NHS
Dorset
Clinical Commissioning Group

NHS England / NHS Dorset Clinical Commissioning Group

Subacromial Shoulder Decompression Surgery

Criteria Access Based Protocol



Supporting people in Dorset to lead healthier lives

NHS DORSET CLINICAL COMMISSIONING GROUP

SUBACROMIAL SHOULDER DECOMPRESSION SURGERY CRITERIA BASED ACCESS PROTOCOL

1.0 INTRODUCTION AND SCOPE

1. This policy sets out when it is appropriate for patients to have shoulder subacromial decompression surgery to treat shoulder impingement.

2. Subacromial shoulder pain is felt on the top and outer side of the shoulder. It is worsened by overhead activity and can cause night pain but patients usually have full passive range of movement of the glenohumeral joint. The pain comes from the subacromial space of the shoulder, which contains the rotator cuff tendons and the subacromial bursa, and NOT from the glenohumeral joint (Royal College of Surgeons).

3. Rotator cuff disorders are considered to be among the most common causes of shoulder pain and disability encountered in both primary and secondary care, with subacromial impingement syndrome in particular being the most common disorder (Khan, 2013).

4. The prevalence of shoulder complaints in the UK is around 14%, with 1–2% of adults consulting their general practitioner annually with new shoulder pain. Painful shoulders pose a substantial socioeconomic burden. This can impair capacity to work, causing time off, and affect performance of household tasks (Royal College of Surgeons).

5. The treatment aim for subacromial pain is to 'improve pain and function'. Success is defined individually with patients to include the degree of improvement needed, and the level of residual symptoms that might be acceptable. Outcome depends on starting level of symptoms, patient demographics and expectations, as well as personal circumstances.

6. NHS England Nov 2018: Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromioclavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

7. 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.

2.0 DEFINITIONS

2.1 Any definitions related to this Criteria Based Access Protocol (CBAP) are included as a Glossary at Appendix B.

3.0 ACCESS CRITERIA

3.1 Treatment will be supported when:

- The patient has undertaken a minimum of six months of conservative treatment documented by primary care, including a course of physiotherapy, self-management advice, NSAIDs and analgesia (unless intolerant) without improvement of symptoms;

AND

- Imaging has ruled out a significant rotator cuff tear;

AND

- Patients have been referred to the Musculoskeletal Triage Service;

AND

- Patients have been offered one subacromial injection. A second injection is occasionally appropriate after six 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.

AND

- Patients have been advised of the risks and benefits of the surgery and are fit and willing to undergo surgery.

4.0 EXCLUSIONS

4.1 There are no exclusions.

5.0 CASES FOR INDIVIDUAL CONSIDERATION

5.1 Should a patient not meet the criteria detailed within this protocol, the Policy for Individual Patient Treatments (which is available on the NHS Dorset Clinical Commissioning Group website or upon request), recognises that there will be occasions when patients who are not considered for funding may have good clinical reasons for being treated as exceptions. In such cases the requesting clinician must provide further information to support the case for being considered as an exception.

5.2 The fact that treatment is likely to be effective for a patient is not, in itself a basis for exceptional circumstances. In order for funding to be agreed there must be some unusual or unique clinical factor in respect of the patient that suggests that they are:

- significantly different to the general population of patients with the particular condition; and

- they are likely to gain significantly more benefits from the intervention than might be expected for the average patient with the condition

5.3 In these circumstances, please refer to the Individual Patient Treatment Team at the address below:

First Floor West
Vespasian House
Barrack Road
Dorchester
DT1 1TG
Telephone no: 01305 368936
Email: individual.requests@dorsetccg.nhs.uk

6.0 CONSULTATION

6.1 Prior to approval from Dorset CCG's Clinical Reference Group this Protocol was reviewed by the MSK Steering Group which includes commissioners, clinicians and other relevant stakeholders.

6.2 An Equality Impact Assessment for this Criteria Based Access Protocol is available on request.

7.0 RECOMMENDATION AND APPROVAL PROCESS

7.1 This access protocol has been approved on behalf of the Clinical Reference Group in line with processes agreed by the CCG's Governing Body.

8.0 COMMUNICATION/DISSEMINATION

8.1 Following approval of Criteria Based Access Protocols at Clinical Reference Group each Protocol will be uploaded to the CCG's Intranet, Internet and added to the next GP Bulletin.

9.0 IMPLEMENTATION

9.1 A communication will be sent to all providers to launch this new CBAP with an agreed implementation date. The implementation date will make allowance for those patients who may have been listed for surgery prior to the launch of this CBAP.

10.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

10.1 This Criteria Based Access Protocol requires a review every three years, or in the event of any changes to national guidance or when new guidance is issued.

10.2 This Protocol has been linked to the Dorset GP IT system and any future changes arising after review will need to be made via this system.

GLOSSARY

N/A

APPENDIX B

FREQUENTLY ASKED QUESTIONS

N/A

APPENDIX C

A	DOCUMENT DETAILS
Procedural Document Number	170
Author (Name and Job Title)	Tracy Hill, Principal Programme Lead
Recommending group	MSK Task and Finish Group / NHSE
Date of recommendation by CDG	December 2018
Date of approval	April 2019
Version	1.0
Review frequency	3 years
Review date	December 2021

B	CONSULTATION PROCESS		
Version No	**Review Date**	**Author and Job Title**	**Level of Consultation**
1.0		Tracy Hill, Principal Programme Lead	MSK Task and Finish Group, national consultation between July 2018 and November 2018 (NHSE)

C	VERSION CONTROL				
Date of recommendation	**Version No**	**Review date**	**Nature of change**	**Approval date**	**Approval Committee**
December 2018	1.0	December 2021	New protocol in line with NHS England Policy January 2019	April 2019	MSK Task & Finish Group / CRG

D	ASSOCIATED DOCUMENTS
• NHS England Policy for Evidence Based Interventions, January 2019 • NICE Accredited Guidance by The British Elbow and Shoulder Society • Policy for individual patient treatment, NHS Dorset Clinical Commissioning Group • Making sense of Local Access Based Protocols, NHS Dorset Clinical Commissioning Group	

E	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES	
Evidence	**Hyperlink (if available)**	**Date**
Other evidence and information can be found at p36 NHSE Evidence Based Interventions – Guidance for CCGs	https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf	January 2019

F	DISTRIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
Yes	Yes	Yes	Yes