERAL PRINCIPLES (CBA)

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the ICB Evidence Based Interventions Service (EBI) by submission of an EBI application form

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary / community care without them meeting the criteria or funding approval not secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the EBI may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patient meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery. https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015)

1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY CRITERIA BASED ACCESS (CBA)

Funding approval for Shoulder Impingement Surgery for Subacromial Pain will only be provided by the ICB for patients meeting criteria set out below:

Somerset Foundation Trust Musculoskeletal Leaflet
https://www.somersetft.nhs.uk/musculoskeletal-physiotherapy-service/wp-content/uploads/sites/189/2020/12/Subacromial-shoulder-pain-FINAL-260722-v2.pdf

2.1 The patient has been assessed (including paper based triage where appropriate) by the Orthopaedic Assessment Services and undertaken a minimum of **6 weeks of conservative treatment**, as advised by and documented in primary care, in general to include:

- Rest
- Exercise
- Physiotherapy
- Analgesics

Physiotherapy rehabilitation is usually for 6 weeks unless a reason is identified by the physiotherapist for early referral to secondary care

If patient improves within the initial 6 weeks of physiotherapy, then a further period of 6 weeks (at least) is justified

2.2 Patients have received one steroid injection from a trained physiotherapist or GP without improvement; (Normally, only one injection should be considered as repeated injections may cause tendon damage (Dean B, 2014)

2.3 A second injection is occasionally appropriate after 6 weeks, but should only be administered in patients who received good initial benefit from their first injection and who need further pain relief to facilitate their structured physiotherapy treatment

2.4 Patients with rotator cuff tears, or shoulder pain with weakness indicating structural damage may not be appropriate candidates for an injection, therefore the appropriateness of such treatment should be discussed with the patient.

Where these patients do not wish to receive injection therapy, this clause may be disregarded **AND**

2.5 Patients have been advised of the risks and benefits of the surgery and are fit and willing to undergo surgery **AND**

2.6 Symptoms are severe with symptoms of joint stiffness and reduced joint function which is compromising their mobility to such an extent that they are in immediate danger of losing their independence

3 Commissioned Surgery for patients who meet the criteria above

3.1 **Rotator Cuff Repair** for patients who have a clinically identified torn rotator cuff

3.2 **Sub Acromial Decompression** is commissioned to treat a clinically confirmed Subacromial Impingement

3.3 **Combined RCRSAD** is only commissioned for patients where there is a confirmed clinical need, i.e. they have a confirmed torn rotator cuff with Subacromial Impingement

3.4 In patients with an indication of a tear, of a likely reparable size, and clinical examination indicates a non-functioning rotator cuff, these patient's may be referred for ultrasound scanning and surgical consideration, without needing to go through 6 weeks of rehabilitation and having a corticosteroid injection

Patients who meet the criteria under 3.3 & 3.4 above may be referred without needing 6 weeks of conservative treatments.

4 RED FLAGS

NHS England EBI Wave 2
EBI_list2_guidance_150321.pdf (aomrc.org.uk)

If shoulder RED FLAGS are present, an urgent referral to secondary care should be arranged for further investigation and management:

- A suspected infected joint needs same day emergency referral
- An unreduced traumatic shoulder dislocation needs same day emergency referral
- Suspected tumour and malignancy will need urgent referral following the local two-week cancer referral pathway
- An acute cuff tear as a result of a traumatic event needs urgent referral and ideally should be seen in the next available outpatient clinic

5 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

5.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

5.2 Completion of a **Generic EBI Application Form** by a patient's GP or Consultant is required

5.3 Applications cannot be considered from patients personally

5.4 Only electronically completed EBI applications will be accepted to the EBI Service

5.5 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBI service. This will reassure the service that the patient has a reasonable expectation of the outcome of the application and its context

5.6 EBI applications are reviewed and considered against clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS Somerset ICB website and input into the 'Search this website' box clinical exceptionality. Click on the link to access the full NHS description of clinical exceptionality

Social, Emotional and Environmental factors *i.e., income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application

5.7 Where appropriate photographic supporting evidence can be forwarded with the application form

5.8 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question

- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

6 ACCESS TO POLICY

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

Or write to us: NHS Somerset ICB, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somicb.pals@nhs.net

7 REFERENCES

The following sources have been considered when drafting this policy:

7.1 Ashbaugh, A. N. (2015). Is arthroscopic subacromial decompression effective for shoulder impingement ? The Journal of Family Practice., PP 732-734

7.2 Dean B, F. S. (2014). Glucocorticoids induce specific ion-channel mediated toxicity in tendon British Journal of Sports Medicine.

7.3 Ketola, S. L. (2013). No evidence of long-term benefits of arthroscopic acromioplasty in the treatment of shoulder impingement syndrome. Bone & Joint Research., pp. 132-139.

7.4 Ketola, S. L. (2015). Which patients do not recover from shoulder impingement syndrome, either with operative treatment or with nonoperative treatment? Acta Orthopaedica., PP 1-6.

7.5 Khan, Y. N. (2013). The painful shoulder: shoulder impingement syndrome. [online]. The open orthopaedics journal. , pp. 347–351.

7.6 Milano G1, G. A. (2007). Arthroscopic rotator cuff repair with and without subacromial decompression: a prospective randomized study. http://www.ncbi.nlm.nih.gov/pubmed/17210431.

7.7 Royal College of Surgeons. (n.d.). Commissioning guide: Subacromial Shoulder Pain. Retrieved 05 21, 2016, from http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/subacromial-shoulder-pain-commissioning-guide.

7.8 Saltychev M, Ä. V. (2015). Conservative treatment or surgery for shoulder impingement: systematic review and meta-analysis. Disability and Rehabilitation, 1-8.

7.9 Thelwall, S. P. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases, , vol. 21, no. 11, p. 1008.e1.

7.10 BESS
Subacromial Shoulder Pain: A Review of BESS Publications – British Elbow & Shoulder Society
Shoulder-Pain-Primary-Community-and-Intermediate-Care-Guidelines.pdf

7.11 NHS England EBI Wave 2
EBI_list2_guidance_150321.pdf (aomrc.org.uk)

7.12 https://www.nice.org.uk/guidance/ipg742/resources/extracorporeal-shockwave-therapy-for-calcific-tendinopathy-in-the-shoulder-pdf-1899876276998341